



health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA



STRATEGIC PLAN 2020-2025

Final Draft
15 May 2020



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Foreword by the MEC for Health

The Department is committed to insure that people of Mpumalanga get the best and high level quality care, as mandated by The Constitution of the Republic of South Africa, 1996, that places obligations on the state to progressively realise socio-economic rights, including access to (affordable and quality) health care. This mandate is further expanded in the New MTSF 2019-2024 priority 3 Education, Skills and Health

As the country enters into the sixth administration of government mandated by the South African community, the department is dedicated to improve efficiency and effectiveness by strengthening collaborations with communities, private sector and other health care service providers to maximise resources and increase coverage for the benefit of communities to access quality health care. These developments lay a foundation for all stakeholders to work together towards achievement of departmental vision "A healthy long living Society".

It is important for the department to reflect on the milestones and challenges as a means to direct resources in a manner that is consistent with departmental priorities for better health services.

One of the biggest challenges that the Department is grappling with is the high number of people who still do not test for HIV and AIDS. In order to address this, the number of male and female condoms being distributed has been increased. Health awareness campaigns and in particular on HIV, AIDS, TB Voluntary Male Medical Circumcision and other diseases of life style have been intensified. Going forward in the new financial year; the Department will together with the Mpumalanga Provincial Aids Council and other key stakeholders, intensify health awareness campaigns. This will be achieved through the implementation of the HIV and AIDS turnaround strategy that the Department is working on.

One of the key targets of the Department is to ensure that maternal, infant and child mortality is reduced. The situation has tremendously improved on maternal mortality rate, whereas child mortality is of great concern.

In the new financial year, the Department will continue will priorities on Perinatal mortality to reduces under 5 mortalities as half of these fatalities contribute to under 5ys mortalities.

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Statement by the Head of Department (HoD)

The reduction of the **maternal and child mortality** rate is a priority, efforts to reduce the rates must focus on ensuring that every mother, woman and child receives a comprehensive package of care at the level of entry into the health system. The department should strengthen Baby Friendly Hospital Initiative and strive to increase the number of hospitals that achieves this status.

In the previous financial year of 2019/20; in August, the department established the first **Oncology** unit in the province since the dawn of democracy at Rob Ferreira tertiary hospital. This marked the beginning of the end of suffering for our people as they will no longer have to travel to Gauteng to access oncology services. Currently the hospital offers chemotherapy services and the plan to provide radiation therapy is underway. The construction of the new Witbank tertiary hospital will include a fully-fledged Oncology unit.

The department is working towards an **unqualified audit report**, as it only had one qualification on contingent liability, to this end the department developed an action plan to close all the gaps identified by AGSA and also deal with the rising litigation costs.

The department experienced a number of security incidences in the facilities across the province where staff members were at risk of being physically harmed by community members. The safety of the staff is a priority hence a focused approach to deal with this issue comprehensively with the support of other relevant sector departments.

I am aware of the conditions that our staff work under, due to shortage of resources and increased workload. The commitment and sacrifices of the staff is **appreciated** and as a department we should work together to take this department to new heights of quality service delivery.

The department undertakes to implement these plans and hereby commits to ensure that no effort is spared in the quest to achieve the targets.

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Official Sign Off

It is hereby certified that this **Strategic Plan** signed on the 18 March 2020:

- Was developed by the management of the [Name of Province] Department of Health under the guidance of [Name of the Executive Authority]
- Takes into account all the relevant policies, legislation and other mandates for which the [Name of Province] is responsible
- Accurately reflects the Impact, Outcomes and Outputs which the [Name of Province] Department of Health will endeavor to achieve over the period [years covered by the plan].

[Ms TR Zondo]

Signature:  _____

Manager Programme 1: Administration

[Ms SE Motau]

Signature:  _____

Manager Programme 2: District Health Services

[Mr NW Sithole]

Signature:  _____

Manager Programme 3: Emergency Medical Services

[Ms M Mohale]

Signature:  _____

Manager Programme 4: General (Regional) Hospitals, Programme 5: Tertiary and Central Hospitals, Programme 7: Health Care Support Services

[Mr B Magagula]

Signature:  _____

Manager Programme 6: Health Sciences and Training

[Mr EL Mokwane]

Signature:  _____

Manager Programme 8: Infrastructure

[Mr PP Mamogale]

Signature:  _____

Deputy Director General: Finance

[Ms MN Shabangu]

Signature:  _____

[Head Official responsible for Planning]

[Dr S Mohangi]

Signature:  _____

Accounting Officer

Approved by:

[Hon. SJ Manzini]

Signature:  _____

Executive Authority

PART A: OUR MANDATE

1. Constitutional Mandate

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

The Constitution of the Republic of South Africa, 1996, places obligations on the state to progressively realise socio-economic rights, including access to (*affordable and quality*) health care.

Schedule 4 of the Constitution reflects health services as a concurrent national and provincial legislative competence

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.

- People also have the right to access information if it is required for the exercise or protection of a right;
- This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and
- This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively

Section 27 of the Constitution states as follows: with regards to Health care, food, water, and social security:

- (1) Everyone has the right to have access to:
 - (a) Health care services, including reproductive health care;
 - (b) Sufficient food and water; and
 - (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
- (3) No one may be refused emergency medical treatment.

Section 28 of the Constitution provides that every child has the right to 'basic nutrition, shelter, basic health care services and social services'.

2. Legislative and Policy Mandates (National Health Act, and Other Legislation)

2.1. Legislation falling under the Department of Health's Portfolio

National Health Act, 2003 (Act No. 61 of 2003)

Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:

- unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
- provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services;
- establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation;
- promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and
- create the foundation of the health care system, and understood alongside other laws and policies which relate to health in South Africa.

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

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

Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973) - Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

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

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

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

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

SA Medical Research Council Act, 1991 (Act No. 58 of 1991) - Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

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

Choice on Termination of Pregnancy Act, 196 (Act No. 92 of 1996) - Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

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

Medical Schemes Act, 1998 (Act No.131 of 1998) - Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

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

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

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

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

Nursing Act, 2005 (Act No. 33 of 2005) - Provides for the regulation of the nursing profession.

Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007) - Provides for the establishment of the Interim Traditional Health Practitioners Council, and registration, training and practices of traditional health practitioners in the Republic.

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

2.2. Other legislation applicable to the Department

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 212 4(a) and 212 8(a) - Provides for establishing the cause of non-natural deaths.

Children's Act, 2005 (Act No. 38 of 2005) - The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court.

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

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993) - Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

National Roads Traffic Act, 1996 (Act No.93 of 1996) - Provides for the testing and analysis of drunk drivers.

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

State Information Technology Act, 1998 (Act No.88 of 1998) - Provides for the creation and administration of an institution responsible for the state's information technology system.

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

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

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

Promotion of Administrative Justice Act, 2000 (Act No.3 of 2000) - Amplifies the constitutional provisions pertaining to administrative law by codifying it.

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000)
Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

Division of Revenue Act, (Act No 7 of 2003) - Provides for the manner in which revenue generated may be disbursed.

Broad-based Black Economic Empowerment Act, 2003 (Act No.53 of 2003) - Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

Labour Relations Act, 1995 (Act No. 66 of 1995) - Establishes a framework to regulate key aspects of relationship between employer and employee at individual and collective level.

Basic Conditions of Employment Act, 1997 (Act No.75 of 1997) - Prescribes the basic or minimum conditions of employment that an employer must provide for employees covered by the Act.

3. Health Sector Policies and Strategies over the five year planning period

3.1. National Health Insurance Bill

South Africa is at the brink of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system in order to realise Universal Health Coverage. To achieve Universal Health Coverage, institutional and organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups.

In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator and a proxy outcome of any country's progress towards Universal Health Coverage.

The phased implementation of NHI is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable and quality health services.

An external evaluation of the first phase of National Health Insurance was published in July 2019. Phase 2 of the NHI Programme commenced during 2017, with official gazetting of the National Health Insurance as the Policy of South Africa. The National Department of Health drafted and published the National Health Insurance Bill for public comments on 21 June 2018. During August 2019, the National Department of Health sent the National Health Insurance Bill to Parliament for public consultation.

3.2. National Development Plan: Vision 2030

The National Development Plan (Chapter 10) has outlined 9 goals for the health system that it must reach by 2030. **The NDP goals are best described using conventional public health logic framework. The overarching goal that measures impact is "Average male and female life expectancy at birth increases to at least 70 years". The next 4 goals measure health outcomes, requiring the health system to reduce premature mortality and morbidity. Last 4 goals are tracking the health system that essentially measure inputs and processes to derive outcomes**

Figure 1: NDP Logical frame work

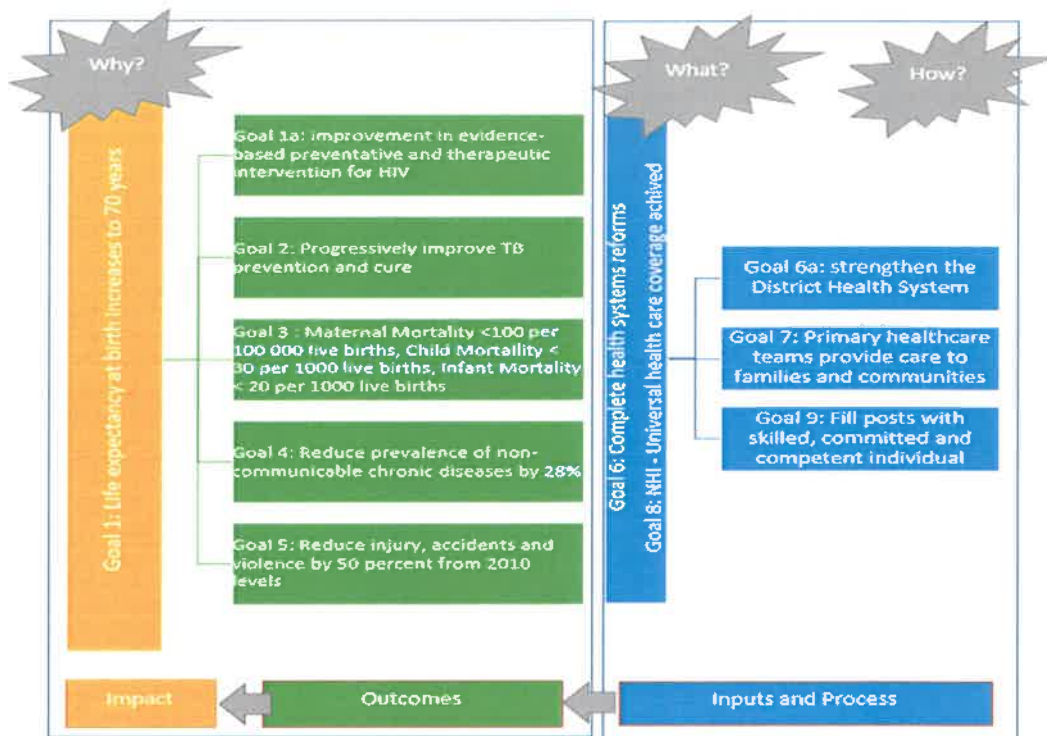
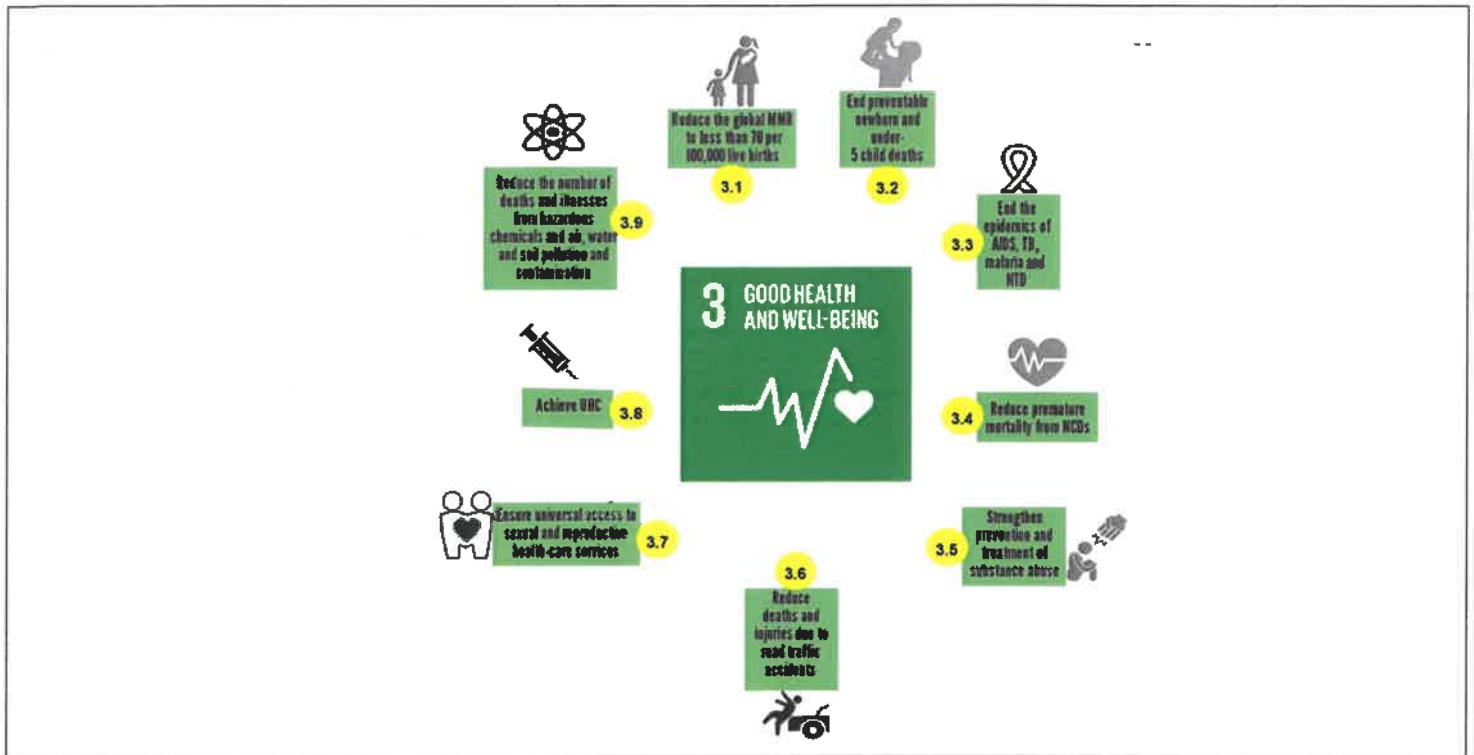


Figure 2: Sustainable Development Goals



Source Sustainable Development Goals

South Africa is one of the 193 (hundred and ninety-three) signatories to United Nations and adopted new agenda for 2030 Sustainable Development, entitled to transform the world. These Global Goals include ending extreme poverty, giving people better healthcare, and achieving equality for women. Goal no 3 is directly linked to health sector and they are as follows:

Goal 3. Ensure healthy lives and promote well-being for all at all ages

- (1) 3.1 - By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- (2) 3.2 - By 2030, end preventable deaths of new borns 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) 3.3 - By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- (4) 3.4 - By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- (5) 3.5 - Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- (6) 3.6 - By 2020, halve the number of global deaths and injuries from road traffic accidents
- (7) 3.7 - 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
- (8) 3.8 - 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
- (9) 3.9 - By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- (10) 3.a - Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- (11) 3.b - 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

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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

- (12) **3.c - 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**
- (13) **Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks**

3.3. Medium Term Strategic Framework and NDP Implementation Plan 2019-2024

The plan comprehensively responds to the priorities identified by cabinet of 6th administration of democratic South Africa, which are embodied in the Medium-Term Strategic Framework (MTSF) for period 2019-2024. It is aimed at eliminating avoidable and preventable deaths (*survive*); promoting wellness, and preventing and managing illness (*thrive*); and transforming health systems, the patient experience of care, and mitigating social factors determining ill health (*thrive*), in line with the United Nation's three broad objectives of the Sustainable Development Goals (SDGs) for health.

Over the next 5 years, the Provincial Department of Health's response is structured into 2 impacts, 4 goals and 10 Health Sector Strategy. These goals and strategic objectives are well aligned to the Pillars of the Presidential Health Summit compact, as outlined in the table below.

Table 1: Sector MTSF 2019-2024 impacts

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
Survive and Thrive	Life expectancy of South Africans improved to 70 years by 2030	Goal 1: Increase Life Expectancy improve Health and Prevent Disease	<ol style="list-style-type: none"> 1. Improve health outcomes by responding to the quadruple burden of disease of South Africa 2. Inter sectoral collaboration to address social determinants of health 	N/A
Transform	Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030	Goal 2: Achieve UHC by Implement NHI	3. Progressively achieve Universal Health Coverage through NHI	Pillar 4: Engage the private sector in improving the access, coverage and quality of health services; and Pillar 6: Improve the efficiency of public sector financial management systems and processes
		Goal 3: Quality Improvement in the Provision of care	4. Improve quality and safety of care	Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care.
			5. Provide leadership and enhance governance in the health sector for improved quality of care	Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels
		6. Improve community engagement and reorient the system towards Primary Health Care through community based health Programmes to promote health	Pillar 8: Engage and empower the community to ensure adequate and appropriate community based care	

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	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
			7. Improve equity, training and enhance management of Human Resources for Health	Pillar 1: Augment Human Resources for Health Operational Plan
			8. Improving availability to medical products, and equipment	Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery Pillar 6: Improve the efficiency of public sector financial management systems and processes
			9. Robust and effective health information systems to automate business processes and improve evidence based decision making	Pillar 9: Develop an Information System that will guide the health system policies, strategies and investments
		Goal 4: Build Health Infrastructure for effective service delivery	10. Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities	Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities

4. Relevant Court Rulings

Table 2. : Litigation pending cases that may impact on resources of Department in the coming financial year 2020/2021

File type	Court date	Amount	Status
1.Cerebral palsy	20/05/2020	R14 000 000	Still to be heard
2.Cerebral palsy	20/02/2020	R29 790 037.50	Postponed sine die
3. Orthopaedics	28/06/2019	R200 000	Postponed sine die
4.Cerebral palsy	04/11/2019	R4 240 000	Postponed sine die
5.Cerebral palsy	07/11/2019	R7 500 000	Postponed sine die
6.Cerebral palsy	24/06/2019	R29 790 037 50	Postponed sine die
7.Orthopaedic	15/04/2019	R1 555 000	Matter settled out of court
8.Cerebral palsy	03/ 06/2019	R20 000 000	Postponed sine die
9.Celebral palsy	18/09 /2019	R30 000 000	Removed from the roll
10.Celebral palsy	14/ 10/ 2019	R32 000 000	Merits conceded at 85 % awaiting Set down for quantum
11. Cerebral palsy	28/01/2020	R11 500 000	Postponed sine die
12.Cerebral palsy	13/05/2019	R21 500 000	Postponed sine die
13.Cerebral palsy	02/09/2019	R21 500 000	Postponed sine die
14. Orthopedic	14/10/ 2019	R5 050 000	Postponed to November 2020
15. Cerebral palsy	11/10/2019	R19 740 000	Removed from the roll

PART B: OUR STRATEGIC FOCUS

5. Vision

"A healthy long living Society"

6. Mission

To provide sustainable health services that are people-centric and aims at ensuring healthier, longer and better lives focusing on access, equity, efficiency and quality for the inhabitants of Mpumalanga

7. Values

The department is committed to enhance quality and accessibility by improving efficiency and accountability. The following Batho Pele principles are adopted by the department as values to apply when rendering service to south African community.

