GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ANNUAL PERFORMANCE PLAN

2016/17 - 2018/19

FEBRUARY 2016

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1. FOREWORD BY THE MEC FOR HEALTH: MS Q.D. MAHLANGU, MPL

The Gauteng Department of Health is committed to create an effective public health system to ensure that we provide our patients with the care they need to live long, healthy lives. To this end, we have started to re-engineer the Public Health (PHC) system aross our province. So far we have rolled out over 100 Ward Based Outreach Teams (WBOTs) in the province and have increased access to our school health services. We are also working to modify patient behaviours by increasing awareness of the risk factors for hypertension and diabetes through a series of health campaigns.

To fulfill our vision and mission, we continue to uphold our commitment to the following priorities for the five year period (2015-2020)

- Strengthen Primary Health Care re-engineering
- Accelerate reduction of in-facility maternal, infant and child mortality
- Strengthen prevention and management of HIV and AIDS and Tuberculosis
- Promote healthy life styles for our patients and residents of Gauteng
- Improve financial and operational management of the Health sector, to achieve a clean audit in 2016
- Increase capacity and skills of health care workers
- Refurbish and develop Health Infrastructure
- Transform the health economy

In order to accelerate improvement in our priority areas, we introduced a concept termed “the 90 day sprint” at our strategic planning meeting held on the 10th and 11th February 2016. The objective of “the 90 day sprint” is to accelerate progress in selected priority initiatives, by committing to deliver on agreed milestones within a 90 day period. The initiatives selected for the sprint include:

- Improve patient experience at our facilities
- Establish an electronic patient record system
- Roll-out an electronic bed management system in our facilities
- Reduce maternal and neonatal in-facility mortality rates
- Ensure clean audit in 2016

We are already seeing progress with the priorities in the 90 day sprint. An improved patient experience survey form has been developed and will be piloted in selected hospitals, some of our institutions in Tshwane have already implemented electronic bed management system, a conference to develop a province-wide action plan to combat maternal and neonatal deaths is scheduled for March 2016 and our institutions are addressing the issues identified in the previous audit.

Though we have made considerable progress, we need to remain focused if we want to meet the 2030 health objectives, as set out in the National Development Plan (NDP). The NDP's goals include: raising the life expectancy of South Africans to at least 70 years, progressively improve TB prevention and cure, reduce maternal, infant and child mortality and significantly reduce prevalence of non-communicable chronic diseases.

According to StatsSA, the province's overall life expectancy at birth stands at 61 years, up from 52 years in 2005. Today, women born in Gauteng have a life expectancy of 63 years and men 58 years. Central to the increased life expectancy is our extensive ARV programme. The Department of Health in Gauteng has the largest HIV and AIDS programme in the country, with an estimated 610 000 patients on treatment by end of quarter 4 2013/14. We have also ramped up the Medical Male Circumcision programme to intensify HIV prevention initiatives.

The department remains committed to reduce maternal and child deaths in the province. We have prioritised accelerating reduction of deaths due Non-pregnancy related infections (NPRIs), hypertension and obstetric haemorrhage as they account for most of the obstetric deaths in the province .

As part of strengthening our health system, we are investing in human resources for health care. We are increasing the number of medical students being trained through a partnership with Cuba, where we send eligible students from Gauteng for their medical training. We are also increasing access to nursing colleges by awarding bursaries to first year nursing students in the province

We have made progress in implementing our contribution to Gauteng's Ten Pillar Programme. As part of our efforts to accelerate social transformation, we are implementing the following initiatives: rolling out NHI initiatives in pilot districts, refurbishing infrastructure in our hospitals (we have refurbished targeted theatres and increased utilization as a result) and transforming our economy by procuring linen from women owned co-operatives. Although we have made great strides, we need to maintain momentum so that we fulfill our ambition of accelerating social transformation in Gauteng province.