- **Consultation:** citizens should be consulted about their needs
- **Standards:** all citizens should know what service to expect
- **Redress:** all citizens should be offered an apology and solution when standards are not met
- **Accessible:** all citizens should have equal access to services
- **Courtesy:** all citizens should be treated courteously
- **Informative:** all citizens are entitled to full, accurate information
- **Openness and transparency:** all citizens should know how decisions are made and departments are run
- **Value for money:** all services provided should offer value for money

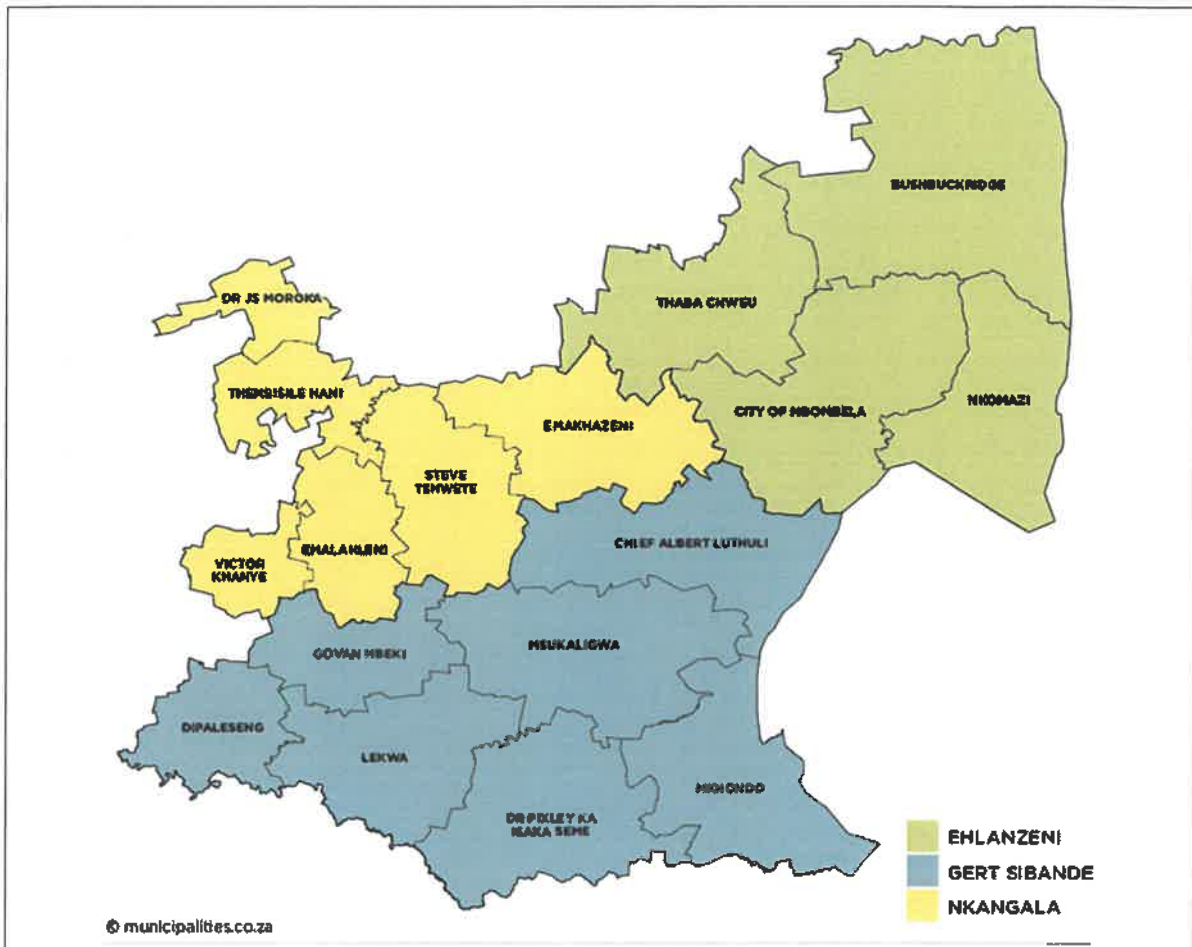
8. Situational Analysis

8.1. Overview of Province

Mpumalanga, the second-smallest province in South Africa after Gauteng, is in the north-eastern part of the country, bordering Swaziland and Mozambique to the east. It also borders Limpopo, Gauteng, Free State and KwaZulu-Natal within South Africa. Mbombela (previously Nelspruit) is the capital of the province and the administrative and business centre of the Lowveld. Other major cities and towns include eMalahleni (previously Witbank), Standerton, eMkhondo (previously Piet Relief), Malalane, Ermelo, Barberton and Sabie. The best-performing sectors in the province include mining, manufacturing and services. Tourism and agro-processing are potential growth sectors. Agriculture in Mpumalanga is characterised by a combination of commercialized farming, subsistence and livestock farming, and emerging crop farming. Crops such as subtropical fruits, nuts, citrus, cotton, tobacco, wheat, vegetables, potatoes, sunflowers and maize are produced in the region. Mpumalanga is rich in coal reserves and home to South Africa's major coal-fired power stations. eMalahleni is the biggest coal producer in Africa and is also the site of the country's second oil-from-coal plant after Sasolburg. Most of the manufacturing production in Mpumalanga occurs in the southern Highveld region. In the Lowveld sub-region, industries are concentrated around the manufacturing of products from agricultural and raw forestry material*

Table 3: Demographic data and attached map of mpumalanga

Demographic Data	MP	Unit of Measure
Geographical area	76 495	Km2
Total population SA Mid-year estimates 2018	4 447 743	Number
Population density (SA Mid-year estimates 2018)	190	Per Km ²
Percentage of population with medical insurance (DHB 2016/17)	40,2	%



8.2. Strategic Approach

The department identified 2 streams of focus which is burden of diseases, imbalances/ transformation in health care, quality of services and status of health infrastructure to identify problem areas there by using the 5 whys panning technique. The department further utilized problem tree solution to arrive on 2 impact statements. The following impact statements were identified as critical to effectively improve on service deliver:

Impact 1: Life expectancy of South Africans Improved to 70 years by 2030

Impact 2: Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030

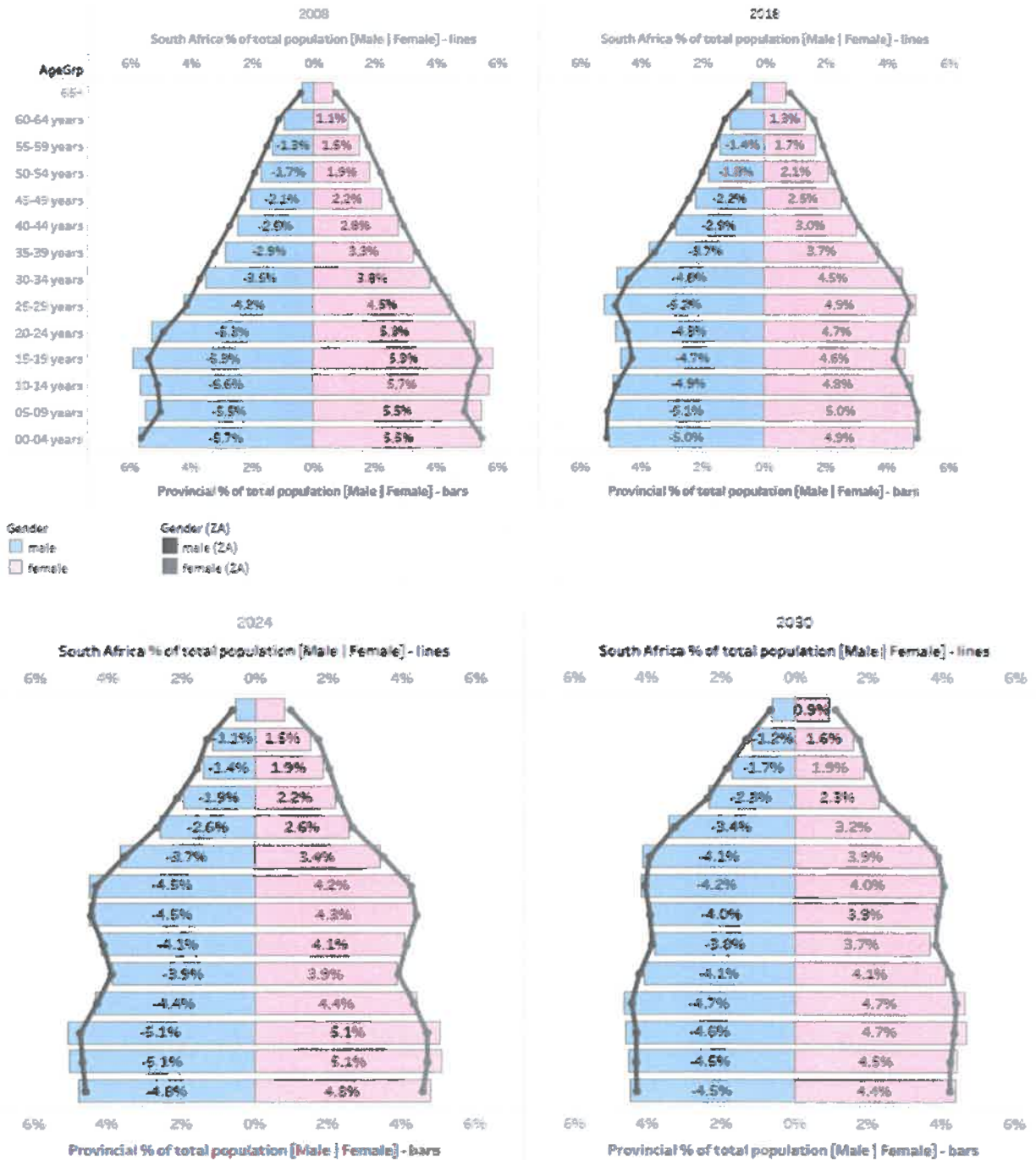
A combination of PESTEL and SWOT analysis techniques was utilized to scan the environment there by identifying areas of focus to strengthen evidence based planning

8.3. External Environmental Analysis

Figure 3: Mpumalanga Demographic data (population by ages-gender

Provincial % population by age-gender group compared to South Africa

MP



As per the table 8.2.1, there is a fair balance of population for both male and female from the age of 0-4 years to 40-44 years. From age of 45-49 upwards there is slight decrease of male population as compared to female. This decrease also explains life expectancy variance between males and female as reflected on table 8.2.2 estimated at 60.6 males and 66.1 females in

2016-2021. It also worth noting that mortality affect more males than females. This status quo may also contribute to an increase in household headed by female as reflected on table 8.2.3 from 39.9 in 2011 to 50.7 in 2016.

8.3.1. Social Determinants of Health for Province and Districts

Globally, it is recognized that health and health outcomes are not only affected by healthcare or access to health services. They result from multidimensional and complex factors linked to the social determinants of health which include a range of social, political, economic, environmental, and cultural factors, including human rights and gender equality.

Health is influenced by the environment in which people live and work as well as societal risk conditions such as polluted environments, inadequate housing, poor sanitation, unemployment, poverty, racial and gender discrimination, destruction and violence*

Political factors

The Health system is impacted by many political factors that include amongst others political stability of the province, high level of inequality in the communities and effects of apartheid in black communities as people affected the most.

The political head of health continues to provide leadership through community engagement to ensure that communities are well-informed with health care programs, progress and departmental challenges in the institution. The programs for stakeholder engagement includes amongst others is **open day activities in all hospitals** where communities are informed of services rendered in the institution, community complaints are addressed and future plans are discussed.

The community protest in relation to service delivery is a concern where workers are blocked from rendering services and some health facilities services are disrupted and forced to close during working hours. However, there is effective communication channels such as top management **whatsapp group** established by Head health, where managers provide instant information to executive management and strategies are communicated to ensure that communities are provided a service despite this challenging environment.

The change in leadership continues to be a challenge as it is in all other public institution because continuity is mostly affected and critical programs are dropped in favour of new programs which require time and money to understand and implement.

The Department does have a zero tolerance in fraud and corruption and is continues to use the National Anti-fraud & Corruption Hotline facility in order to:

- Deter potential fraudsters by making all employees and other stakeholders aware that the MDoH is not a soft target, as well as encouraging their participation in supporting, and making use of such a facility;
- Raise the level of awareness that the Mpumalanga Department of Health is serious about fraud, corruption, theft, maladministration or any other dishonest activity;
- Detect incidents by encouraging whistle blowers to report incidents that they witness;

Presidential hotline was established in 2009 to create an interactive accessible and responsive government where members of the public use tollfree hotline no 17737 to lodge complaints and queries. The department continues to monitor all complaints and provide response or action appropriate to issues raised.

Economic Factors

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

- Emalahleni – mining, steel manufacturing, industry, agriculture;
- Middelburg – stainless steel production, agriculture;
- Secunda – power generation, coal processing;

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- Mashishing – agriculture, fish farming, mining, tourism;
- Malelane – tourism, sugar production, agriculture; and
- Barberton – mining town, correctional services, farming centre.

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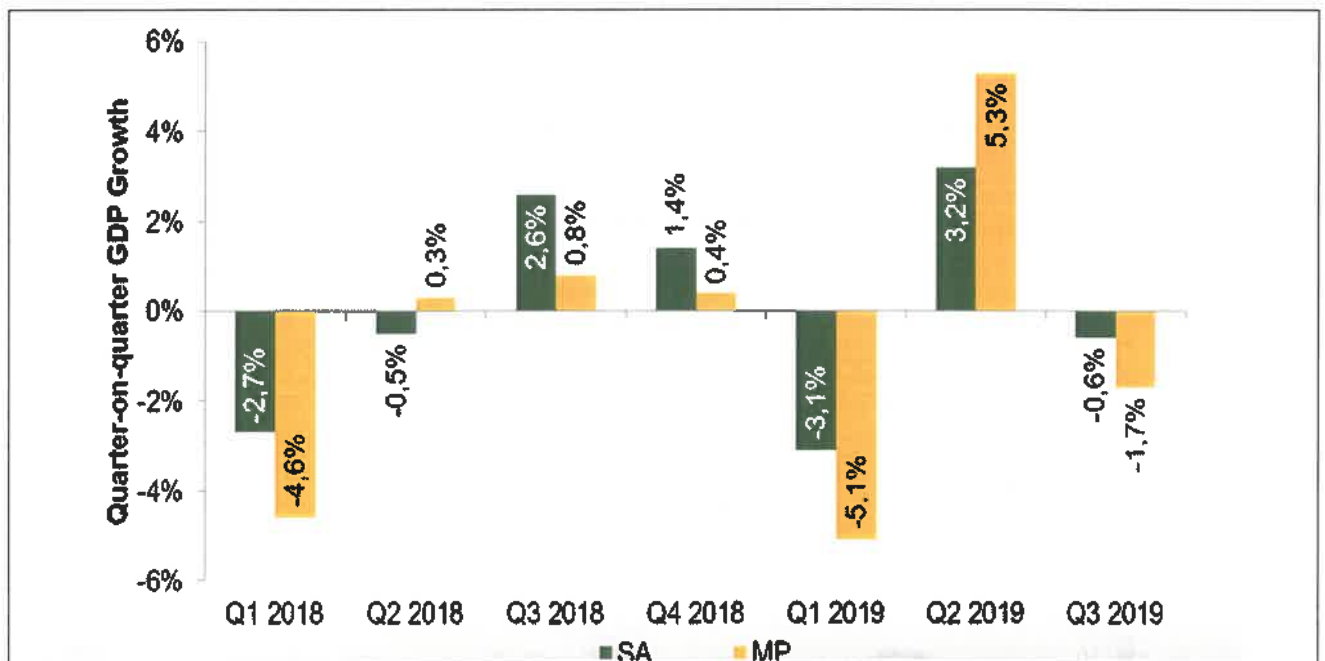
Table 4: SA growth per industry in 2nd quarter 2018 to 3rd quarter 2019

Economic industry	Growth % quarter-on-quarter (seasonally adjusted and annualised)					
	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Agriculture	-42.3%	13.7%	7.9%	-16.8%	-4.2%	-3.6%
Mining	8.1%	-8.9%	-3.8%	-10.8%	17.4%	-6.1%
Manufacturing	1.4%	7.5%	4.5%	-8.8%	2.1%	-3.9%
Utilities (electricity/gas/water)	0.7%	0.8%	0.2%	-7.4%	3.2%	-4.9%
Construction	1.5%	-1.7%	-0.7%	-2.0%	-1.4%	-2.7%
Trade	-1.2%	3.4%	-0.7%	-3.6%	3.4%	2.6%
Transport and communication	-3.8%	6.8%	7.7%	-4.4%	-0.3%	-5.4%
Finance	1.7%	2.1%	2.7%	1.1%	4.1%	1.6%
General government services	0.2%	1.9%	-0.6%	2.4%	3.2%	2.4%
Personal services	0.8%	0.6%	1.7%	1.1%	0.8%	0.4%
Total	-0.5%	2.6%	1.4%	-3.1%	3.2%	-0.6%

Source: SERO report 2018/19

The table above indicate strains in the economic growth of the province in Agriculture, Mining, Manufacturing, Utilities, Construction and Transport & communication which will affect employment of communities and bring deterioration in their living condition. This will impact on status of health many people. It must also be noted that only General Government Services and Personal services seem to be consistently growing making communities to be more reliant on government services for a living. Mpumalanga is not exception to this situation as reflected in Paragraph below.

Figure 4: SA and Mpumalanga comparison in 1st quarter 2018 to 3rd Quarter 2019



Source: SERO report 2018/19

Social Factors

In South Africa and Mpumalanga inequalities exist in socio economic status and in access to basic services are exacerbated by inequalities in health. As depicted in the graph below percentage of people living in poverty continues to grow and share income by poorest 40% of household is stable. This indicate that more people cannot afford for their medical bills and are reliant on public health

Table 5: Comparative provincial ranking income below poverty line

INDICATOR	Vision 2030 target	Baseline - 2014	2018	Trend 2014-2018	Comparative provincial ranking (1=best & 9=worst)
Number of grant recipients	-	1.32 million	1.49 million		6
Percentage of people in poverty (LBPL)	Reduce the % of households with income below poverty income to 5%	41.9%	46.4%		6
Share of income earned by poorest 40% of households	The % of income earned by poorest 40% should rise to 10%	7.8%	7.8%		3
Gini-coefficient	-	0.61	0.60		2
Human Development Index (HDI)	-	0.59	0.61		6

Source: SERO report 2018/19

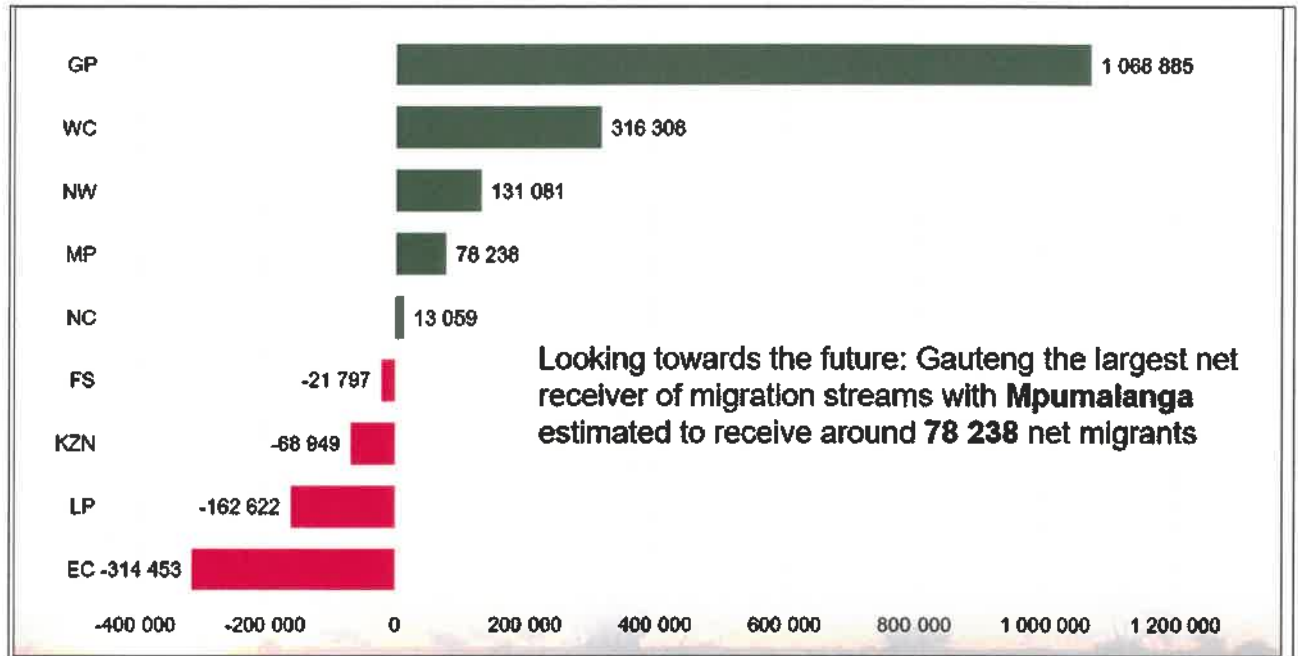
The health care service in Mpumalanga was directly affect by crime that took place in some of health facilities specifically in Nkangala where health personnel and patients were attacked within hospital premises, facility such as computers equipment's were stolen. This affected safety and security of health personnel which prompted intervention from other stakeholder engagement on this matter. The department of Health, in collaboration with Department of Education, Department of Community Safety and Liaison and Organized Labour conducted Safety Indaba which developed safety intervention plan.

Alcohol and substance abuse continues to be a challenge in the country which also affect the provinces. There is a rise of statistic this effect as reflected in on table 5: leading cause of death where population 05-49 years die due to hypertension, low respiratory infection and TB. This means that more resources need to be allocated to educate, screen and put patients on treatment.

Mpumalanga do serve people and communities from across the provincial boundaries of the province, where the nearest facilities are within province. A more complicated phenomenon is where the province is providing health services to neighbouring countries on the borders of Swaziland and Mozambique. Although these exact numbers are not known, these instances place an additional burden on the staff and the facilities Cross boarder migration. Taking all aspects into consideration, it would difficult to adopt or implement standards and norms blindly as it will be unreasonable to apply these standards without considering additional information and facts, in order to provide a sustainable as well as an affordable health service to the community. Net migration in the country indicate that there is immigration in Mpumalanga, Gauteng,

Northwest and Western Cape whereas Free State, KZN, Limpopo and Eastern Cape are experiencing emigration as per table below. This indicate that South African Population may not be enough for planning and equitable resource allocation.

Figure 5: Net migration per province from 2016-2021



Source: Sero Report 2018/19

The injuries and deaths due to Motor vehicle accidents is a major concern across the country especially during festive season which is characterized by increased traffic volumes, offenses such as drinking and driving. during festive season of 1 December 2018 to 8 January 2019 South Africa recorded 1612 deaths on roads and Mpumalanga contributing by 124. It is recorded that 58% of those accidents involved alcohol country wide.

Technological factors

Digitization of medical equipment in health facilities is critical for access to health care service especially to rural communities who travel distances to access health care. The department is also in the process of implementing Telemedicine to 20 sites in the next 5 years. This is a remote diagnosis and treatment of patient by means of technology where patients at lower level receive a direct access of specialized services at the comfort of their nearest clinic or facility instead of travelling long distance to receive medical care.

Social media such as Facebook, Instagram and twitter in this current dispensation continues to be more effective to market health care services, identify and communicate health challenges such as outbreaks, service delivery protest that are hindering continuity of care and also used as effective tool to give management directives when need arise. It must be noted that this innovative channels of communication also come with disadvantages such as fake news that may directly impact on health service and lives of people. The department must continue to engage and monitor such news to ensure that communities are provided with correct information.

With the advent of 4th Industrial Revolution (4IR) which focus on artificial intelligence and robotic systems, it is highly important for the province to invest in this technology to augment departmental work force where skilled human resources are lacking or insufficient.

Environmental Factors

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Mpumalanga province has been identified as having the highest levels of air pollution on Nitrogen Oxide levels across six continents in the world as per Greenpeace report conducted in 01 June to 31 August 2018. coal mines, transport and Eskom coal fire power stations have been identified as major source of pollution. This challenge poses a threat to mining communities that are likely to be affected by Non Communicable Diseases such as among cardio vascular diseases, respiratory infections, cancer and diabetes.

Ehlanzeni district is sharing a boarder with Mozambique and Swaziland which are malaria endemic countries. The district also shares the boarder with Limpopo province which is also a malaria endemic province. The department signed a memorandum of understanding with Mozambique, Swaziland and Limpopo province for collaboration in the management of malaria and other health related issues.

Legal Factors

The increase in medical litigation claims has both direct and indirect implications on financial sustainability of health care services in the public sector. This challenge takes away financial resources of the department where resources meant for service delivery are directed to payment of litigation and legal fees. The department will continue to monitor and address malpractices through adverse events committees to ensure that these cases are prevented in future and that those who are non-compliant with prescripts are held accountable.

Section 27 of the Constitution of South Africa act no 108 of 1996 states that; every person has the right "to have access to health care services, including reproductive health care". No person "may be refused emergency treatment". To effect this constitutional obligation, the department has established a complaints management system and MECs hotline "0800 111 151" to monitor the provision of accessible quality health care.

Table 6: Social determinants of health summary per district

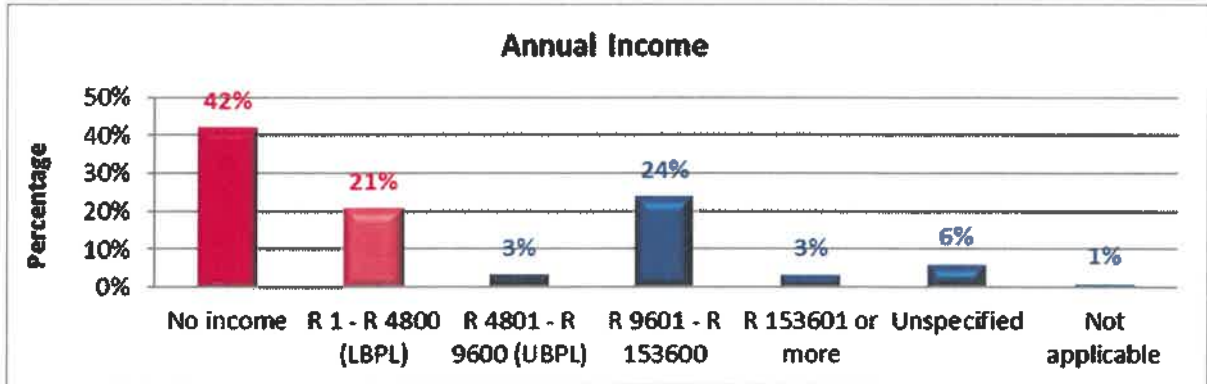
	Mpumalanga		mp Ehlanzeni District Municipality	mp Gert Sibande District Municipality	mp Nkangala District Municipality
	Census 2011	CS 2016	CS 2016	CS 2016	CS 2016
Female Headed Household	39,9%	50,7%	54,7%	48,4%	47,4%
Child headed household	0,9%	0,4%	0,6%	0,3%	0,2%
Household head older than 65 years	11,5%	14,2%	4,1%	11,8%	11,2%
Informal dwelling	10,6%	8,5%	1,5%	7,4%	2,5%
Traditional dwelling	4,4%	3,4%	14,0%	14,1%	14,6%
Household with no access to piped (tap) water	12,4%	8,8%	15,5%	10,2%	9,3%
Household with no electricity for lighting	14,1%	8,0%	3,6%	11,3%	10,7%
Household with no flush toilet connected to sewerage	58,4%	60,4%	84,5%	36,0%	50,3%
Household with no access to refuse removal	56,0%	60,1%	79,5%	42,6%	50,2%
No schooling	9,0%	17,6%	19,9%	16,8%	15,3%
Matric	20,3%	21,1%	19,6%	20,6%	23,3%
Higher education	3,0%	4,8%	4,2%	4,9%	5,5%

Source: Census 2016

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The above table provides a summary of social determinants of health which are critical to the provision of health care services. The decrease on informal and traditional dwellings as well as households with no access to piped (tap) water and electricity brings hope towards lessening effects of social determinants of health. The increase on households headed by 65-year-old persons from 11.5% to 14.2%, households with no flush toilet connected to sewerage from 58.4% to 60.4% and households with no access to refuse removal from 56% to 60.1% is a cause for concern.

Figure 6: Annual Income



Source: Census 2016

The above table reflect that 73% of people in Mpumalanga cannot afford medical aid. This includes 42% of those who do not have an income and 12% who earn from 1-4800 rand. This means that they rely on public health care service.

8.3.2. Epidemiology and Quadruple Burden of Disease

Epidemiologically, South Africa is confronted with a quadruple Burden of Diseases due to HIV & AIDS and TB pandemic, high maternal and child morbidity and mortality, rising non-communicable diseases and high levels of violence and trauma.

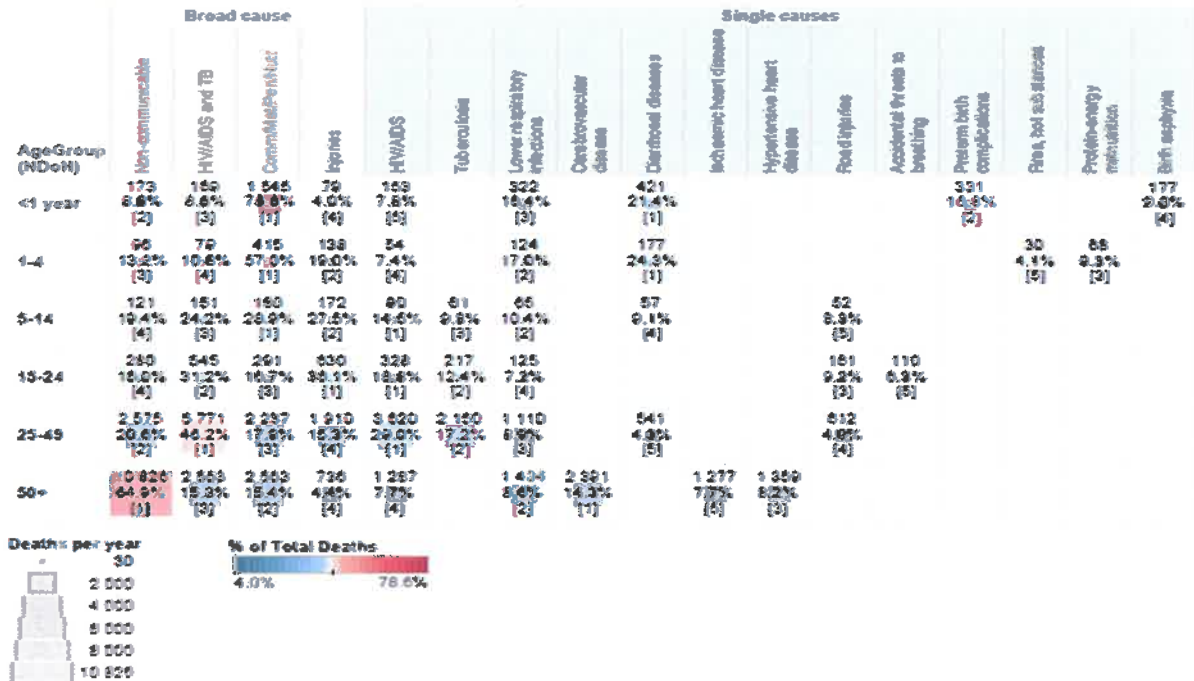
Years of Life Lost

Years of Life Lost (YLLs) are an estimate of premature mortality based on the age at death and thus highlight the causes of death that should be targeted for mortality prevention. The biggest contributor to YLL in Mpumalanga is Non Communicable Diseases followed by HIV & AIDS and TB dominated by 25-49yrs group, and other viral diseases.

Tuberculosis maintained its rank as the leading cause of death in South Africa. Diabetes mellitus was the second leading natural cause of death, followed by other forms of heart disease and cerebrovascular disease. Human immunodeficiency virus (HIV) disease is in the fifth position. Overall, the results show a considerable burden of disease from non-communicable disease mostly affecting 50-year and above age group. The other cause for concern is perinatal mortality at 78.6% affecting under 1-year group and children between 1-4 at 57%.

Table 7: Leading causes of Death

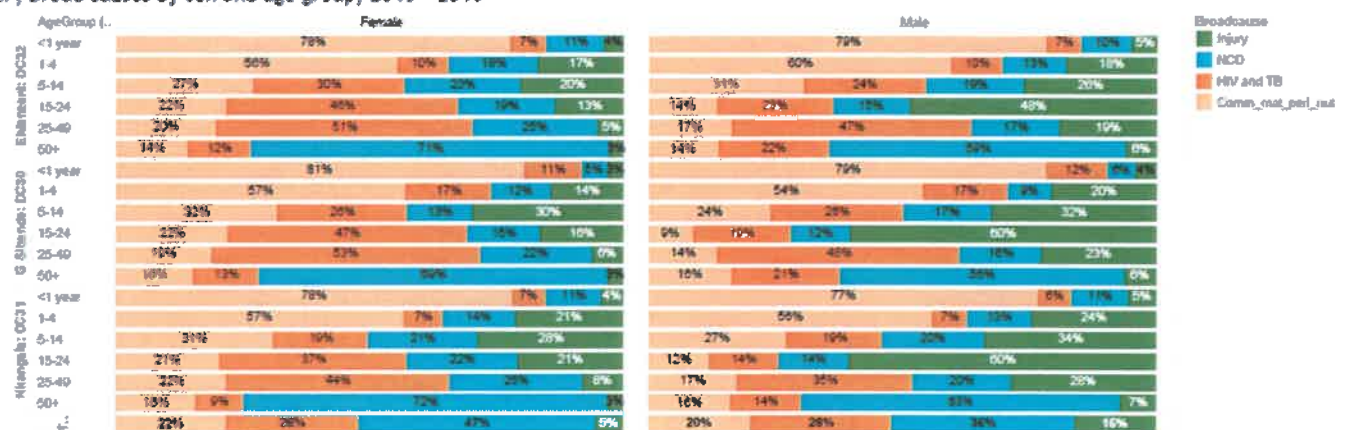
Leading causes of death by age group (Broad cause & Single causes), 2013 - 2015: MP
Average number of deaths per year, % of total and [rank] per age group



Source: District Health Barometer 2017/18

Figure 7: Broad cause of death by sex and age group

MP, Broad causes by sex and age group, 2013 - 2015



Source District Health Barometer 2017/18

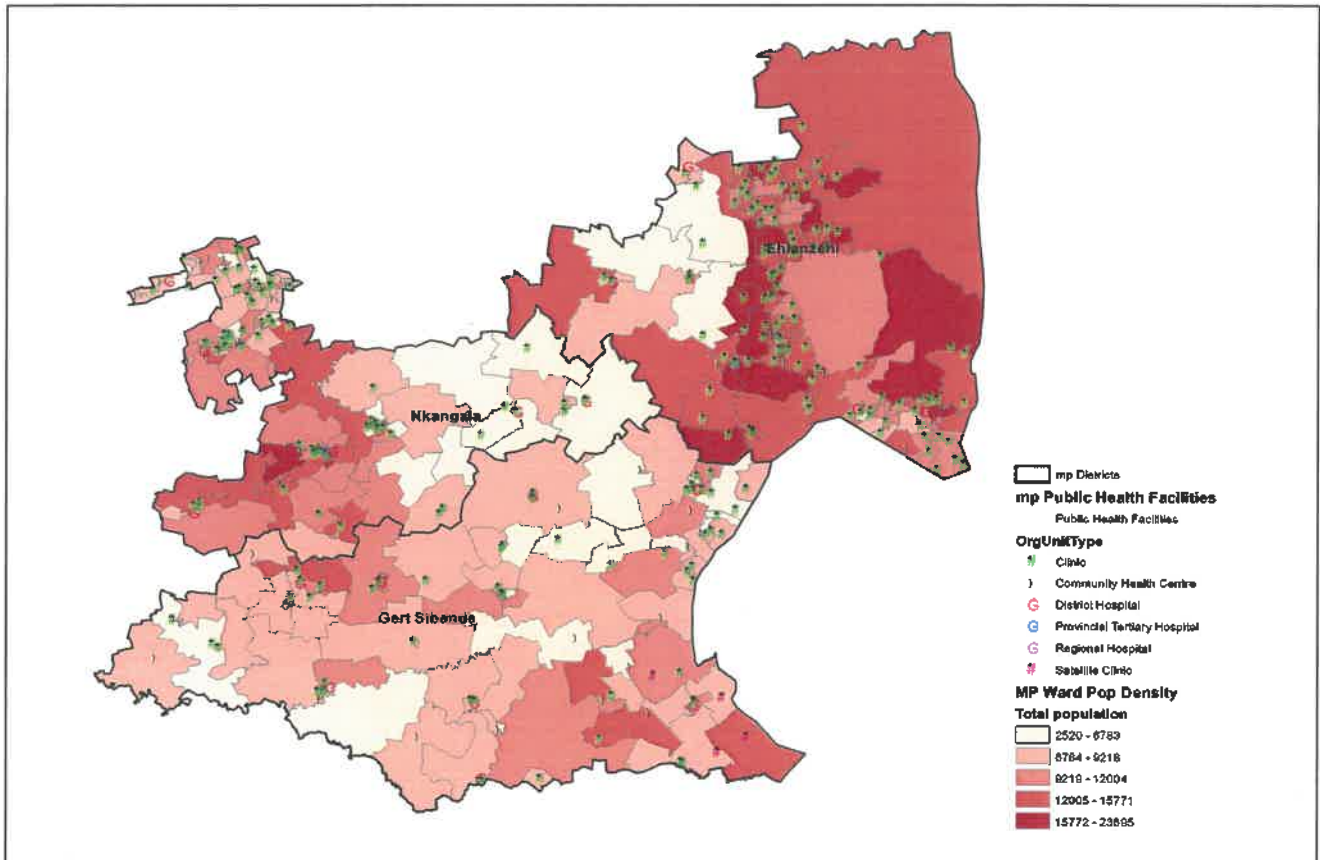
The above graph shows Non-communicable diseases as one the leading cause of death includes amongst others **cardiovascular diseases, chronic respiratory diseases, cancer and diabetes**. Key risk factors contributing to NCD are unhealthy diet, tobacco use, harmful use of alcohol and physical inactivity. Nkangala district is the most affected in this regard when compared to the other two districts.

The department will continue to invest in healthy lifestyle and health promotion programmes. The department will continue to monitor the incidence of diabetes and hypertension to determine the impact of these interventions.

HIV and AIDS mainly affects the 15-49 years' age group as compared to other age groups. The department has implemented a combination of HIV prevention methods and bio-medical interventions to prevent new HIV infections and to reduce HIV related morbidity and mortality. However, the uptake of both HIV testing and antiretroviral treatment (ART) initiation remains low among males and the youth, whilst HIV incidents among females (15-24 years) remain higher compared to the males of the same age group. Furthermore, viral load suppression is higher among females compared to males. In response to these realities, the Department, through the Phuthuma Project, is targeting men through index testing and targeted testing for HIV testing and ART initiation. Community HIV testing and HIV Self screening is implemented in men dominated and youth dominated communities and institutions. This will reduce the HIV mortality which is high among these age groups 15-24 years and 24-64 years.

8.4. Internal Environmental Analysis

Figure 8: Service Delivery Platform/Public Health Facilities map



Source: DHB 2017/18

Mpumalanga is unique in terms of the type of residential areas in the province. The population is scattered across the province and the types of populated areas differ from formal residential areas, such as in and around towns, as well as scattered villages and rural communities, as may be evidenced in the map above:

Table 8: Number of facilities per district

Facility type	Ehlanzeni	Gert Sibande	Nkangala	Total
Clinic	108	54	69	231
CHC	15	22	22	59
Satellite clinic	2	5	-	7
Mobile clinic	39 (953 points) 24 non-functional cars)	31 (924 points) 2 non-functional cars	22 (320 points) 9 non-functional cars	92 (2190 points)
District hospital	8	8	7	23
Regional hospital	2	1	-	3
Tertiary hospital	1	-	1	2
Specialized TB hospital	2	2	1	5
EMS station	14	13	13	40

In line with the accessibility standards for Integrated Health Facility Planning Framework, 90% of the population should have access to a Primary Health Care facility within 5km radius (5km for clinics and 15km for CHC's). The IHPF further indicates that there should be a clinic for an average minimum population of 8000 to 10,000, and a Community Health Centre for a minimum population of 50 000 to 60 000. Approximately 142 of clinics in the province are situated within the range of 10,000 – 15,000 catchment population. This further suggests that there are still communities that are underserved in the area of Primary Health Care. However, mobile services are used to increase access to primary health care services.

Ehlanzeni district

Ehlanzeni district has an estimated total population of 1 743 182 with five sub-districts. It is the largest of the three district that constitute Mpumalanga province. The service delivery platform includes, 01 (one) tertiary hospital, 2 (two) regional hospitals, 2 (two) TB Specialized hospitals, 08 (eight) district hospitals, 15 (fifteen) CHCs, 108 (one hundred and eight) clinics and 39 (thirty- nine) mobile clinics with 953 (nine hundred and fifty- three) points.

Gert Sibande district

Gert Sibande district has an estimated total population of 1 210 593 with 07 (seven) sub-districts. It is the smallest of the three district that constitute Mpumalanga province. The service delivery platform includes 01 (one) regional hospitals, 2 (two) TB Specialized hospitals, 08 (eight) district hospitals, 22 (twenty- two) CHCs, 54 (fifty- four) clinics and 20 (twenty) mobile clinics with 911 (nine hundred and eleven) points

Nkangala district

Nkangala district has an estimated total population of 1 210 593 with 06 (six) sub-districts. The service delivery platform includes 01 (one) Tertiary hospital, 01 (one) TB Specialized hospitals, 07 (seven) district hospitals, 22 (twenty- two) CHCs, 69 (sixty- nine) clinics and 22 (twenty- two) mobile clinics with 320 (three hundred and twenty) points

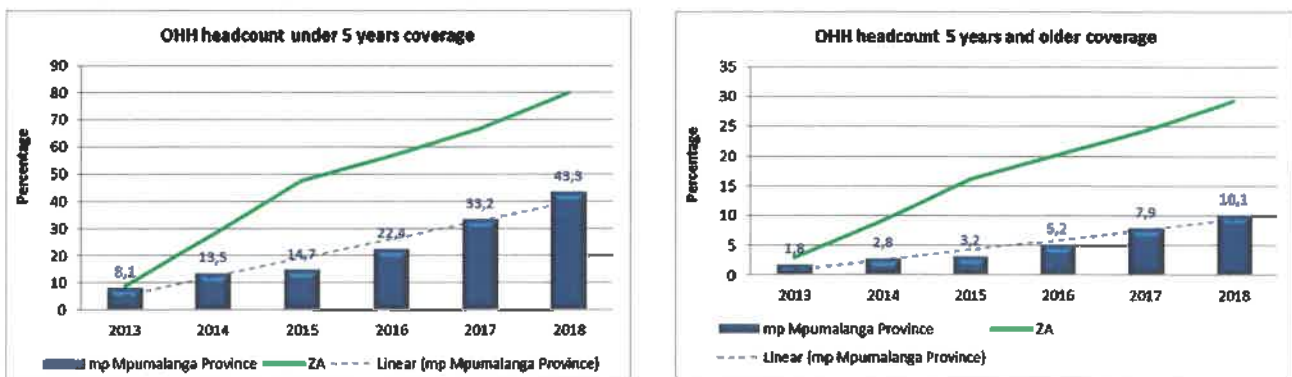
**8.4.1. Universal Health Coverage (Population and Service Coverage)
Community Health Workers Programme**

WBPHCOTs are linked to a PHC facility and consist of CHWs lead by a nurse. CHWs assess the health status of individuals and households and provide health education and promotion service. They identify and refer those in need of preventive, curative or rehabilitative services to relevant PHC facilities*

Outreach Visits

Support visit types monitor the different types of basic health care provided to households as proportion of total number households visited by the WBPHCOT. Most of the household visits are for child health and adherence support.

Figure 9: OHH Headcount coverage



Source: DHIS

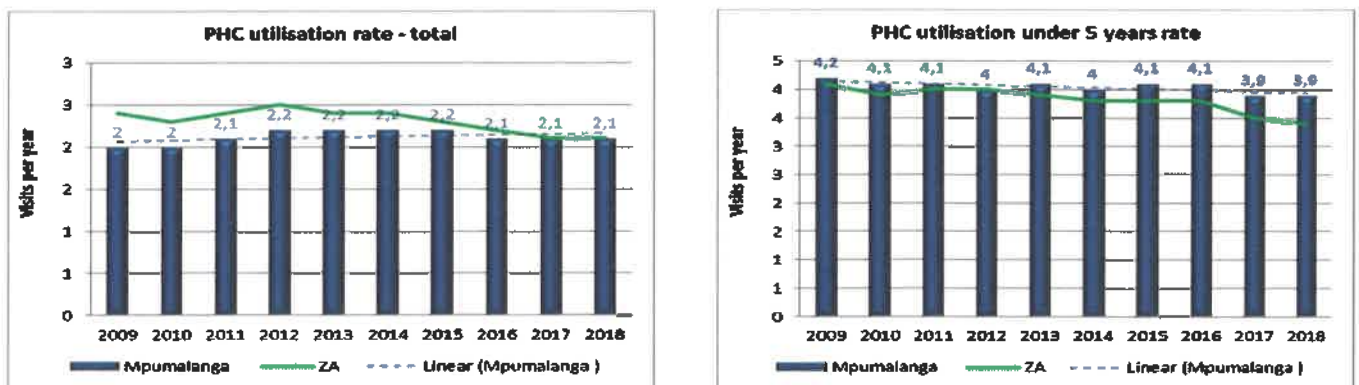
The above table reflects an upward trajectory of the outreach households' headcount coverage in the province.