We take our financial performance seriously and are committed to achieve a clean audit in 2016. In order to realize this, we have partnered with the South African Institute for Accountants (SAICA) to provide management support to our tertiary and central hospitals to ensure that we address all the challenges highlighted by the auditor general in the previous audit. We are also monitoring our institutions closely to ensure they continue to rectify issues highlighted in the previous audit

We are energized about executing on the commitments made in this Annual Performance Plan. We have outlined details of the efforts we'll be taking to highlight how we, as the Gauteng Department of Health, will strengthen the public health system to respond to – amongst others – high mortality and morbidity rates, whilst improving access to primary health care services in Gauteng.

2. STATEMENT BY THE HEAD OF DEPARTMENT: DR T.E. SELEBANO

The Gauteng Department of Health's Annual Performance Plan seeks to highlight our key priorities towards achieving the Medium Term Strategic Framework (MTSF). Our plan sets out targets with measurable timeframes to improve the quality of healthcare and our health outcomes in the Gauteng City Region.

In this Annual Performance Plan for the 2016/17-2018/19 Financial Years, we provide the annual work plan towards achieving the strategic goals for 2014 – 2019

We are committed to refocusing our priorities and interventions towards achieving the National Health Insurance (NHI) goals. This will be done through following the national guidelines. We have expanded the number of districts implementing NHI to five from one. This will be coupled with establishment of provincial NHI forum and annual provincial dialogue with patient groups by 2019/20.

To date, the Department has made remarkable strides in areas such as reduction in the incidence of TB and achieving a treatment cure rate of 85.1%, above the target of 84%. Furthermore, we plan to reduce the rate of new HIV and TB infections by increasing awareness and testing opportunities and ensuring the availability of the right products, services and medication (condoms, circumcision, and ARV for pregnant women).

The scourge of HIV and AIDS continues to debilitate our society despite our awareness campaigns. We encourage our communities to work with us in partnership to reduce the level of infections. To that end, we aim to reduce the HIV incidence rate from 1.72% in 2013/14 to 0.86% in 2019/20, the percentage of babies born to HIV positive mothers who test positive from 2% in 2013/14 to 0.8% in 2019/20.

This is part of our drive to reach 90-90-90 targets proposed by UNAIDS, which call for a scale-up of HIV testing so that 90% of people with HIV are aware of their infection, 90% of people diagnosed with HIV are linked to antiretroviral treatment (ART) and 90% of those on ART adhere and have undetectable levels of HIV in their blood.

Many of the illnesses we treat in our facilities come about as a result of lack of healthy lifestyles in our society. We therefore plan to put more resources in a bid to reduce the incidence and prevalence of non-communicable diseases (NCDs) and the number of non-natural deaths by promoting healthy and safe lifestyles.

In keeping with Gauteng City Region's Transformation Modernisation and Redevelopment (TMR) programme, we plan to develop and implement standard integrated patient-based information system in all 408 health facilities by 2019/20. We also plan to increase the Broadband network

access in the Department so that that 100% of Primary Healthcare Care facilities and hospitals have broadband network access and 100% of total staff has email access by 2019/20.
We will continue to uphold and enforce national core standards while carrying out our mandate and, our work will be underpinned by transparency and integrity.

It would be amiss of me not to extend my gratitude to our most important asset, our human capital. We continue to pride ourselves of the good work done by our health workers under strenuous and demanding socio-economic conditions. Our staff should not, for a fleeting moment, believe that their hard work and sacrifice has gone unnoticed.

We are making good progress in building a credible, responsive and caring Gauteng Department of Health and as such we are confident that we will achieve all these goals.

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3. OFFICIAL SIGN OFF OF THE PROVINCIAL ANNUAL PERFORMANCE PLAN **BY THE CHIEF FINANCIAL OFFICER; HEAD OF STRATEGIC PLANNING; HOD AND MEC FOR HEALTH**

It is hereby certified that this 2016/17 - 2018/19 Annual Performance Plan was developed by the Gauteng Department of Health and prepared in line with the current Strategic Plan of Gauteng Department of Health under the guidance of MEC Qedani Mahlangu; accurately reflects the performance targets which the Gauteng Department of Health will endeavour to achieve given the resources made available in the budget for 2016/17.