- (a) The Department established 235 out of 560 Ward-based PHC Outreach teams which are meant to service 402 wards in the province.
- (b) The Department plans to absorb all 6119 community health workers (CHWs) that currently are currently under the funded non-profits organizations (NPOs).

PHC Utilization Rate

The primary health care (PHC) utilisation rate indicators measures the average number of PHC visits per person per year to a public PHC facility. It is calculated by dividing the PHC total annual headcount by the total catchment population*

Figure 10: PHC Utilisation



Source: DHIS

The above graphs reflect the underutilization of PHC facilities in the province when compared to the national norm of 3.5 visits per adult patient per annum and 5 visits for under 5 per annum across all the years.

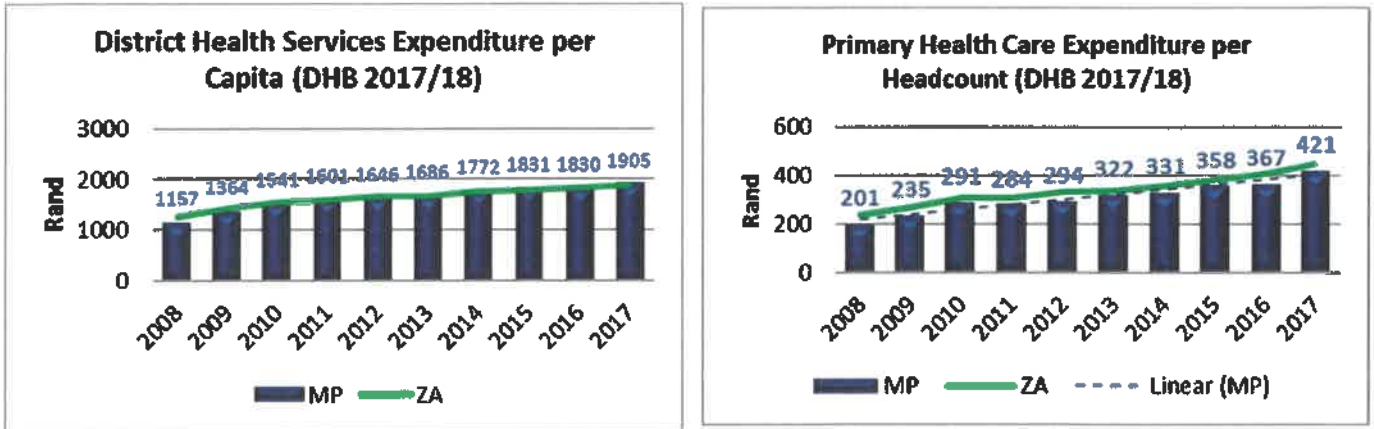
This may be attributed to the number of interventions that are being implemented at both PHC facilities, households and community levels. These interventions include ward-based PHC outreach teams, central chronic medicine distribution and dispensing (CCMDD) and school services which aim to increase access to PHC services, decongestion of PHC facilities and reduction of waiting time.

It must also be noted that patients still bypass PHC facilities to hospitals which overburdens this second level of care with primary health care services.

PHC Expenditure per Headcount

While PHC expenditure per capita can provide insight into equity in resource distribution and the prioritization of PHC across districts, looking at how much was spent per headcount/visit might be a better measure to evaluate efficiency.

Figure 11: PHC Expenditure per Headcount



Source: DHB 2017/18

The numerator PHC expenditure per headcount is the same as in the previous indicator (community health clinics, community health centers, community-based services, other community services, HIV AIDS, nutrition and LG PHC expenditure) while the denominator is the number of primary health care headcounts.

The above graph shows district health services expenditure per capita and PHC expenditure per head count. The equitable distribution of resources in the province is in line with the national average.

Hospital Care

OPD new client not referred rate is new OPD clients not referred as a proportion of total OPD new clients and does not include OPD follow-up and emergency clients in the denominator. The indicator monitors utilisation trends of client's bypassing PHC facilities and the effect of PHC re-engineering on OPD utilisation*

A high OPD new client not referred rate value could indicate overburdened PHC facilities or a sub-optimal referral system. In light of the National Health Insurance Policy, a PHC level is the first point of contact with the health system and therefore key to ensure health system sustainability. If PHC works well and the referral system is seamless, it will result in fewer visits to specialists in referral hospitals and emergency rooms**

Table 9: Hospital Efficiency Indicators

mp Mpumalanga Province	OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
Hospital Type	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District Hospital	64,1	67,5	65,3	4,8	4,2	4,4	75,3	69,5	69,9
Regional Hospital	60,4	49,8	47,1	4,4	4	4,5	81,2	77,9	67,4
Provincial Tertiary Hospital	32,2	30,4	28,6	7,1	6,1	6,8	85,8	79,8	81,4

mp Mpumalanga Province	Inpatient crude death rate			Delivery by Caesarean section rate		
Hospital Type	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District Hospital	5,2	4,7	4,7	20,5	21,2	21,1
Regional Hospital	4,8	4,7	4,9	26,5	26,6	26,8
Provincial Tertiary Hospital	5,8	6,2	6,5	31,9	33,7	34,3

Source: DHIS

The outpatient department (OPD) new clients not referred rate in all hospitals is a concern as it shows that there is high number of patients who bypass primary health care facilities to be attended in hospitals for cases that predominantly require primary health care services.

The bed utilization rate and average length of stay (ALOS) in tertiary hospitals is high due to the fact that they are referral hospitals mostly dealing with complicated cases requiring specialized care which will require patients to stay for longer periods. There is a need to implement gate keeping strategies to ensure that patients receive medical care at service points dedicated for such services. The crude death rate in the districts and regional hospitals has shown a decline.

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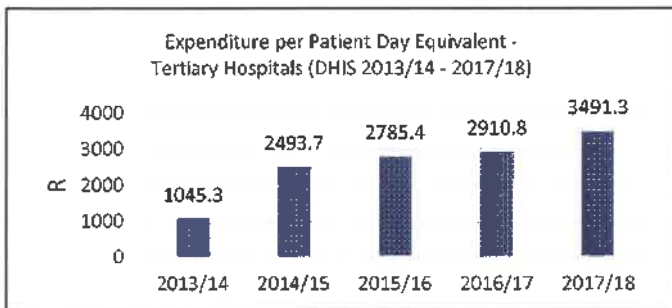
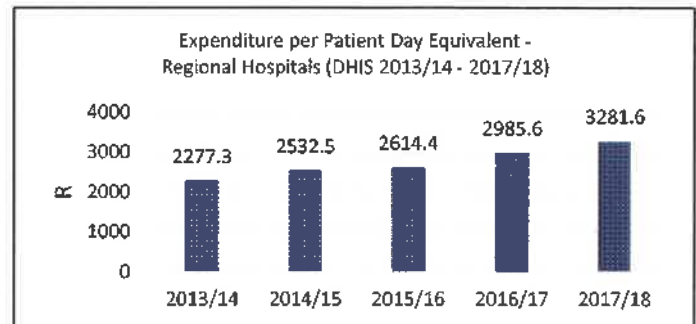
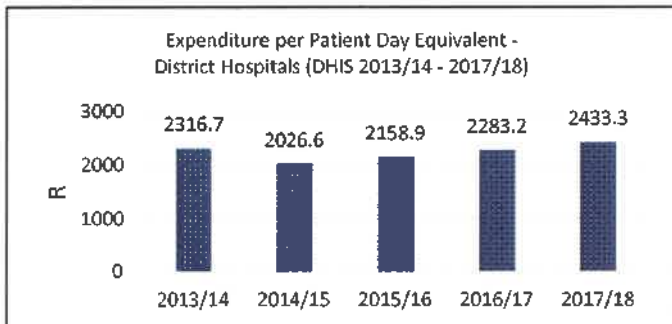
Table 10: Hospital Efficiency Indicators

		OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
Referral Hospitals		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	mp Ermelo Hospital	55,6	24,3	46	3,1	2,1	2,9	68,3	63,4	61,5
	mp Mapulaneng Hospital	83,5	78,4	71,9	4,6	5,3	4,7	86,2	79,5	61
	mp Themba Hospital	45,3	38	23,8	5,4	5	6	85,1	84,9	75,5
Provincial Tertiary Hospital	mp Rob Ferreira Hospital	14,5	19,8	17,5	7,7	7	8,4	82,4	78,5	89,8
	mp Witbank Hospital	57,9	44,4	43	6,6	5,3	5,4	89,7	81,2	72,6

Source: DHIS 2016-2019

The above table shows that all regional hospital bed Utilisation are declining. Ermelo hospital is the only regional hospital in Gert Sibande and is under-utilized as reflected on the bed utilization rate from 2016/17 to 2018/19 FY. It is also noted that in Gert Sibande there is no tertiary hospital hence many cases are referred to Witbank tertiary hospital in Nkangala district. The province will be required to capacitate Ermelo regional hospital and implement strategies to ensure that most of the cases that may require specialists' services are dealt with in Ermelo to minimize referral to the already overburdened Witbank tertiary hospital. It is also evident that Rob Ferreira tertiary hospital also has high Inpatient bed utilization rate meaning that all regional hospitals in the province need to be capacitated.

Figure 12: Hospital Expenditure per Patient Day Equivalent



Source: DHIS 2013-2018

Mpumalanga province is performing well on expenditure per patient day equivalent across all hospitals. This is attributed to gate keeping strategies that are being implemented to monitor utilization of resources against hospital activities.

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Table 11: Hospital Case Management Indicators

		Inpatient crude death rate			Delivery by Caesarean section rate		
Referral Hospitals		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	mp Ermelo Hospital	3.6	3	3.9	28.7	30	27.9
	mp Mapulaneng Hospital	5.1	6.5	5.7	20.1	16.9	14.9
	mp Themba Hospital	5.5	5.2	5.3	30	32.6	36.6
Provincial Tertiary Hospital	mp Rob Ferreira Hospital	6	6.1	6.5	28.4	26.5	29
	mp Witbank Hospital	5.6	6.3	6.6	35.4	40.5	40

Source: DHIS

According to Stats SA Midyear estimate 2002- 2019 the inpatient crude death rate has declined from 12.6 to 9.1 deaths per 1000 population. In all hospitals listed above, the crude death rate is low compared to the national average which is at 9.1.

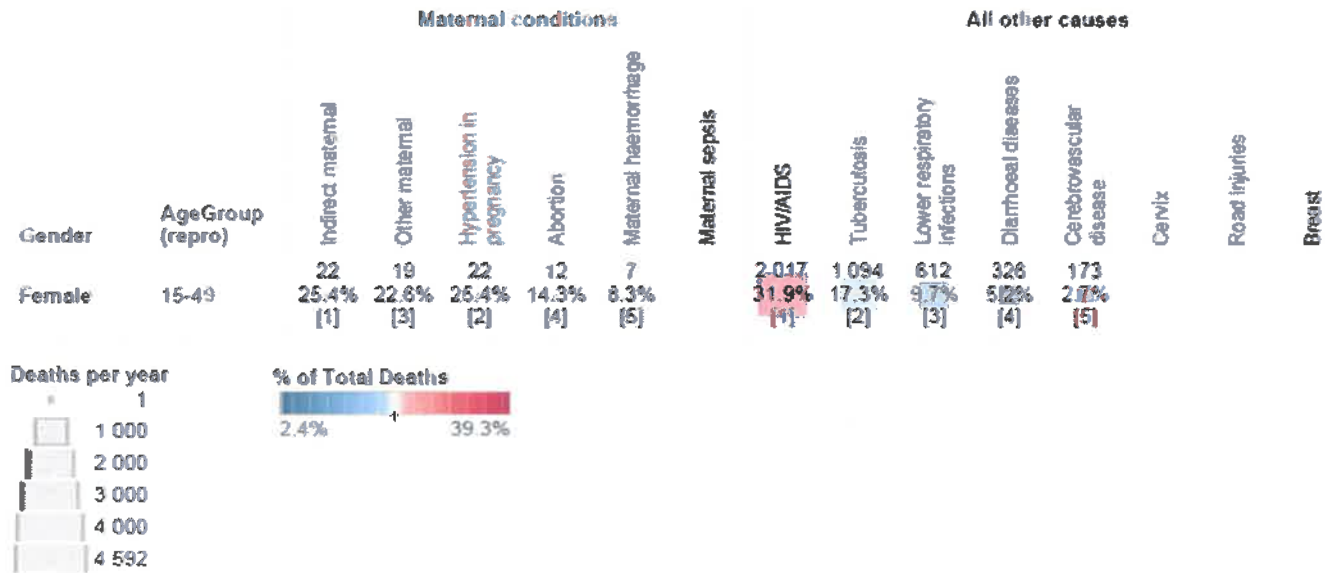
The table above indicates that Themba hospital has a high caesarean section rate. This hospital has high deliveries when compared to other regional hospitals and is also referral hospital for Tonga and Shongwe hospital which also have high deliveries.

Maternal and Women's Health

A maternal death is a death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in a facility. The maternal mortality in facility ratio is a proxy indicator for the population based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys.

Figure 13: Maternal Mortality death rate

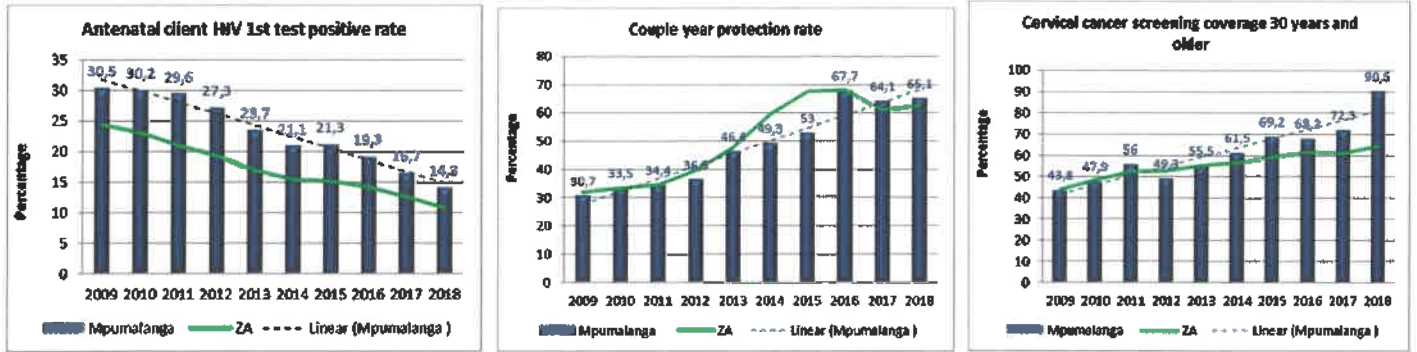
Leading causes of death by age group (Single causes), 2013 - 2015: MP
Average number of deaths per year, % of total and [rank] per age group



Source: DHB 2018/19

HIV/AIDS is predominantly a major cause of maternal mortality at 31.9% followed by indirect maternal conditions and hypertension at 25.4% each.

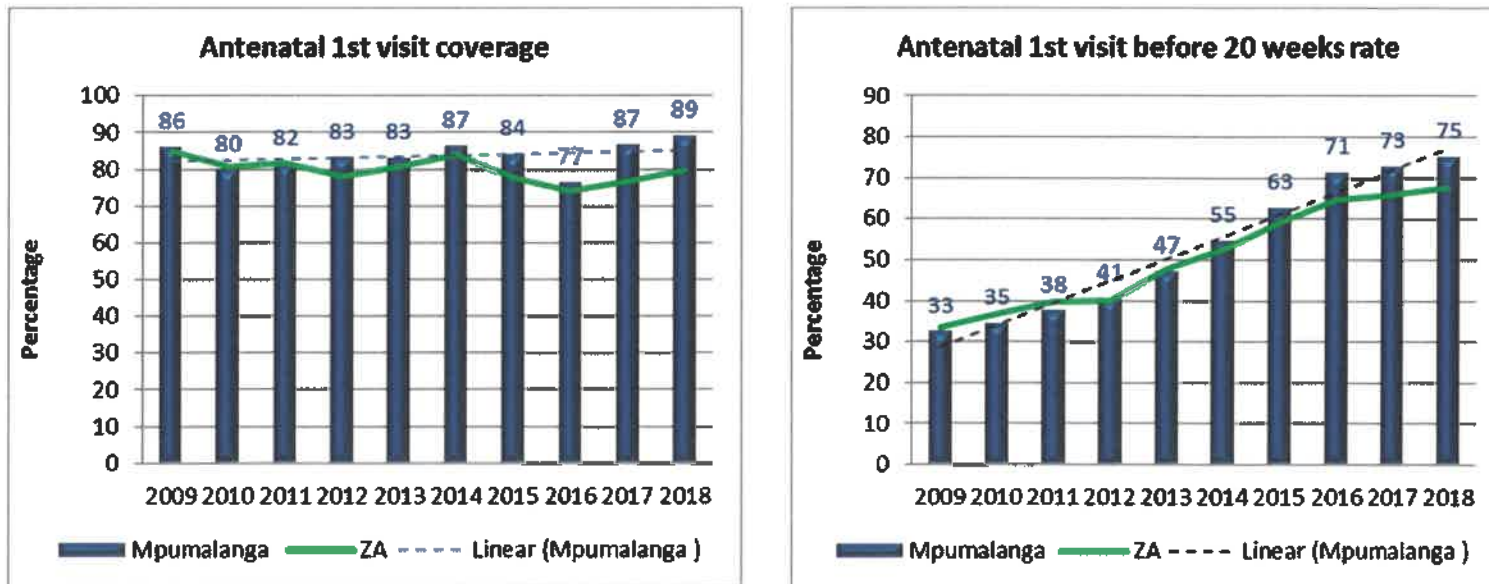
Figure 14: Maternal and Women's Health Trends



Source: District Health Barometer 2017/18

The Antenatal clients HIV 1st test positive rate, couple year protection and cervical cancer screening are proxy indicators effective for women's health and maternal outcomes. There is significant improvement in antenatal testing and uptake in ART services in the province and improvement in family planning (couple year protection) which significantly impacted on Maternal mortality ratio at 92 per 100 000 live births which is below the National Target of 115 per 100 000 live births. Improvement in the antenatal 1st visit coverage is essential to ensure adequate basic antenatal care which is critical for safe maternal delivery.

Figure 15: Antenatal visit coverage

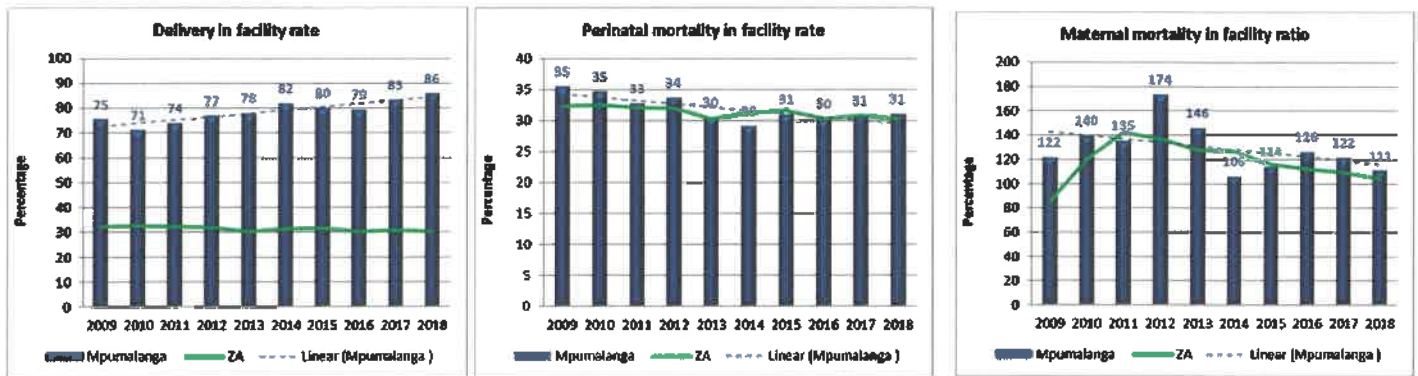


Source: District Health Barometer 2017/18

There is a significant drop on antenatal client HIV 1st test positive rate at 14.3% in 2018 against 30% in 2009, ANC 1st visit before 20 weeks at 75.6% in 2018 against 33% in 2009, couple year protection from 30.7% in 2009 to 65.1% in 2018 and cervical cancer screening from 43.8% in 2009 to 90.5% in 2018. This has contributed greatly towards the reduction of maternal mortality in the province as reflected on the above table. The maternal mortality ratio at 92.4/ 100 000 in 2018/19 live births against the national performance at 106.9/ 100 000 live births.

The gradual improvement in Antenatal 1st visit before 20 weeks rate also allows early identification of the HIV positive mothers, early enrollment into Antiretroviral treatment which results in effective maternal viral suppression; minimizing the risk of mother to child transmission and ultimately leading to a reduction in infant and maternal morbidity and mortality.

Figure 16: Maternal health indicators



Source: District Health Barometer 2017/18

The province experienced an increase on delivery in health facilities from 75% in 2009 to 86% in 2018 which significantly contributed to reduction in perinatal mortality in facility rate from 35% in 2009 to 31% in 2018 and reduction in maternal mortality. The high maternal mortality in 2012 at 174 per 100 000 live births led to intensive intervention that resulted in a significant decline in maternal mortality, improving to 111 per 100 000 live birth in 2018.