Mr G Mahlangu

Chief Financial Officer Signature

Mr L.M, Mosenogi

Head official responsible for planning Signature

Dr T.E Selebano

Accounting Officer Signature

APPROVED BY:

Ms Q.D. Mahlangu, MPL

Executive Authority Signature

LIST OF ACRONYMS

AG	Auditor General	IT	Information Technology
A&E	Accident and Emergency	LAN	Local Area Network
AIDS	Acquired Immune Deficiency Syndrome	MEDSAS	Medical Supplies Administration System
ALOS	Average Length of Stay	M&E	Monitoring and Evaluation
ANC	Antenatal Care	MDGs	Millennium Development Goals
APP	Annual Performance Plan	MDR TB	Multiple Drug Resistant Tuberculosis
ART	Antiretroviral Treatment	MEC	Member of Executive Council
B	Billion	M	Million
BAS	Basic Accounting System	MINMEC	Minister & Members of the Executive Committees Council
BLS	Basic Life Support	MIS	Management Information System
BOR	Bed Occupancy Rate	MISP	Management Information System Plan
BUR	Bed Utilisation Rate	MMR	Maternal Mortality Rate
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality Africa	MOU	Memorandum of Understanding
CARMMSA	Campaign for Accelerated Reduction of Maternal Mortality in South Africa	MSD	Medical Supplies Depot
		MSM	Men who have sex with men
CBO	Community Based Organisation	MTEF	Medium-Term Expenditure Framework
CCMT	Comprehensive Care, Management and Treatment	MYE	Midyear Population Estimates
CEO	Chief Executive Officer	NCDs	Non-communicable diseases
CFO	Chief Financial Officer	NDMP	National Drug Master Plan
CHBAH	Chris Hani Baragwanath Academic Hospital	NDOH	National Department of Health
CHC	Community Health Centre	NGO	Non-Governmental Organisation
CHW	Community Health Worker	NHI	National Health Insurance
CMR	Child Mortality Rate	NHLS	National Health Laboratory Services
COE	Compensation of Employees	NIMART	Nurse-initiated management of ART
CPD	Continuing Professional Development	NPO	Non-Profit Organisation
CPI	Consumer Price Index	NSP	National Strategic Plan
CPIX	Consumer Price Index Excluding Mortgage	OAG	Office of the Auditor General
DAC	Departmental Acquisition Council	OPD	Outpatient Department
DCST	District Clinical Specialist Teams	OSD	Occupation Specific Dispensation
DHIS	District Health Information System	OVC	Orphans and Vulnerable Children
DHS	District Health System	PBC	Premier's Budget Committee
DID	Department of Infrastructure Development	PDE	Population Development and Environment
DPSA	Department of Public Service and Administration	PDE	Patient Day Equivalent
EE	Employment Equity	PEP	Project Execution Plan
EML	Essential Medicine List	PEP	Post-exposure Prophylaxis
EMS	Emergency Medical Services	PFMA	Public Finance Management Act
EPI	Expanded Programme on Immunisation	PHC	Primary Health Care
EPWP	Expanded Public Works Programme	PICT	Provider Initiated HIV Counselling and Testing
ESMOE	Essential Steps in Managing Obstetric Emergencies	PLHIV	People living with HIV
EXCO	Executive Committee / Council	PMDS	Performance Management Development System
FBO	Faith-Based Organisations	PMTCT	Prevention of Mother to Child Transmission
FY	Financial Year	POA	Programme of Action
GAS	Gauteng Audit Service	PPM	Programme in Project Management
GDoH	Gauteng Department of Health	PPP	Public-Private Partnership
GIS	Geographic Information System	PTC	Pharmacy Therapeutic Committee
GPC	Gauteng Planning Commission	PSETA	Public Service Education and Training Authority
GPG	Gauteng Provincial Government	PTP	Prioritised Township Programme
GPS	Gauteng Strategic Plan (HIV and AIDS)	PWD	People with disabilities
HAART	Highly Active Antiretroviral Treatment	RAF	Road Accident Fund
HAST	HIV, AIDS, STIs and TB	RWOPS	Remunerated Work Outside Public Service
HCT	HIV Counselling and Testing	QA	Quality Assurance
HDACC	Health Data Advisory Coordination Committee	SADC	Southern African Development Community
HFM	Health Facilities Management	SDGs	Sustainable Development Goals
HIV	Human Immunodeficiency Virus	SADHS	South African Demographic and Health Survey
HOD	Head of Department	SAHR	South African Health Review
HPC	Health Processing Centre	SANBS	South African National Blood Service
HR	Human Resources	SAPS	South African Police Service
HWSETA	Health & Welfare Sector Education and Training Authority	SLA	Service-level Agreement
ICD10	International Classification Diseases version 10	TB	Tuberculosis
ICT	Information & Communication Technology	TOR	Terms of Reference
ICU	Intensive Care Unit	TAS	Turn Around Strategy
IEC	Information, Education and Communication	WISN	Workforce Indicators of Staffing needs
IGR	Intergovernmental Relations	WAN	Wide Area Network
IHPF	Integrated Health Planning Framework	XDR TB	Extremely Drug Resistant Tuberculosis
ILS	Intermediate Life Support		
IMCI	Integrated Management of Childhood Illnesses		
IMR	Infant Mortality Rate		
IPRS	Indicator Protocol Reference Sheet		

PART A

4. STRATEGIC OVERVIEW

4.1 Vision

Daily we provide high - quality, efficient and accessible healthcare to transform people's lives

4.2 Mission

Create an effective public health care system in Gauteng by ensuring we have the right people, skills, systems and equipment to provide the care our patients need to live healthy, quality lives

4.3 Values

Patient centered care - Everything we do should benefit the patient

Patients must be at the center of everything we do. All the decisions we make and the actions we take should be driven by our vision to provide high-quality, efficient and accessible care to our patients – at both clinical and non-clinical functions.

Accountability – We take ownership of our responsibilities and go above and beyond and expect our colleagues to do the same to achieve the best outcomes for our patients

We aspire to be an organisation in which employees take full responsibility for their work. We will provide clear job descriptions, relevant training programmes, performance contracts and consequence management to ensure that our employees deliver on their commitments. We praise and celebrate achievements when colleagues go the extra mile. Role modelling is essential to embed this value. Accountability is about making our colleagues responsible for their work; we have the leadership strength and capabilities to have the difficult and courageous conversations with our teams.

Transparency – We strive to be open and honest in all that we do

We want to be a transparent organisation free of internal politics and bureaucracy. Our decisions will be based on facts and we will communicate openly across the different levels in the organisation. We are open and honest with all our stakeholders

Efficiency - We work efficiently to optimize the scarce resources to achieve more with less

We know that budgets are tight and human resources are limited. We know that wasting resources has a negative impact on our patients' health. We will focus on improving efficiency at every level and in every department.

4.4 STRATEGIC GOALS

National Development Plan 2030

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

By 2030, South Africa should have:

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

Sustainable Development Goals 2030

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

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

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture

By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

GOAL 3: Ensure healthy lives and promote well-being for all at all ages

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

- By 2020, halve the number of global deaths and injuries from road traffic accidents 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.
- 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.
- By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
- Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.
- Support the research and development of vaccines and medicines for the communicable and no communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
- 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.
- Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

GOAL 5: Achieve gender equality and empower all women and girls

Ensure universal access to sexual and reproductive health and reproductive rights

NDP Goals 2030	**SDG Goals 2030**
Average male and female life expectancy at birth increased to 70 years	
Tuberculosis (TB) prevention and cure progressively improved	• End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
Maternal, infant and child mortality reduced	• Reduce the global maternal mortality ratio to less than 70 per 100,000 live births. • End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under 5 mortality to at least as low

NDP Goals 2030	SDG Goals 2030
	as 25 per 1,000 live births • By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons
Prevalence of Non-Communicable Diseases reduced	• Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol • Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
Injury, accidents and violence reduced by 50% from 2010 levels	• By 2020, halve the number of global deaths and injuries from road traffic accidents
Health systems reforms completed	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Primary health care teams deployed to provide care to families and communities	• ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
Universal health coverage achieved	• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Posts filled with skilled, committed and competent individuals	• Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

The Gauteng Provincial Government [GPG] Strategic Approach

The Gauteng Provincial Government has adopted a 10 pillar programme that is aimed at radically transforming, modernising and re - industrialising Gauteng over the next five to fifteen years with special focus on '*Accelerated social transformation'*

In response to the call from GPG to accelerate social transformation the Gauteng Department of Health has committed to the following priorities for the five-year period 2015 – 2020 and commenced implementation in the 2014/15 financial year.