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Table 12: Women and Maternal health

Women and Maternal Health

				Country	Province	District		
				ZA	MP	DC30	DC31	DC32
				South Africa	Mpumalanga	G Sibande DM	Nkangala DM	Ehlanzeni DM
Maternal mortality in facility ratio (per100K)	Impact	2018/19	DE	105.9	92.4	95.8	109.3	82.4
Maternal death in facility (No)		2018/19	DE	1 065	78	20	23	35
Live birth in facility (No)		2018/19	DE	959 720	80 483	19 689	20 060	40 734
Delivery in 10 to 19 years in facility rate (%)	Outcome	2018/19	DE	12.9	14.8	15.9	10.9	16.2
Delivery 10-19 years in facility (No)		2018/19	DE	124 628	11 819	3 163	2 207	6 449
Delivery in facility - total (No)		2018/19	DE	964 209	80 024	19 866	20 304	39 854
Antenatal client initiated on ART rate (%)	Outcome	2018/19	DE	95.8	99	99.2	98.7	99.1
Antenatal client start on ART (No)		2018/19	DE	109 900	11 717	3 092	2 779	5 846
Antenatal client known HIV positive but NOT on ART ..		2018/19	DE	18 005	1 064	337	267	460
Mother postnatal visit within 6 days rate (%)	Output	2018/19	DE	75.3	67.7	63.9	75.5	65.6
Mother postnatal visit within 6 days after delivery (..		2018/19	DE	725 586	54 183	12 688	15 336	26 159
Antenatal 1st visit before 20 weeks rate (%)	Output	2018/19	DE	68.1	75.6	68.4	71.1	82.3
Antenatal 1st visit before 20 weeks (No)		2018/19	DE	729 259	66 866	14 772	18 595	33 499
Antenatal 1st visit - total (No)		2018/19	DE	1 071 081	88 486	21 605	26 162	40 719
Couple year protection rate (%)	Output	2018/19	DE	61	64.3	61.3	50.8	77.8
Contraceptive years dispensed (No)		2018/19	DE	7 247 868	579 306	150 043	159 560	269 703
Cervical cancer screening coverage (%)	Output	2018/19	DE	65.1	89.9	111.6	77.8	87.9
Cervical cancer screening 30 years and older (No)		2018/19	DE	861 893	88 226	29 005	26 901	32 320

Other
■ Best 10 DM
■ Worst 10 DM

Source: DHIS

The provincial maternal mortality ratio was further reduced to 92.4/ 100 000 live births in 2018/19 FY against the national performance of 106.9/ 100 000 live births. Nkangala district is the highest at 109.3/100 000 live births. This is due to the fact that Witbank hospital is providing tertiary services for both Nkangala and Gert Sibande districts. The province will be required to capacitate Ermelo regional hospital and implement strategies to ensure that most of the cases that may require specialists' services are dealt with in Ermelo to minimize referral to the already overburdened Witbank tertiary hospital. It is also evident that Rob Ferreira tertiary hospital also has high Inpatient bed utilization rate meaning that all regional hospitals in the province need to be capacitated.

There is a significant achievement of ART initiation for antenatal clients which has improved from 95.8% to 99% in 2018/19. ANC first visit before 20 weeks has improved from 68.1% to 75.6% in 2018/19 compared to the national performance which is at 68.1% in 2018/19 with Ehlanzeni being the highest at 82.3%, Nkangala 71.1% and Gert Sibande at 68.4% in 2018/19. The province will continue to monitor the implementation of routine pregnancy screening of child bearing potential women and same day booking of all those who are found to be pregnant. Of note is that there is a consistent upward improvement trend in all districts. This has contributed greatly towards the reduction of the maternal mortality ratio of the province as reflected on the table above.

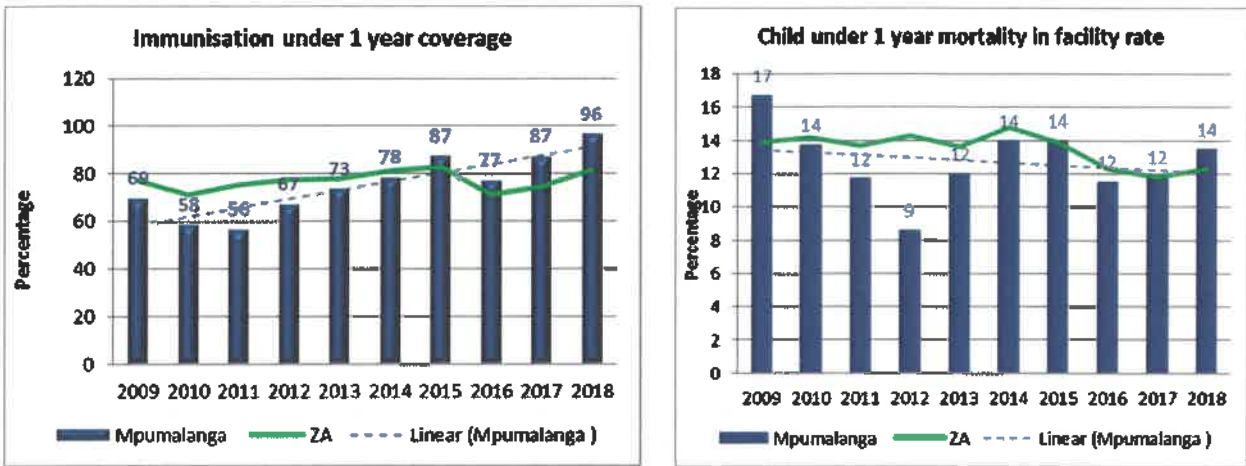
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The provincial couple year protection rate in 2018/19 was at 64.3% with Nkangala recording the lowest percentage of 50.8%. The province experienced inconsistent supply of contraceptives and condoms from national. To mitigate against contraceptive stock-outs, the province has embarked on re-orientation of health professionals on expansion of contraceptive method mix.

The department will continue to encourage early booking, HIV testing, initiation of ANC clients and early diagnosis and prompt treatment of pre-existing conditions. Furthermore, auditing of maternity case records, functional patient safety incidence committees, ESMOE fire drills and BANC plus trainings are also crucial to further reduce maternity mortality.

8.4.2. Child Health

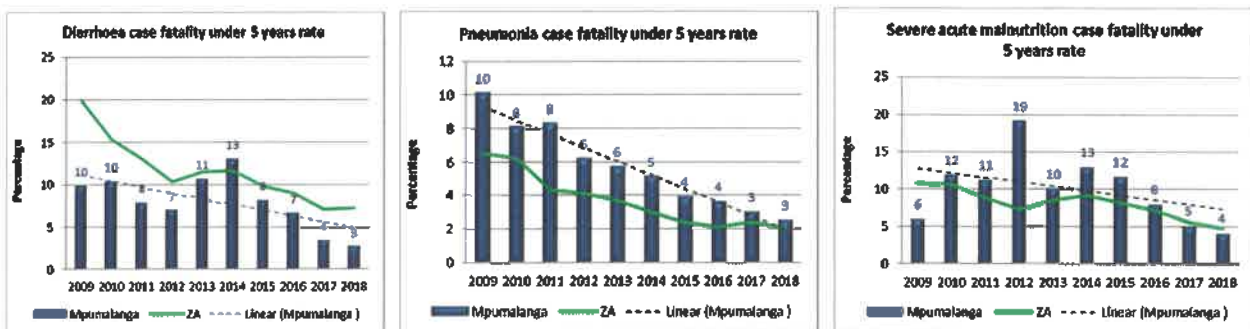
Figure 17: Women and Maternal health



Source: DHB 2017/2018

The province is performing well on Immunization under 1 year coverage at 96% in 2018 from 69% in 2009. An improvement has been noted in the child under 1 year mortality rate from 17% in 2009 to 14% in 2018.

Figure 18: Case fatality under 5 years



Source: DHB 2017/2018

Across all case fatalities of children under 1 year there is a decline of diarrhoea case fatality rate from 10% in 2009 to 3% in 2018, Pneumonia case fatality rate from 10% in 2009 to 3% in 2018 and Severe malnutrition case fatality rate from 6% in 2009 to 4% in 2018. However, there was a pick of 19% in 2012 where there was severe acute malnutrition case fatality under 5 years rate which led to intensive intervention in collaboration with other stakeholders.

Table 13: Child Health

Child Health

			2018/19	Country	Province	District		
				ZA	MP	DC30	DC31	DC32
				South Africa	Mpumalanga	G Sibande DM	Nkangala DM	Ehlanzeni DM
Death in facility under 1 year rate (%)	Impact	DE	2018/19	7.5	10.6	7.6	8	16.1
Death in facility under 1 year (No)		DE	2018/19	14 841	1 174	322	238	614
Death in facility under 5 years rate (%)	Impact	DE	2018/19	4.8	7.4	5.6	5.9	9.8
Death in facility under 5 years (No)		DE	2018/19	16 844	1 322	347	257	718
Diarrhoea case fatality under 5 years rate (%)	Impact	DE	2018/19	1.9	2.3	1.8	3.4	2.4
Diarrhoea death under 5 years (No)		DE	2018/19	679	57	18	11	28
Diarrhoea separation under 5 years (No)		DE	2018/19	36 009	2 519	1 015	324	1 180
Early neonatal death in facility rate (per1K)	Impact	DE	2018/19	9.8	10.2	12	7.3	10.7
Death in facility 0-7 days (No)		DE	2018/19	9 431	817	236	147	434
Live birth in facility (No)		DE	2018/19	959 720	80 483	19 689	20 060	40 734
Neonatal death in facility rate (per1K)	Impact	DE	2018/19	12.1	11.5	13.6	8.9	11.9
Death in facility 8-28 days (No)		DE	2018/19	2 212	111	31	31	49
Pneumonia case fatality under 5 years rate (%)	Impact	DE	2018/19	1.9	2.7	1.4	3.2	3.3
Pneumonia death under 5 years (No)		DE	2018/19	962	77	13	9	55
Pneumonia separation under 5 years (No)		DE	2018/19	50 212	2 876	915	279	1 682
Severe acute malnutrition case fatality under 5 years rate ..	Impact	DE	2018/19	7.1	9.1	5.2	8.6	10.5
Severe acute malnutrition death under 5 years (No)		DE	2018/19	806	68	7	14	47
Severe acute malnutrition inpatient under 5 years (No)		DE	2018/19	11 280	744	134	163	447
Infant PCR test positive around 10 weeks rate (%)	Outcome	DE	2018/19	0.74	0.89	0.61	0.93	1
Infant PCR test positive around 10 weeks (No)		DE	2018/19	1 371	178	32	43	103
Infant PCR test around 10 weeks (No)		DE	2018/19	185 318	19 890	5 247	4 607	10 036
Immunisation under 1 year coverage (%)	Output	DE	2018/19	81.9	96.8	93.4	85.9	107.3
Immunised fully under 1 year new (No)		DE	2018/19	944 650	84 697	20 217	22 404	42 076
Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose..	Output	DE	2018/19	49.5	52.2	58.1	53.6	48.9
Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexaval..		DE	2018/19	477 984	42 175	10 329	12 187	19 659
DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose (No)		DE	2018/19	966 387	80 768	17 778	22 747	40 243
Measles 2nd dose coverage (%)	Output	DE	2018/19	76.5	85.9	84.4	78.1	92.2
Measles 2nd dose (No)		DE	2018/19	890 235	75 626	18 687	20 989	35 950
School Grade 1 screening coverage (%)	Output	DE	2018/19	17.7	39.6	27.5	35.6	50.1
School Grade 1 - learners screened (No)		DE	2018/19	381 110	35 040	12 074	15 590	7 376
School Grade 1 - learners total (No)		DE	2018/19	1 166 792	88 562	23 791	25 105	39 666
School Grade 8 screening coverage (%)	Output	DE	2018/19	13.1	0.71	20.8	18.4	52.4
School Grade 8 - learners screened (No)		DE	2018/19	196 461	18 097	7 019	6 639	4 439
School Grade 8 - learners Total (No)		DE	2018/19	889 304	66 038	17 542	19 177	29 319
Vitamin A dose 12-59 months coverage (%)	Output	DE	2018/19	56.6	66	59.4	60.2	73.7
HIV test around 18 months (No)		DE	2018/19	238 392	39 635	9 596	9 005	21 034
Live birth to HIV positive woman (No)		DE	2018/19	267 329	26 544	7 501	5 612	13 431

Performance
 Other
■ Best 10 DM
■ Worst 10 DM

Source: DHIS

The department has conducted a baseline assessment to identify key areas that require robust intervention to improve performance on the child health programme. It was identified that an average of 25% professional nurses were trained on Integrated Management of Childhood Illness (IMCI) case management. This low percentage has contributed to underperformance of the province due to capacity challenges. The department has already established a training plan to train at least 80% of professional nurses by 2025 who will contribute towards capping poor performance. In addition, the department is planning to conduct training for WBOTs on household community components (HHCC) on IMCI to further improve capacity.

Pneumonia case fatality under five years' rate for the province was at 2.7% 2018/19 compared to the national performance which was at 1.9% 2018/19 with Ehlanzeni recording 3.3% followed by Nkangala at 3.2% and lowest in Gert Sibande at 1.4% in 2018/29. The province will continue to immunize children under 1year and train health professionals on IMCI.

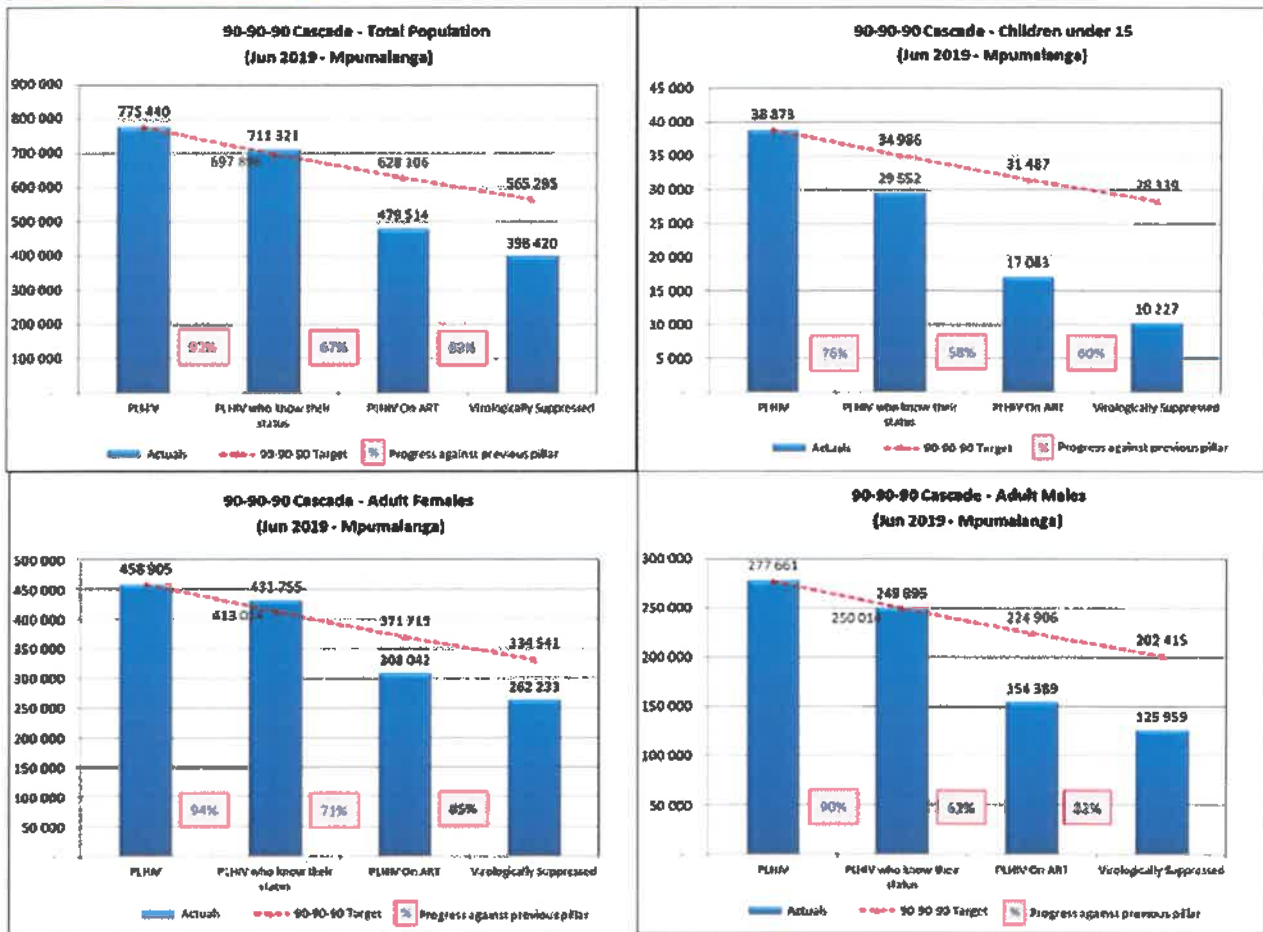
Severe acute malnutrition in patient under five- year performance for the province was at 9.1% compared to the national performance which was at 7.1% 2018/19, with Ehlanzeni recording 10.5%, Nkangala at 8.6% and Gert Sibande at 5.2%. The contributory factors include poverty, high burden of disease, child headed households and growing inequalities as depicted on Figure 5: Comparative provincial ranking income below poverty line.

Neonatal death in facility rate was at 11.5 per 1000 live birth in 2018/19 compared to the national performance which was 12.1 per 1000 live birth with Gert Sibande at 13.6 followed by Ehlanzeni at 11.9 and Nkangala at 8.9 per 1000 live birth in 2018/19. The contributory factors are late booking leading to birth asphyxia and prematurity, late diagnosis of hypertensive disorders in pregnancy, late booking at antenatal clinic. The province will continue to monitor implementation of policy guidelines BANC plus, management of hypertension in pregnancy and conduct community engagements.

Measles 2nd dose coverage was at 85,9% in 2018/19 compared to the national performance at 76,5% in 2018/19, with Ehlanzeni performing at 92,2%, Gert Sibande 84,4% and Nkangala at 78,1% in 2018/19. Inadequate visit to early child development centers due to insufficient school health teams. The Department is planning to expand the number of school health teams.

8.4.3. HIV and AIDS

Figure 19: Province 90 90 90 cascade



Source: DHB 2017/2018

Mpumalanga province is currently at 92-67-83 in terms of performance against 90-90-90 target across the total population. The results for each of the sub-populations vary, with adult females at 94-71-85, adult males at 90-62-82, and children at 76-58-60. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care.

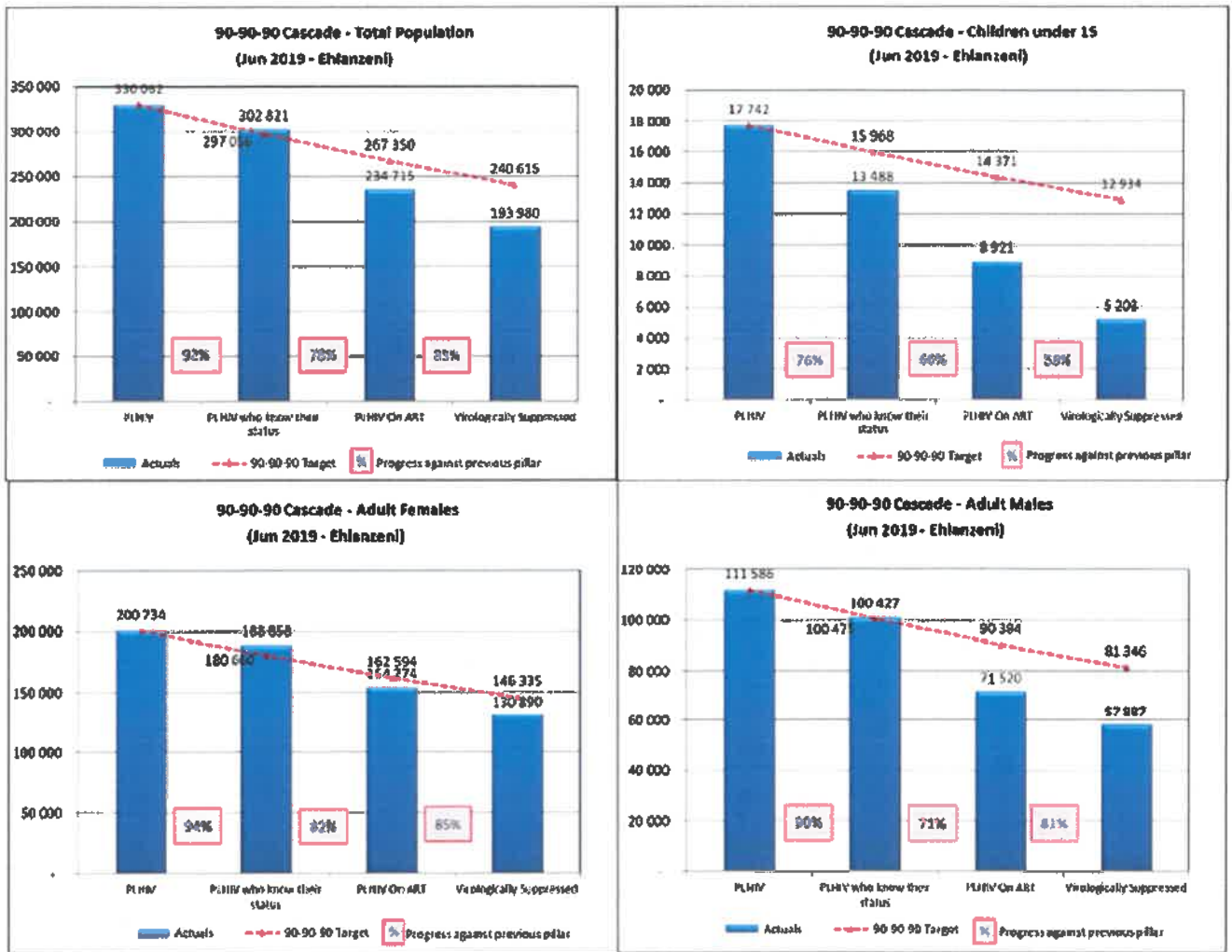
There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated.

The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention and should be addressed through focused interventions.

To achieve 90-90-90 targets, the province must increase the number of adult men on ART by 70517, the number of adult women on ART by 63671, and the number of children on ART, by 14404, by December 2020.

Across the province, Ehlanzeni and Gert Sibande are the closest to attaining 90-90-90 based on preliminary data collected.

Figure 20: Ehlanzeni 90 90 90 cascade



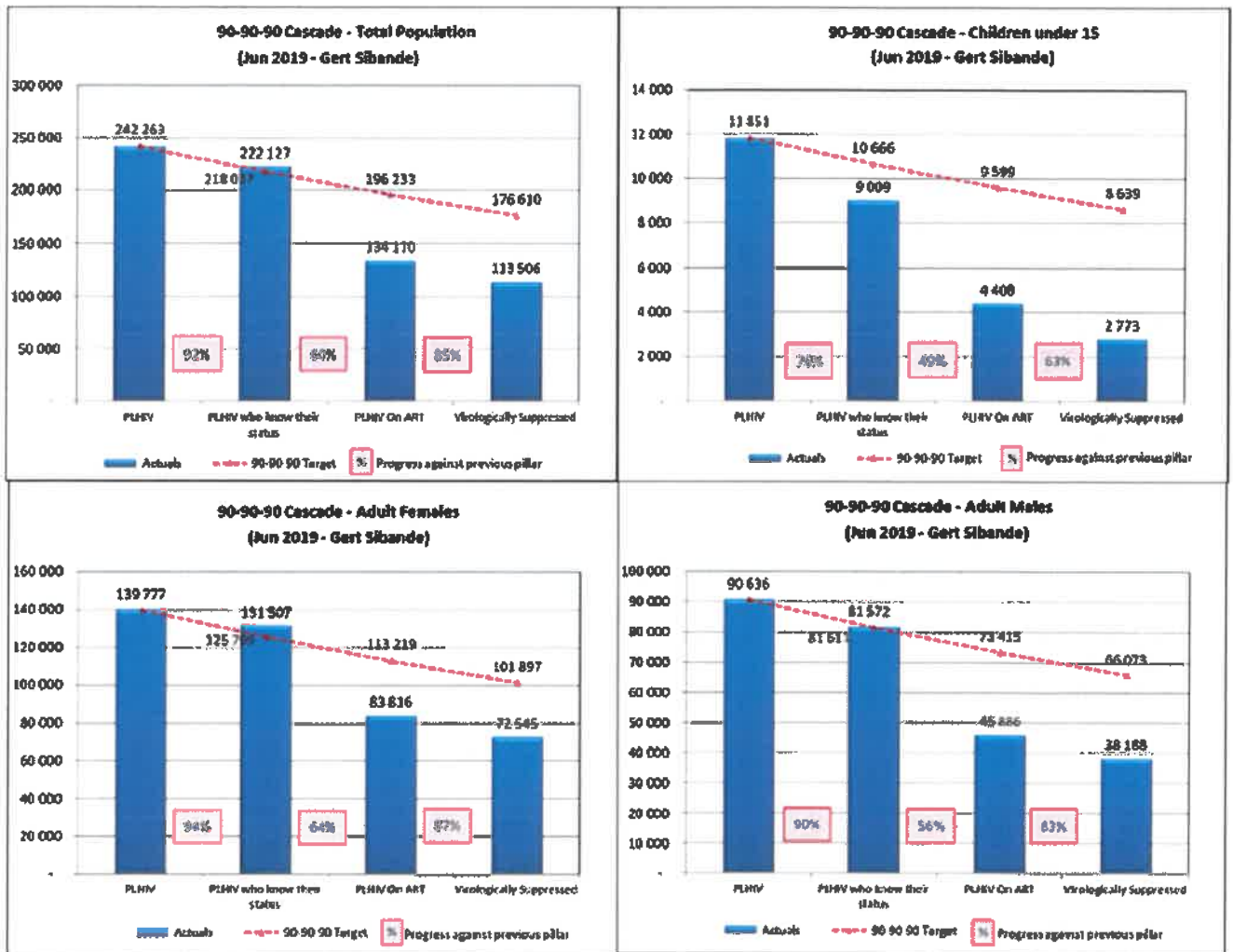
Source: DHB 2017/2018

Ehlanzeni is currently at 92-78-83 in terms of performance against 90-90-90 across its total population. The District is ranked 1st out of the 3 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-82-85, adult males at 90-71-81, and children at 76-66-58. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care.

There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years.

Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 18864, the number of adult women on ART by 8321, and the number of children on ART, by 5450, by December 2020.

Figure 21: Gert Sibande 90 90 90 cascade



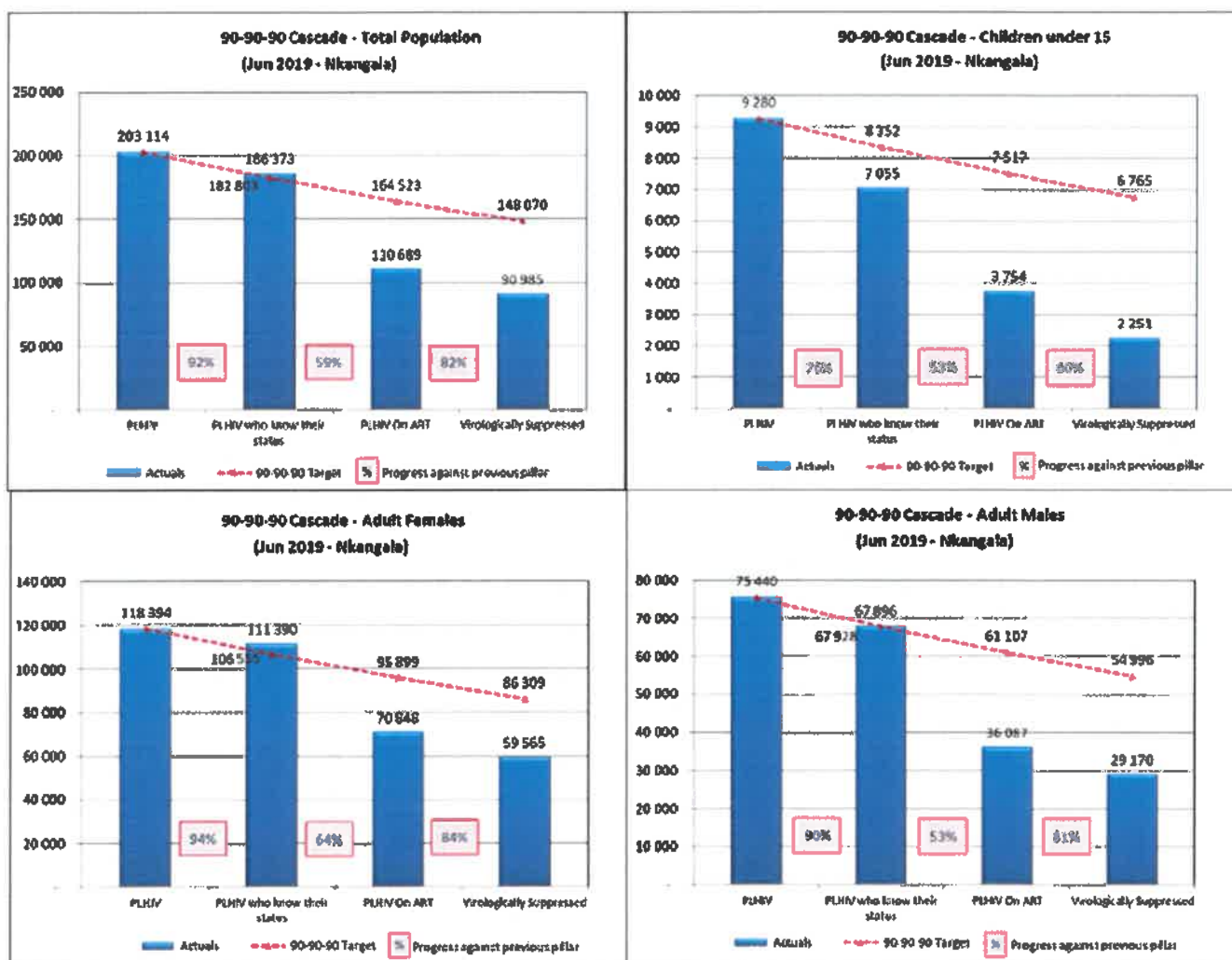
Source: DHB 2017/2018

Gert Sibande is currently at 92-60-85 in terms of performance against 90-90-90 across its total population. The District is ranked 2nd out of the 3 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-64-87, adult males at 90-56-83, and children at 76-49-63.

For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated.

The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 27528, the number of adult women on ART by 29404, and the number of children on ART, by 5191, by December 2020.

Figure 22: Nkangala 90 90 90 cascade



Source: DHB 2017/2018

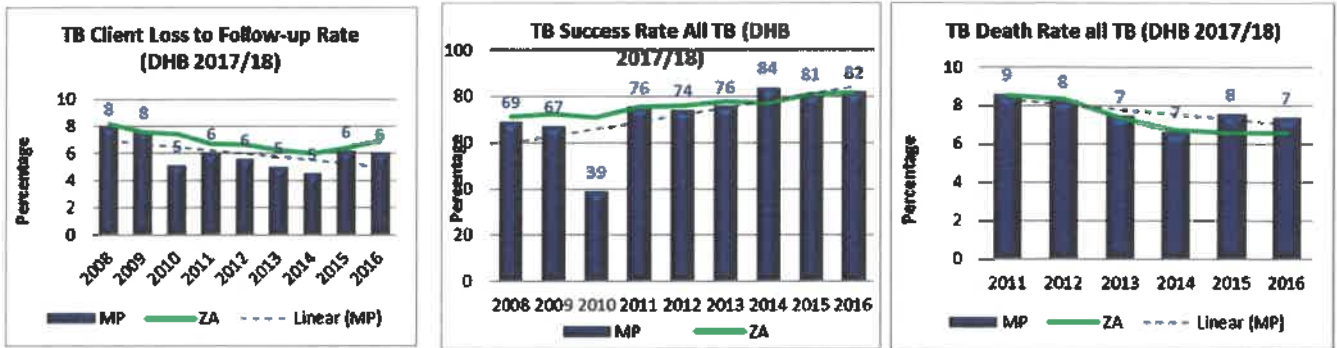
Nkangala is currently at 92-59-82 in terms of performance against 90-90-90 across its total population. The District is ranked 3rd out of the 3 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-64-84, adult males at 90-53-81, and children at 76-53-60. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher.

There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 25019, the number of adult women on ART by 25051, and the number of children on ART, by 3763, by December 2020. There is urgent need of recruitment of HAS and CCMT coordinators and allocation of dedicated transport.

Overall performance in all districts indicates that the second 90 and children is a challenge. Ehlanzeni is at 78% performing better than the other two districts. Gert Sibande and Nkangala way below recording 60% and 59% respectively. Develop and monitor the implementation of the algorithm for universal HTS for all under 15 years. Monitor the implementation of the adherence to guidelines and implementation of clinical stationary.

TB

Figure 23: Treatment Trends TB Indicators



Source: DHB 2017/2018

The TB loss to follow-up rate is a mirror to TB death rate as outlined in the above graphs. The loss to follow up has decreased from 8% in 2008 to 6% in 2016. This significantly contributed the TB death rate to decreasing from 9% in 2011 to 7% in 2016 which resulted in good performance on TB success rate growing from 69% in 2008 to 82% in 2016. Although there is a positive performance on deaths due to TB, Mpumalanga is still under performing at 7.3% in 2017 against the national performance of 6.5%.

There was a good performance on TB MDR treatment success rate which was at 60.2% in Nkangala above the national performance of 53% and at 61.7% in Ehlanzeni above national performance of 49.6% in 2018/19 FY.

Table 14: TB indicators 2016-2018

TB

				Country	Province	District		
				ZA	MP	DC30	DC31	DC32
				South Africa	Mpumalanga	G Sibande DM	Nkangala DM	Ehlanzeni DM
TB DS death rate (%)	Impact	DE Ind	2017	6.5	7.3	7.5	7.3	7.2
DS TB patients who died (No)		DE Ind	2017	16 133	1 106	244	238	624
All DS TB patients in cohort (No)		DE Ind	2018	225 553	11 800	2 631	3 098	6 071
TB DS client lost to follow up rate (%)	Outcome	DE Ind	2017	8	7.4	8.6	9.6	6.2
DS TB patients who were lost to follow up (No)		DE Ind	2017	19 761	1 129	279	312	538
TB DS treatment success rate (%)	Outcome	DE Ind	2017	76.3	80.3	78.8	78.2	81.7
DS TB patients who completed treatment or were cured ..		DE Ind	2017	188 352	12 217	2 570	2 542	7 105
TB MDR client death rate (%)	long regimen Impact	DE Ind	2016	20.8	23.1	26.5	18.9	24.6
	short regimen Impact	DE Ind	2017	17.3	20.4	17.9	18.9	22.5
TB MDR client loss to follow up rate (%)	long regimen Outcome	DE Ind	2016	19.6	13.3	10.6	17.2	11.7
	short regimen Outcome	DE Ind	2017	14.6	11.2	10.7	16.3	8.6
TB MDR treatment success rate (%)	long regimen Outcome	DE Ind	2016	53.9	55	46.9	60.2	55.2
	short regimen Outcome	DE Ind	2017	49.6	56.5	52	51.1	61.7
TB XDR client death rate (%)	long regimen Impact	DE Ind	2016	21.3	4.8		4.8	
	short regimen Impact	DE Ind	2017	20.7	11.8		6.3	100
TB XDR client loss to follow up rate (%)	long regimen Outcome	DE Ind	2016	11.3	14.3		14.3	
	short regimen Outcome	DE Ind	2017	7.7	17.6		18.8	0
TB XDR treatment success rate (%)	long regimen Outcome	DE Ind	2016	58.1	81		81	
	short regimen Outcome	DE Ind	2017	31.3	17.6		18.8	0
TB symptom 5 years and older screened in facility rate (..	Process ..	DE Ind	2018/19	83.7	80.9	77.9	71.9	86.8
Screen for TB symptoms 5 years and older (No)		DE Ind	2018/19	82 929 115	6 081 014	1 371 577	1 362 005	3 347 432
PHC headcount 5 years and older (No)		DE Ind	2018/19	99 082 287	7 512 561	1 761 441	1 893 703	3 857 417
TB symptom child under 5 years screened in facility rate ..	Process ..	DE Ind	2018/19	81.7	83.4	79.1	74.2	89.6
Screen for TB symptoms under 5 years (No)		DE Ind	2018/19	16 547 063	1 452 345	299 265	323 703	829 377
PHC headcount under 5 years (No)		DE Ind	2018/19	20 264 739	1 740 800	378 384	436 431	925 985
TB/HIV co-infected client on ART rate (ETR.Net) (%)	Outcome	DE Ind	2017	89.1	97.3	95.8	94.4	99.5
HIV-positive TB cases who are on ART (No)		DE Ind	2018	108 481	7 655	1 863	1 847	3 945
HIV-positive TB cases (No)		DE Ind	2018	125 222	8 266	1 991	2 029	4 246

Other
 Best 10 DM

Source DHIS

TB death rate was at 7.3% compared to the national target of 6.8% in the province, with Gert Sibande recording the highest TB death rate of 7.5% in 2017. Coinfection and inadequate implementation of TPT prophylaxis are the leading causes of death amongst TB patients. The Department is planning to establish advanced clinical care and pharmacovigilance clusters.

Lost to follow was at 7.4% compared to national target of 8% with which Nkangala district recorded 9.6% and Gert Sibande at 8.6% in 2017. The Department is planning to improve adherence counseling on admission and management of early missed appointments.

TB success rate was at 80.3% compared to national target of 76.3% in 2017.

TB screening was at 80.9% compared to the national target of 83.7% with Nkangala recorded the lowest performance at 71.9% and Gert Sibande at 77.9% in 2017. The plan is to implement the finding missing TB patient strategy.

TB MDR short term success rate was at 56.5% compared to the national target of 49.6% with Ehlanzeni being the highest at 61.7%, Gert Sibande 56% and Nkangala 51.1% in 2017. TB MDR long term success rate is at 55% compared to the national target of 53.9% with Nkangala being the highest at 60.2%, Gert Sibande 55.2% and Ehlanzeni 46.9% in 2017. Decentralization of DR care to district hospitals is already implemented and yielding better results.

8.4.4. Covid-19 Outbreak and Readiness.

The whole world has been shaken by the outbreak of Coronavirus-19 abbreviated as COVID- 19, which is a new strain of coronavirus that has not been previously identified in humans. The virus was first isolated in the 1960s, circulating among animals (zoonotic). In 2003, a new coronavirus emerged leading to the SARS (severe acute respiratory syndrome) outbreak. In 2012, the Middle East respiratory syndrome (MERS) was found to be caused by a coronavirus associated with transmission from camels. 31 December 2019, the World Health Organization (WHO) China country office reported a cluster of pneumonia cases in Wuhan, Hubei Province of China. 7 January 2020, causative pathogen identified as a novel (new virus) coronavirus (COVID-2019)

Following this development and the impact of the disease globally, Corona virus was declared as National disaster in South Africa and all government institutions and private sector were required to develop and implement strategies to fight this pandemic. Furthermore, the National Government, implemented amongst others national lockdown, closure of schools, social distancing, closure of economic sector, imposed a travel ban on foreign nationals from high-risk countries and South African citizens returning from high-risk countries will be subjected to testing and self-isolation or quarantine on return to South Africa. This was done to reduce the impact and flatten the curve of Corona virus pandemic.

After the WHO declared the outbreak as a Public Health Emergency of International Concern on 30 January 2020 the following structures were activated to respond to the outbreak:

- The Provincial Outbreak Response Team
- The Provincial Joint Operations and Provincial Command Council
- The District and Local Joint Operations Command Councils
- The Department COVID Committee is chaired by the Hon MEC
- The Provincial Incident Committee, chaired by the HOD, was established with subcommittees that had to come up with specific plans to contribute to the containment of the spread of the disease in the province, similar committees were established at a district levels
- All these committees meet daily to review the progress made in the implementation of strategies and interventions

The department has developed a Response strategy that covers the following key Areas:

- Preparedness and response
- Surveillance & epidemiology
- Infection Prevention & Control
- Case Management
- Ports of Entry
- Emergency Medical Services
- Community Strategy
- Stakeholder Engagement
- Monitoring & Evaluation

8.4.5. Stakeholder Analysis

Table 15: Stakeholder Analysis

Stakeholder	Characteristics	Influence	Interest	Linkage with other stakeholders
Internal Stake holders				
Executive Management	Decision makers	High	High	National department of health National Health Council and member of SANAC
Programme Managers	Policy Implementers	High	High	Health Sector Regulatory bodies
District Management	Proponents of service delivery	High	High	Municipalities
Internal Audit	Early warning system and controls	High	High	Auditor General Audit Committee
Trade Unions	Labour representatives	High	Low	Civil Society
External Stakeholders				
SCOPA, Audit committee and AGSA, Portfolio Committee	Oversight Institutions	High	High	Parliament/ Cabinet
Faith based organization	Spiritual care	Low	High	Civil Society
National Health Laboratory Service (NHLS)	Service Provider	Low	High	Health facilities
Pharmaceuticals	Service Providers	Low	High	Health facilities
Non-Governmental Organizations	Service providers Implementing partners	High	High	Partnership with National Department of Health
National Department of Health	Policy Makers	High	High	Sectoral collaboration with other departments.
Communities	Beneficiaries of Health services	High	High	Relate with all other sector departments
Researchers	Design research, undertake research and analyze information	High	High	Education Department and Tertiary institutions on bursary issues and admission to tertiary institution including research activities

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8.4.6. MTEF Budgets

Table 10.8: Summary of payments and estimates: Administration

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2016/17	2017/18	2018/19				2019/20	2020/21	2021/22
1. Office of the MEC	7 752	7 140	7 899	9 980	15 908	15 068	17 435	18 468	19 349
2. Management	274 249	334 973	281 484	312 296	400 236	401 923	349 929	375 622	395 847
Total payments and estimates	282 001	342 113	289 363	322 276	416 142	416 989	367 364	394 090	415 196

Table B.3(I): Payments and estimates by economic classification: Administration

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2016/17	2017/18	2018/19				2019/20	2020/21	2021/22
Current payments	232 997	265 063	247 249	282 742	352 382	352 500	337 458	362 577	362 379
Compensation of employees	124 420	135 808	133 309	142 449	151 849	149 546	164 908	177 578	188 672
Salaries and wages	100 191	110 424	115 370	123 860	132 186	129 499	142 623	153 864	163 465
Social contributions	15 229	18 384	17 939	18 589	19 483	20 047	22 283	23 714	25 207
Goods and services	108 476	129 216	113 829	140 293	200 733	202 929	172 552	184 999	193 707
Administrative fees	1 024	875	803	655	906	906	1 144	1 199	1 256
Advertising	4 483	3 628	2 156	4 463	5 271	7 847	9 012	9 109	9 546
Minor Assets	700	84	104	37	3	35	-	-	-
Audit cost: External	14 819	18 820	18 859	18 146	18 146	18 146	20 021	20 982	21 989
Catering: Departmental	784	399	825	642	913	1 054	830	870	911
Communication (G&S)	5 285	4 991	5 715	5 500	6 105	6 106	3 068	3 212	3 363
Computer services	15 732	30 940	24 005	53 918	65 885	64 307	71 504	74 216	77 719
Consultants: Business	11 219	5 337	4 413	6 003	7 823	7 823	4 892	5 127	5 386
Laboratory services	10	2	-	-	-	-	-	-	-
Legal costs	16 576	28 640	32 907	21 252	62 906	72 768	33 804	40 667	42 567
Contractors	75	43	2	-	1	5	-	-	-
Agency and support / out	895	1 876	156	1 988	200	1 128	528	554	580
Fleet services (incl. gover	3 999	9 884	2 731	1 570	1 570	1 570	4 288	4 494	4 705
Inventory: Clothing mater	-	49	-	-	-	-	-	-	-
Inventory: Food and food	-	-	33	50	67	67	75	79	83
Inventory: Medical suppli	6	-	-	6	-	-	-	-	-
Inventory: Other supplies	-	59	-	-	-	-	-	-	-
Consumable supplies	2 526	693	203	981	1 583	1 583	1 089	1 121	1 173
Cons: Stationery, printing	3 530	2 219	2 982	3 560	4 667	4 667	3 031	3 176	3 326
Operating leases	8 220	3 498	2 427	4 184	4 172	4 172	975	1 020	1 066
Property payments	5 449	4 517	4 060	4 806	5 008	5 008	2 129	2 232	2 336
Travel and subsistence	13 351	11 189	10 122	11 696	13 641	13 616	14 736	15 425	16 150
Training and development	322	239	236	-	146	420	-	-	-
Operating payments	868	826	774	336	496	496	704	738	773
Venues and facilities	503	210	332	700	686	292	176	778	814
Rental and hiring	-	-	184	-	540	916	588	-	-
Interest and rent on land	101	39	111	-	-	25	-	-	-
Interest (incl. interest on fi	101	39	111	-	-	25	-	-	-
Transfers and subsidies	35 152	69 025	38 977	25 422	50 648	50 648	27 906	29 417	30 620
Provinces and municipalities	552	519	1 292	859	859	859	1 000	1 048	1 098
Provinces	551	519	1 291	859	859	859	1 000	1 048	1 098
Provincial agencies and	551	519	1 291	859	859	859	1 000	1 048	1 098
Municipalities	1	-	1	-	-	-	-	-	-
Municipal bank account	1	-	1	-	-	-	-	-	-
Households	34 600	68 506	37 685	24 563	49 789	49 789	26 906	28 369	29 522
Social benefits	345	724	1 423	154	380	380	-	171	-
Other transfers to househo	34 255	67 782	36 262	24 409	49 409	49 409	26 906	28 198	29 522
Payments for capital assets	3 827	8 025	3 137	14 112	13 112	13 841	2 000	2 096	2 197
Machinery and equipment	3 827	8 025	3 137	14 112	13 112	13 841	2 000	2 096	2 197
Transport equipment	-	383	1 384	3 000	3 000	1 937	-	-	-
Other machinery and equ	3 827	7 662	1 753	11 112	10 112	11 904	2 000	2 096	2 197
Payments for financial asse	10 026	-	-	-	-	-	-	-	-
Total economic classificat	282 001	342 113	289 363	322 276	416 142	416 989	367 364	394 090	415 196

Human Resources for Health

Table 16: Human Resource Tables

Staff Category	Number of staff	Actual Population to Staff Ratio per 100 000 pop	Staffing Norm per 100 000 pop
Community Health Workers	6119	0.0	111.7
Nursing Assistants	1465	32.9	69.7
Enrolled Nurse	1832	41.2	64.04
Professional Nurses	5619	126.3	147.95
Medical practitioner	1082	24.3	33.1
Pharmacists	320	7.2	11.89
Dental practitioner	107	2.4	2.55
Occupational therapists	96	2.2	2.64
Physiotherapists	107	2.4	3.1
Speech Therapy/Audiology	70	1.6	1.51

The table above reflect that all categories of staff have shortage of personnel with exception of Speech therapy which is at 1.6 against 1.51 per 100 000 thousand population.

8.4.7. Audit outlook (Regulatory audit assessment)

The department will utilize AGSA Audit Opinion as yard stick to measure its effort and efficiency towards financial management. In the financial year 2018/19, the AGSA Audit findings was a qualified audit opinion with contingent liability. The department has established hospital support teams to conduct financial management assessments. The department has developed and is implementing an accrual reduction & efficiency strategy. Provincial finance forums are held on quarterly basis to improve financial management and accountability. The department has developed and is currently implementing AGSA audit action plan.

PART C: MEASURING OUR PERFORMANCE

9. Institutional Programme Performance Information

9.1. Impact Statements

MTSF 2019-2024 priority	3. Education, Skills and Health
Impact A	Life expectancy of South Africans improved to 70 years by 2030
Impact B	Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030

9.2. Measuring our Outcomes

MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)		
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Ehlanzeni	District Gert Sibande	District Nkangala
Improve access to maternal health services; Improve the Integrated Management of Childhood Diseases services Protect children against vaccine preventable diseases	Maternal, Neonatal, Infant and Child Mortality reduced	1. Institutional Maternal Mortality Ratio	DHIS	129 per 100 000 live births	<100 per 100 000 live births	92.4 per 100 000 live births	<87 per 100 000 live births	<75 per 100 000 live births	<88 per 100 000 live births	<100 per 100 000 live births
		2. Neonatal (<28 days) death in facility rate	DHIS	12 per 1,000 live births	<10 per 1,000 live births	11.5 per 1,000 live births	<8.4 per 1,000 live births	<8.8 per 1,000 live births	<10 per 1,000 live births	<6.5 per 1,000 live births
		3. Death under 5 years against live birth rate	DHIS	32 per 1000 live births	25 per 1000 live births	19.2 (1300/67 689)	14.8 (1068/72 000)	14.8 per 1000 live births	14.8 per 1000 live births	14.8 per 1000 live births
		4. Children <5 who are stunted	SADHS 2016	27%	23%	20%	17.2%	17.2%	17.2%	17.2%

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MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)		
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Ehlanzeni	District Gert Sibande	District Nkangata
Provide prompt treatment of HIV and other sexually transmitted infections	Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	5. HIV positive 15-24 years (excl ANC) rate	Survey	88 000	<44 000 by 2024/25	No baseline	<5%	<5%	<5%	
		6. ART client remain on ART end of month - total	Tier system	-	-	464 569	720 472	322 598	216 732	232 531
		7. ART Death rate	DHIS (Tier.net)	115 167 ³	68 302	Not in plan	<1%	<1%	<1%	
	Morbidity and Premature mortality due to Non-Communicable diseases reduced by 10%	8. All DS-TB Client Death Rate	DHIS (Tier.net)	29 513 ⁴ (2016)	8 510	7.2%	<5%	<5%	<5%	
		9. Malaria inpatient case fatality rate	DHIS	70 / 581 700	Malaria eliminated by 2023	0.6	Malaria eliminated by 2023	Malaria eliminated	Malaria eliminated	Malaria eliminated
		10. Overweight or obese child under 5 years incidence	SADHS 2016	13%	10%	new Indicator	10%	10%	10%	
	Package of services available to the population is expanded with priority given to	11. Men and Women 15 years and older with hypertension 2	SADHS 2016	44%	50% (TBC)	New Indicator	50%	50%	50%	
		12. Men and Women 15 years and older with diabetes ²	SADHS 2016	8%	10% (TBC)	ew Indicator	10%	10%	10%	
		13. Universal Health Coverage (UHC) service Index	SAHR 2018	68%	80%	New Indicator	80%	80%	80%	

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MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Ehlanzeni	District Gert Sibande	District Nkangala		
	equity and most cost-effective services,											
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for NHI;	Quality of health services in public health facilities improved	14. Percentage of patients satisfied with their experience of care in public health facilities	Patient surveys	76.5%	85%	76.5%	85%	80%	85%	85%		
		15. Ideal clinic status obtained rate	Ideal Health Facility software	56% (1920 / 3400)	100%	46.3%	100%	100%	100%	100%		
Mitigate the risks related to medical litigation	Contingent liability of medico-legal cases reduced by 80%	16. Contingent liability of medico-legal cases	Medico-legal case management system	R 90 bn	R 18 bn	R10 296 793 298.84	2 billion	N/A	N/A	N/A		
		17. Patient Safety Incident (PSI) case closure rate	PSI Software	Baseline to be determined	(TBD)	No baseline	89%	89%	89%	89%		
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for	Leadership and governance in the health sector enhanced to improve quality of care	18. Number of Districts with Quality Improvement; monitoring and Response Forums formalized and convened	Terms of Reference of Monitoring and Response Forums	Baseline to be determined	52 Districts	New indicator	3	1	1	1		

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MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Ehlanzeni	District Gert Sibande	District Nkangala		
NHI;		quarterly										
		19. Percentage of PHC facilities with functional Clinic committees	Minuted meetings of committee	-	(TBD)	New indicator	288/288	122/122	76/76	90/90		
		20. Percentage of Hospitals with functional hospital boards	Minuted meetings of committee	-	(TBD)	New Indicator	32/32	13/13	10/10	9/9		
	Co-ordinating health services across the care continuum, re-orienting the health system towards primary health	21. EMS urban response time	EMS Management System with Computer Aided Dispatch	-	-	63.3%	65%	65%	65%	65%		
		22. EMS P1 rural response time		-	-	63.3%	70%	70%	70%	70%		
Public health facilities supplied with adequate ICT infrastructure to implement the Digital Health Strategy 2019-2024 of South Africa	Robust and effective health information systems to automate business processes and improve evidence based decision making	23. Percentage of health facilities electronically recordings clinical codes for their patient visits	(TBC)	-	50%	New Indicator	80%	80%	80%	80%		
Not Applicable	Improve financial management	24. Audit opinion of Provincial DoH	Annual Reports	Unqualified	Clean Audit	Qualified Audit Opinion	Unqualified Provincial Audit Opinion	N/A	N/A	N/A		

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MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)		
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Ehlanzeni	District Gert Sibande	District Nkangala
Implement the costed infrastructure plan to improve efficiency and effectiveness of health services delivery	Infrastructure maintained and back log reduced	25. Percentage of Health facilities with major refurbishment or rebuild	Project management Information Systems (PMIS)	10-year infrastructure plan drafted	80%	No baseline	8.6% (28/312) Facilities	10% (13/126) Facilities	8% (7/87) Facilities	8% (8/99) Facilities

² Diabetes and Hypertension Prevalence measured by SADHS 2016

¹ Rapid Mortality Surveillance 2017, MRC 2019 (published 2019)

³ NCEEMD, 2018

⁴ Leading causes of Mortality in South Africa 2016, StatsSA 2018

Explanation of the Planned Performance over the Five Year Planning Period

In the financial year 2018/19, the AGSA Audit findings is at qualified audit opinion with contingent liability. The department has established hospital support teams to conduct financial management assessment. The department has developed and is implementing accruals reduction & efficiency strategy. Provincial finance forums are held on quarterly basis to improve financial management and accountability. The department has developed and is currently implementing AGSA audit action plan. This will assist the department to obtain unqualified audit which will contribute to attainment of Universal Health Coverage for all South Africans and that all citizens be protected from the catastrophic financial impact of seeking health care by 2030

Primary health care facilities (fixed clinics and community health centres) render first contact with patients and also ensure continuity of care from community based health services, ward-based PHC outreach teams and mobile clinics. There is a need for services to be managed in a sustainable and efficient manner for communities to have access to quality health services.

The following are planned interventions to deliver all the outputs:

Implementation and monitoring of the ideal health facility framework to improve quality and access to the primary health care facilities.

Monitoring the complaints resolution rate within 25 working days which will make it possible for the Department to promptly address identified gaps in order to increase positive client experience of care.

Maternal Child Women and Youth & Integrated Nutrition Program is one of the priorities for the improvement of lives of mothers and children thus reducing both maternal and child mortality rates. There is a need not to only reduce mortality rates but also reduce modifiable factors that are seen to be increasing every year as indicated in the Saving mothers report 2014-16.

The following are the planned interventions to improve the outputs of this program;

Improving the couple year protection rate (CYP),

Reduction of teenage pregnancies through intersect oral collaboration with other departments like Department of Social Development and Department of Education on provision of Sexual Reproductive Health services through the integrated school health program (ISHP)

Monitoring the implementation of Household IMCI component to prevent childhood illnesses i.e. diarrhea, pneumonia and severe acute malnutrition case fatalities thus improving the quality of life among children.

Increase the number of school health teams to improve the provision of SRH services within schools through integrated school health program

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HIV and AIDS, STIs and TB is one of the priority interventions to prolong lives. Prevention and reduction of new HIV and TB infections and STIs will increase life expectancy.

The following are the planned interventions: Provide information, Education and Communication materials in health care facilities and during community outreach services. Department will also Scale-up STI prevention by providing high quality health information and timely health services for persons at risk. Implement the 90-90-90 strategy for HIV entails the following:

90% of all people living with HIV know their HIV status.

90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy.

90% of all people receiving antiretroviral therapy are virally suppressed.

Implement the 90-90-90- strategy for TB

- To screen 90% of all clients visiting all health care facilities
- To initiate 90% of TB patients on appropriate treatment.
- To achieve 90% treatment success.

South Africa is seeing an increase the prevalence of Non Communicable Diseases while still grappling with Communicable Diseases. The United Nations has prioritized the reduction on incidence of Non Communicable diseases and Communicable diseases as one of the goals in the set of Sustainable Developmental goals.

The program is planning to increase the number of clients on Diabetic and hypertension treatment which is new indicator for this financial year which will assist the province on quantifying the burden that the province is having of Diabetic and Hypertension diseases. The program is still committed to the plan of eliminating malaria by 2023 in the province and reduce the Malaria Case Fatality rate to be below 0.5% through the Implementation of MOSWASA memorandum of understanding with the tripartite countries, Mozambique, Kingdom of Eswatini and the province.

EMS P1 response time in both rural and urban response time is critical for to improve urban response time. Over the mid term period EMS P1 Urban response time will increase from 63.5% baseline in 2018/19 FY to 65% over the mid-term period and EMS P1 rural response time increase from 63.4 baseline in 2018/19 FY to 70% by 2022/23 mid-term period. This will improve on Leadership and governance in the health sector enhanced to improve quality of care

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All the above intervention and plans will ensure that Life expectancy of South Africans improved to 70 years by 2030 and Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030 is attained.

9.3. Budget Allocations

Table 10.3: Summary of payments and estimates: Health

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2016/17	2017/18	2018/19				2019/20	2020/21	2021/22
1. Administration	282 001	342 113	289 363	322 276	418 142	416 989	367 364	394 090	415 166
2. District Health Services	6 524 844	7 182 004	8 031 679	8 795 457	8 737 891	8 747 884	9 482 771	10 250 947	10 757 184
3. Emergency Medical Services	328 189	371 519	363 412	435 317	436 595	427 875	483 772	529 755	621 150
4. Provincial Hospital Services	1 221 480	1 302 741	1 368 773	1 541 312	1 444 677	1 463 883	1 535 414	1 656 335	1 734 385
5. Central Hospital Services	1 026 751	1 154 508	1 222 888	1 327 268	1 303 618	1 320 848	1 324 132	1 618 977	1 590 388
6. Health Sciences and Training	372 901	367 787	365 838	452 353	425 158	385 413	480 857	524 931	550 109
7. Health Care Support Services	140 693	177 021	157 928	194 851	276 297	272 632	314 702	321 870	337 179
8. Health Facilities Management	683 021	1 185 312	1 256 062	1 317 975	1 240 793	1 245 785	1 599 182	1 428 621	1 490 450
Total payments and estimates:	10 579 880	12 083 013	13 035 843	14 386 809	14 280 909	14 280 909	15 568 194	16 625 526	17 496 022

Table B.3: Payments and estimates by economic classification: Health

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2016/17	2017/18	2018/19				2019/20	2020/21	2021/22
Current payments	6 793 872	10 657 396	11 577 331	12 829 578	12 654 518	12 776 710	13 977 490	15 265 159	16 057 341
Compensation of employees	6 686 878	7 217 105	7 662 953	8 487 251	8 420 581	8 408 590	9 389 758	10 006 685	10 509 680
Salaries and wages	5 877 405	6 339 940	6 706 068	7 441 429	7 402 262	7 366 328	8 118 302	8 678 568	9 106 272
Social contributions	808 273	877 165	956 885	1 025 822	1 018 289	1 043 284	1 271 456	1 328 117	1 403 407
Goods and services	3 064 888	3 439 974	3 913 891	4 362 327	4 433 937	4 366 917	4 587 732	5 258 474	5 547 661
Administrative fees	180 334	216 139	200 566	198 932	278 731	278 667	231 186	244 138	253 438
Advertising	6 077	5 031	5 776	10 533	11 236	13 812	19 848	22 275	22 139
Minor Assets	9 462	4 939	4 170	26 418	7 078	7 286	23 279	23 248	29 811
Audit cost: External	14 819	18 820	18 859	18 146	18 146	18 146	20 021	20 982	21 969
Bursaries: Employees	804	1 057	-	-	-	1 561	-	-	-
Catering: Departmental activities	2 903	2 708	3 381	9 262	4 806	4 761	9 542	10 540	10 687
Communication (G&S)	44 325	37 048	38 614	41 502	39 174	39 819	41 211	43 530	45 485
Computer services	16 269	38 649	24 515	54 836	67 581	55 401	82 285	85 883	89 724
Consultants: Business and advisory services	15 328	5 594	4 413	7 770	9 266	12 110	6 763	7 077	7 409
Laboratory services	373 723	411 385	495 105	687 683	607 505	538 469	566 747	743 841	798 402
Legal costs	18 576	28 640	35 831	21 252	62 808	72 768	33 804	40 657	42 567
Contractors	83 778	113 787	102 012	172 116	152 022	152 059	219 824	218 930	228 264
Agency and support / outsourced services	117 582	73 931	113 936	103 827	110 740	110 060	88 362	82 695	86 141
Fleet services (incl. government motor transport)	104 309	107 885	114 691	102 161	105 295	105 816	109 540	128 977	138 960
Inventory: Clothing material and accessories	-	1 650	-	-	-	-	-	-	-
Inventory: Farming supplies	-	4 048	-	11 848	-	-	-	-	-
Inventory: Food and food supplies	89 076	87 220	79 158	96 788	86 930	85 771	104 606	106 826	114 788
Inventory: Chemicals, fuel, oil, gas, wood and coal	30 952	7 021	-	243	121	-	-	-	-
Inventory: Learner and teacher support material	-	-	-	18	18	18	-	-	-
Inventory: Materials and supplies	199	-	-	750	750	750	-	-	-
Inventory: Medical supplies	360 795	383 126	434 707	491 644	498 178	493 329	469 360	536 987	567 564
Inventory: Medicine	1 077 749	1 399 628	1 616 131	1 655 888	1 568 359	1 571 218	1 757 252	2 087 096	2 177 284
Inventory: Other supplies	-	12 138	-	11 832	2 080	2 050	-	-	-
Consumable supplies	117 007	92 517	118 661	122 674	158 465	160 863	181 091	198 888	201 107
Cons: Stationery, printing and office supplies	19 994	16 257	17 871	24 813	41 988	38 582	54 807	54 543	55 742
Operating leases	45 716	44 526	50 690	54 811	54 944	54 287	50 052	53 483	59 381
Property payments	280 374	274 759	358 588	336 836	453 177	453 178	387 601	443 971	477 482
Transport provided: Departmental activity	216	280	399	354	711	702	906	950	995
Travel and subsistence	67 613	60 403	66 803	75 825	86 584	85 515	92 967	98 619	95 205
Training and development	5 090	5 310	4 713	6 822	5 188	5 431	7 870	8 575	8 878
Operating payments	4 307	4 147	2 582	13 188	4 134	4 592	4 683	4 848	5 065
Venues and facilities	1 871	1 290	665	700	969	610	1 449	2 112	2 148
Rental and hiring	839	60	963	43	940	1 310	806	252	-
Interest and rent on land	2 306	317	487	-	-	203	-	-	-
Interest (incl. interest on finance leases)	2 306	317	487	-	-	203	-	-	-
Transfers and subsidies	306 487	368 261	448 900	376 138	414 363	488 922	188 517	198 002	207 407
Provinces and municipalities	582	519	2 326	859	1 359	1 358	2 000	2 098	2 196
Provinces	561	519	2 325	859	1 359	1 358	2 000	2 096	2 196
Provincial Revenue Funds	-	-	1 034	-	-	-	1 000	1 048	1 098
Provincial agencies and funds	561	519	1 291	859	1 359	1 358	1 000	1 048	1 098
Municipalities	1	-	1	-	-	-	-	-	-
Municipal bank accounts	1	-	1	-	-	-	-	-	-
Departmental agencies and accounts	177	6 925	14 185	15 052	39 044	30 943	23 819	24 963	26 136
Departmental agencies (non-business entities)	177	6 925	14 185	15 052	39 044	30 943	23 819	24 963	26 136
Non-profit institutions	182 733	194 987	308 946	264 641	264 641	333 679	71 351	74 484	77 679
Households	123 025	185 830	124 443	95 586	115 319	120 941	91 347	96 479	101 406
Social benefits	88 770	97 988	35 264	9 340	14 007	16 836	16 441	17 401	18 841
Other transfers to households	34 255	87 842	89 179	86 248	101 312	101 306	74 906	79 078	83 455
Payments for capital assets	509 496	1 057 358	1 028 712	1 181 093	1 012 028	1 017 277	1 402 187	1 462 365	1 231 274
Buildings and other fixed structures	437 584	938 812	896 065	952 804	742 383	747 632	1 057 185	887 565	924 797
Buildings	437 584	938 812	896 065	952 804	742 383	747 632	1 057 185	887 565	924 797
Machinery and equipment	71 802	120 544	132 647	228 289	269 645	269 645	345 002	274 800	306 477
Transport equipment	4 823	24 299	21 354	70 304	69 370	68 497	83 586	83 248	120 876
Other machinery and equipment	67 079	96 245	111 293	157 985	200 275	201 148	261 416	191 554	185 601
Payments for financial assets	10 025	-	-	-	-	-	-	-	-
Total economic classification	10 579 880	12 083 013	13 035 843	14 386 809	14 280 909	14 280 909	15 568 194	16 625 526	17 496 022

Explanation of the contribution of resources towards achievement of outputs.

The increase above the CPI in the programme in 2020/21 is due to the funding of the initiative to strengthen health system amounting to R 1.9 million, funding of the communication strategy amounting to R 7 million. A budget of R 10 million to fund the monitoring and evaluation system as well as increase the budget for computer services to address the pressure in data lines for ICT.

9.4. Key Risks

Outcome	Risk	Mitigating factors
Maternal, Neonatal, Infant and Child Mortality reduced	<ul style="list-style-type: none"> Inadequately trained clinicians Increase in preventable deaths Poor recording keeping leading to increased litigations 	<ul style="list-style-type: none"> Prioritize training of clinicians Prioritize the appointment of skilled clinicians Conduct clinical audits
		<p>Monitor ESMOE fire drills in facilities</p> <ul style="list-style-type: none"> Conduct community engagements Monitor the availability of essential equipment's and medicines including contraceptives Prioritize neonatal units in district hospital (infrastructure especial high volume delivery) Strengthen provision of neonatal high care units and ICU in regional and tertiary hospitals Strengthen SRH services within school through appointment of ISHP teams <p>Monitor the availability of youth friendly contraceptives methods</p>

Outcome	Risk	Mitigating factors
Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	<ul style="list-style-type: none"> Low levels of HIV and TB screening Increase in new HIV and TB infections. 	<ul style="list-style-type: none"> Implement and monitor the 90-90-90 strategy for both HIV and TB.

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<p>Morbidity and Premature mortality due to Non-Communicable diseases reduced by 10%</p>	<p>Shortage of medication for chronic diseases</p> <ul style="list-style-type: none"> • Late presentation of the public for treatment of non communicable diseases. 	<ul style="list-style-type: none"> • Monitor availability of medication and address issues as per the problem identified • Public screening of people at risk • Training of community health workers to screen as per the revised training manual for CHW
<p>Package of services available to the population is expanded with priority given to equity and most cost-effective services,</p>	<p>Shortage of medication including immunizations and medical supplies</p>	<p>Monitor availability of medication and medical supplies and address identified gaps.</p>
	<p>Shortage of staff resulting in inaccessible and poor quality of care</p>	<p>Prioritize filling of vacant funded and critical posts</p>
	<p>Organogram not responding to service delivery needs</p>	<p>Review and align organogram to be responsive to service delivery needs</p>
	<p>Inadequate medical equipment and instruments resulting in poor quality of care</p>	<p>Prioritize procurement of essential medical equipment and instrument</p>
	<p>Inadequate cleaning material resulting in an increased infection rate</p>	<p>Prioritize procurement of non - negotiables including cleaning material</p>
	<p>Inadequate and poorly maintained infrastructure</p>	<p>Prioritize development and implementation of infrastructure maintenance plan</p>
<p>Quality of health services in public health facilities improved</p>	<p>Collapse of Health System due to Corona Virus</p>	<p>Implement Provincial Covid-19 response strategy</p>
	<p>Non-compliance to the promulgated norms and standards Compromised quality of health care</p>	<p>Monitor implementation of quality improvement plans.</p>
	<p>Suspension of X-ray services by Radiation Control (sealing of X-ray units due to noncompliance).</p>	<p>a. Fast track the filling of critical vacant posts. b. Develop, implement, and monitor maintenance plans for X-ray equipment for all facilities. c. Conduct Quality Assurance audits for compliance. Replacement of obsolete X-ray equipment.</p>
	<p>Insufficient supply of Essential Medicines due to inadequate warehouse management system.</p>	<p>a. Procure warehouse stock management system. b. Fast track the filling of critical vacant posts.</p>

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	Delayed production and issuing of MOP devices	<ul style="list-style-type: none"> a. Develop maintenance plan of MOP equipment and sign Service Level Agreement with service provider. b. Procurement of machinery and adequate consumables.
	Irrational use of blood and blood products.	Appointment of Senior Clinicians and training of health care professionals.
	Closure of FPS facilities by Department of Labour due to noncompliance to relevant legal prescripts.	<ul style="list-style-type: none"> a. Facilitate routine maintenance of FPS facilities and equipment b. Facilitate filling in of critical vacant funded pots c. Conduct academic training sessions for Medical Officers Facilitate Employee Wellness programme for employees
Contingent liability of medico-legal cases reduced by 80%	Failure to report adverse events by health facilities and implementing partners resulting in increased risk for litigations.	a. Monitor implementation of patient safety incident Policy and SOP in relation to reporting.
	Inadequate human resources (Quality Assurance Coordinators) at facility level	b. Prioritize appointment of QA Coordinators in the 2020/21-2022/23 MTSF
	Patients' failure to adhere to Medical Male Circumcision post-operative care instructions resulting in infection and wound dehiscence.	c. Conduct community engagement and education.
	Non-compliance to Voluntary Medical Male Circumcision guidelines on data recording and reporting resulting in double reporting and capturing of unverifiable data.	d. Monitor compliance to guidelines.
	Non-compliance to HIV Testing Quality Controls resulting in potential risk of unreliable HIV test results.	Monitor Rapid Testing Continuous Quality Improvement (RTCQI) <ul style="list-style-type: none"> a. Organize and expose HIV testers to proficiency testing.
Management of patient safety incidents improved	Unsafe health facilities to patients	<ul style="list-style-type: none"> a. Fill the critical vacant positions b. Develop implement and monitor clinical protocols and procedures c. Procure the needed medical equipment and consumables b. Conduct clinical audits and peer reviews per discipline

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Leadership and governance in the health sector enhanced to improve quality of care	<ul style="list-style-type: none"> • Uninformed communities regarding available services • Poor health seeking behavior • Increased complaints • Negative patient experience of care 	<ul style="list-style-type: none"> • Establish and train clinic committees and hospital board as for all health facilities. • Community awareness campaigns • Monitor functionality of governance structures. • Monitor patient experience of care.
	<ul style="list-style-type: none"> • EMS failure to take control of PPTS (Planned Patient Transport Services) 	<ul style="list-style-type: none"> a. Integration of PPTS into EMS b. Implement PPTS plan
	<p>Ineffective Emergency Communication Center (ECC)</p> <p>Inaccessible Control Centre's leading to non-response to calls</p> <ul style="list-style-type: none"> • Late response to calls 	<ul style="list-style-type: none"> a. Appointment of shift leaders. <p>Suitable infrastructure for the Emergency Management Centre in Mbombela and installation of a system for</p> <ul style="list-style-type: none"> ▪ call taking ▪ Vehicle tracking ▪ Dispatching and Workforce management ▪ Upgrading of the communication management system
	<ul style="list-style-type: none"> • Non – availability of ambulances 	<p>Procurement of ambulances to attend to possible calls</p>
	<ul style="list-style-type: none"> • Long turnaround times from service merchants 	<ul style="list-style-type: none"> • Engaging service merchants to prioritized EMS vehicle repairs
Co-coordinating health services across the care continuum, re-orienting the health system towards primary health	<p>EMS failure to take control of PPTS (Planned Patient Transport Services)</p>	<ul style="list-style-type: none"> c. Integration of PPTS into EMS Implement Operational PPTS plan
	<p>Ineffective Emergency Communication Center (ECC)</p>	<ul style="list-style-type: none"> b. Appointment of shift leaders. <p>Upgrading of the communication center system</p>
	<p>Inadequate/ inappropriate emergency vehicles</p> <p>Inadequate/ inappropriately qualified personnel</p>	<ul style="list-style-type: none"> a. Procure some additional EMS vehicles b. Appropriate skilled ALS practitioners c. Appointment of Emergency Care Technicians and ALS Practitioners
Improve financial management	Qualified audit opinion	Implement provincial audit action plan

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Infrastructure maintained and back log reduced	Inadequate access to health facilities impacting on health outcomes Unsafe health facilities to patients and employees	Conduct assessment of health facilities and prioritization Develop and implement maintenance plan Establish maintenance Hubs.

10. Public entities

Name of Public Entity	Mandate	Outcomes
Not Applicable	Not Applicable	Not Applicable

**PART D: TECHNICAL INDICATOR DESCRIPTION (TID) FOR STRATEGIC
PLAN**

TECHNICAL INDICATOR DESCRIPTION (TID) FOR STRATEGIC PLAN

No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
				Numerator	Denominator						
1	Maternal Mortality in facility Ratio	Death occurring during pregnancy, childbirth or the within 6 weeks after maternal 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) against 100 000 live births in facility	Maternity Register, DHIS	Maternal death in facility	Live births known to facility (Live birth in facility + Born alive before arrival at facility)	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Annual progress against the five year target	Lower	MCWH&N Programme
2	Neonatal (<28 days) death in facility rate	Percentage infants who delivered as live birth and died within 0-28 days during their stay in the facility	Delivery register, Midnight report	Neonatal deaths (under 28 days) in facility (Death in facility 0-6 days) + (Death in facility 7-28 days)	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Annual progress against the five year target	Lower	MCWH&N Programme
3	Death under 5 years against live birth rate	Percentage of Children under 5 years who died during their stay in the facility	Delivery/Maternity register/Midnight Report	Death in facility under 5 years total	Live birth in facility	Accuracy dependent on quality of data submitted by health facilities	children	All Districts	Annual progress against the five year target	Lower	MCWH&N Programme
4	Children <5 who are stunted	Percent of children hindered from growing properly aged 0-59 months classified as per World Health Organization standard as moderate (height-for-age below -2 standard deviations from the WHO Child Growth Standards median) or severe	South African Demographic and Health Survey 2016	Not Applicable	Not Applicable	The main limitation of this indicator is that length or height can be difficult to obtain, thus leading to problems of	children	All Districts	Annual progress against the five year target	Lower	MCWH&N Programme

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No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
		(height-for-age below -3 standard deviations from the WHO Child Growth Standards median).			validity.					
5	HIV positive 15-24 years (excl ANC) rate	Percentage of persons within the age of 15 to 24 years who tested HIV and confirmed as positive	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,D HIS	HIV positive 15-24 years (excl ANC) HIV test 15-24 years (excl ANC)	Accuracy dependant on Individuals self-reporting HIV-positive status and/or individuals with detectable ART metabolites among all PLHIV (antibody test)	Youth	All Districts	Annual progress against the five year target	Lower	HIV/AIDS Programme Manager
6	ART Death Rate	Percentage of clients who were on ART treatment who died during the reporting period excluding those who were transferred out of facility.	ART Register; TIER.Net; DHIS	ART cumulative death - total ART start minus cumulative excluding transfer out	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Annual progress against the five year target	Lower	HIV/AIDS Programme Manager
7	ART client remain on ART end of month - total	Total number of clients who are receive Anti Retroviral Treatment including Any client on treatment in the reporting month, Any client without an outcome reported in the reporting month either identified as newly starts (native)/ Experienced (Exp)/ Transfer in from other institutions and restart treatment excluding those who died, lost to follow up or Transfer out	ART Register; TIER.Net; DHIS	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	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Annual progress against the five year target	Higher	HIV/AIDS Programme Manager

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No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
				<p>ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TF)] + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]</p> <p>Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TF)] + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]</p> <p>All DS- TB client died</p>						
8	All DS-TB Client Death Rate	TB clients who already enrolled' started drug-susceptible tuberculosis (DS-TB) treatment who died	DS -TB Clinical stationery; TIER.Net	All DS- TB patients in treatment outcome cohort	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Annual progress against the five year target	Lower	TB Programme Manager
9	Malaria inpatient case fatality rate	Percentage of patients who were confirmed as malaria infected and died of malaria as an outcome.	Malaria Information System	Malaria new case reported	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Annual progress against the five year target	Lower	Environmental Health- Malaria Program

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No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
10	Overweight or obese child under 5 years incidence	Measure of occurrence of Children under 5 years newly diagnosed with overweight and obesity per population	South African Demographic and Health Survey 2016	Not Applicable (Survey Data)	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Annual progress against the five year target	Lower	MCWH&N Programme
11	Men and Women 15 years and older with hypertension 2	An individual is classified as having hypertension with a systolic blood pressure of 140 mmHg or above or a diastolic blood pressure of 90 mmHg or above at the time of the survey, or was currently taking antihypertensive medication to control blood pressure.	South African Demographic and Health Survey 2016	Not Applicable	Not Applicable	Not Applicable	All Districts	Annual progress against the five year target	Lower	Communicable Diseases
12	Men and Women 15 years and older with diabetes?	An individual is classified as having diabetes with HbA1c above or equal 6.5%	South African Demographic and Health Survey 2016	Not Applicable	Not Applicable	Not Applicable	All Districts	Annual progress against the five year target	Lower	Communicable Diseases
13	Universal Health Coverage (UHC) service index	Coverage on provision essential health services which includes reproductive, maternal, new born and child health, infectious disease control, non-communicable diseases and service capacity and access to the community	South African Health Review (SAHR 2018)	Not Applicable	Not Applicable	Not Applicable	All Districts	Annual progress against the five year target	Lower	Communicable Diseases

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No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
14	Patient Experience of Care survey rate	Proportion of clients who participated in the patient experience of care survey of health facility and responded to a questionnaire to determine whether they are satisfied with services in facilities.	Patient Surveys	<p>Patient Experience of Care survey satisfied responses</p> <p>Patient Experience of Care survey total responses</p>	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Annual progress against the five year target	Higher	Quality Assurance
15	Ideal clinic status obtained rate	Fixed PHC health facilities that was assessed according to ideal clinic manual which obtained Ideal Clinic status which is either bronze, silver, gold conducted by Perfect Permanent Ideal Clinic Realization Maintenance Team (PPICRM)	Ideal Health Facility software	<p>Fixed PHC health facilities have obtained Ideal Clinic status</p> <p>Fixed PHC clinics or fixed clinics and CHCs</p>	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Annual progress against the five year target	Higher	Quality Assurance
16	Contingent liability of medico-legal cases	Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March 2019	Medico-legal case management system	<p>Total rand value of the medico legal claims for all backlog cases that were on the case register as at 31 March 2019</p> <p>Not Applicable</p>	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Annual progress against the five year target	Lower	Legal services
17	Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case were reported in the health facility which were investigated, resolved and closed	Patient Safety Incident Software	<p>Patient Safety Incident (PSI) case closed</p> <p>Patient Safety Incident (PSI) case reported</p>	Accuracy dependent on reporting of data at facility level	Not Applicable	All Districts	Annual progress against the five year target	Higher	Quality Assurance

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No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
18	Number of Districts with Quality Improvement; monitoring and Response Forums formalized and convened quarterly	Total number of Districts with Quality Improvement; Response Forums with formally appointed members and terms of reference that convene quarterly with clinical governance responsibility	Terms of Reference for response forums.	Number of Districts with Quality Improvement; monitoring and Response Forums convened quarterly	Not Applicable	Not Applicable	All Districts	Annual progress against the five year target	Higher	Quality Assurance
19	Percentage of PHC facilities with functional Clinic committees	Percentage of clinics committees established which conduct regular meetings and have regular minutes of meetings.	Attendance Registers of meetings of Clinic committees	Number of functional clinic committees	Attendance Registers are accurately kept	Not Applicable	All Districts	Annual progress against the five year target	Higher	Quality Assurance
20	Percentage of Hospitals with functional hospital boards	Percentage of hospitals committees established which conduct regular meetings and have regular minutes of meetings.	Attendance Registers of meetings of hospital boards	Number of functional Hospital Boards	Attendance Registers are accurately kept	Not Applicable	All Districts	Annual progress against the five year target	Higher	Quality Assurance
21	EMS urban response time	Percentage of Emergency medical logged call for life threatening emergency (EMS P1) urban with response time to measure time taken from the time call is logged to the time a patient is attended by EMS professional at the scene	EMS System	EMS P1 urban response under 30 minutes	Functional call logging system	Not Applicable	All Districts	Annual progress against the five year target	Higher	Emergency Medical Services
22	EMS P1 rural response time	Percentage of Emergency medical logged call for life threatening emergency (EMS P1) rural with response time to measure time taken from	EMS System	EMS P1 rural response under 60 minutes	Functional call logging system	Not Applicable	All Districts	Annual progress against the five year target	Higher	Emergency Medical Services

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No	Indicator Title	Definition	Source of Data	Method of Calculation/Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
		the time call is logged to the time a patient is attended by EMS professional at the scene								
23	Audit opinion of Provincial DoH	Auditor General audit outcome/opinion released to the department after assessment or regulatory audit conducted.	Audit report	Audit outcome report	Completed audit assessment by AGSA	Not applicable	Provincial	Annual	Unqualified opinion	Finance
24	Percentage of health facilities electronically recordings clinical codes for their patient visits	Percentage of facilities using electronic clinical coding to classify diagnosis and treatment of patients	ICD	Number of facilities using clinical coding to classify diagnosis and treatment of patients	The coding system available and functional	Not applicable	Districts	Annual	Higher	Health Information Clinical Services
25	Percentage of Health facilities with major refurbishment or rebuild	Percentage of health facilities which undergone major refurbishment and completed or were rebuild and completed		Total number of health facilities which undergone major refurbishment and completed or were rebuild and completed	Adequate budget available	Not applicable	Districts	Annual	Higher	Infrastructure

ANNEXURE A: DISTRICT DEVELOPMENT MODEL

Area of Intervention (Example)	Five-years planned period					
	Project Description	Budget Allocation	District Municipality	Location: GPS Coordinates	Project Leader	Social Partner
New Construction	Kamdladla Clinic - Construction of New clinic and Refurbishment of Existing Facilities	7,094,000	Kamdladla		Mzamo Gonya	None
New Construction	KaNyamazane Community Health Centre (Construction of new Community Health Centre and accommodation u	39,702,000	Kanyamazane		Kazumba Kumizuku	None
New Construction	Themba Hospital: Construction of a New Maternity Ward	8,000,000	Kabokweni		Lourens Coetzer	None
New Construction	Oakley Clinic: Construction of Clinic, 2 x 2 staff accomodation units, guard house, fence, water	5,406,000	Bushbuckridge (Oakley)		Basil Sande	None
Upgrading	Rob Ferreira hospital: Upgrading of Allied building to an Oncology Ward	15,000,000	Mbombela		Mzamo Gonya	None
New Construction	Mapulaneng Hospital: Construction of building works (Phase 3A)	56,336,000	Mapulaneng		Kazumba Kumisuku	None
New Construction	Mapulaneng Hospital: Construction of building works (Phase 3B)	14,035,000	Mapulaneng		Kazumba Kumisuku	None
New Construction	Mapulaneng Hospital: Construction of building works (Phase 3C)	19,960,000	Mapulaneng		Kazumba Kumisuku	None
New Construction	Rob Ferreira Hospital: (Phase 2A) Renovations and alterations to the existing nurses accommodation	7,274,560	Mbombela		Basil Sande	None
Upgrading	Rob Ferreira Hospital: (Phase 2B)Renovations and Alterations to the Existing Nurses Accommodation Bu	6,065,000	Mbombela		Basil sande	
Upgrading	Rob Ferreira Hospital: (Phase 2C)Renovations and Alterations to the Existing Nurses Accommodation Bu	6,170,000	Mbombela		Basil Sande	

ANNEXURE B: STATSSA – MPUMALANGA POPULATION PROJECTIONS 2019-2024

Sex	Age	2020	2021	2022	2023	2024
Male	0-4	237347	238464	239852	239492	237935
Male	5-9	233506	233034	233548	234857	236661
Male	10-14	231066	234480	235253	235424	234978
Male	15-19	196866	202255	207899	214430	220225
Male	20-24	196183	192424	191605	191345	191842
Male	25-29	222628	220650	217102	213035	210491
Male	30-34	235988	236624	237017	236287	234083
Male	35-39	199845	209902	218233	224974	231310
Male	40-44	142325	151466	161208	172381	183607
Male	45-49	109793	114063	118052	122473	127635
Male	50-54	82001	84676	88272	92257	96297
Male	55-59	68154	69589	70634	71399	72363
Male	60-64	51906	53053	54458	56133	57782
Male	65-69	39581	40644	41386	41980	42571
Male	70-74	24732	26085	27552	28967	30232
Male	75-79	14536	14903	15191	15670	16418
Male	80+	14624	15009	15351	15722	16155
Female	0-4	233007	234005	235202	234823	233236
Female	5-9	229921	229728	230570	231989	233967
Female	10-14	229180	232527	232778	232582	231922
Female	15-19	195977	200985	206410	213073	218901
Female	20-24	192145	189355	187815	186666	186796
Female	25-29	204164	201764	200052	197567	195658
Female	30-34	210962	212261	212794	212378	210991
Female	35-39	179385	186871	193530	199995	206044
Female	40-44	142523	147285	153185	160107	167562
Female	45-49	125551	128543	130926	132192	133643
Female	50-54	106058	107743	109808	112844	115967
Female	55-59	90586	93487	95466	96987	98346
Female	60-64	69407	71280	74189	77347	80600

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Sex	Age	2020	2021	2022	2023	2024
Female	65-69	56318	58217	59563	60710	61592
Female	70-74	38079	40173	42533	44967	47378
Female	75-79	24989	25721	26341	27203	28483
Female	80+	33642	34522	35023	35744	36685
Total		4662974	4731787	4798800	4864002	4928356