- Strengthening Health Systems and NHI rollout focusing on:
  - Universal coverage through implementation of NHI;
  - Expansion of primary health care including Re-engineering of PHC (Cuban Model)
  - Improved hospital management;
  - Improved quality of health care through compliance with National Core Standards (six key priority areas);
  - Improved human resource development and management and finance and financial management;
  - Improved Health infrastructure development and management; and
  - Improved medico-legal services and reduced litigation.
- Prevention and reduction of the burden of disease, which include:
  - Improving maternal, infant and child health; intensify the fight against HIV and AIDS, TB;
  - Address Social Determinants of Health;
  - Promotion of preventive health and healthy life styles; and
  - Strengthen provision of mental health, substance abuse and detoxification services.
- Transforming the health economy through localised production and procurement of goods and services.
- Modernisation of public service with focus on development and implementation of E-health programme.

KEY INTERVENTION TO IMPLEMENT THE FIVE YEAR GAUTENG HEALTH STRATEGY

A 90 day sprint

On the 10th and 11th February 2016, senior managers in Gauteng Department of Health reviewed progress of initiatives in the 'ICU' – a Rapid Delivery Unit for GDOH. Following the review, there was consensus among participants that a new approach was required to accelerate progress. A new concept named the 90-day sprint was introduced. A sprint is a coordinated effort over a short time period to achieve a defined goal. The goal of the 90-day sprint is to disaggregate initiatives into small, manageable tasks and then deliver on the tasks within a period of 90 days

Characteristics of a Sprint		
Coordinated Effort	**Short - time period**	**Achieved a defined goal**
- demand collective buy - in - build a supportive environment by aligning colleagues	- breakdown problems into manageable parts - demand commitment, positivity and intensity that can be sustained for a short period	- force prioritisation - breeds a common understanding

Rationale for establishing the 90-day sprint

- To foster a team and environment that is geared towards solving problems.
- To break down problems.
- To build momentum for future sprints.
- To make excellence a habit.

Five priority focus themes

1. Improve patient experience
2. Establish a patient record system
3. Roll - out bed management system
4. Reduce mother and child mortality
5. Ensure clean audit

How will it be implemented

- The 90 - day - sprint is structured and staffed in the following way:

- A champion was selected to drive the 90 - day - sprint.

STRATEGIC GOALS 2020

TABLE A1: STRATEGIC GOALS AND STRATEGIC OBJECTIVES

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
1. Improved health and well-being of all citizens, with an emphasis on children and women	We will improve basic and preventive care for children and women to reduce the infant mortality rate from [1]34 per 1,000 live-births in 2013/14 to 20 per 1,000 live-births in 2019/20, the neonatal mortality rate from 15/1,000 live births in 2013/14 to 6/1,000 live births in 2019/20, the child (under 5) mortality rate from 43 per 1,000 live births in 2013/14 to 23 per 1,000 live births in 2019/20 and the in-facility maternal mortality ratio from 143 per 100,000 live births in 2013/14 to 80 per 100,000 live births in 2019/20.	1.1 Increase percentage of mothers whose first antenatal visit is before 20 weeks from 43.7% in 2013/14 to 70% by 2019/20 1.2 Increase number of mothers' visits within 6 days of delivery of their babies from 86.5% in 2013/14 to 90% by 2019/20 1.3 Reduce in-facility maternal mortality ratio from 143 in 2013/14 to 80 per 100,000 live births in 2019/2020 1.4 Reduce infant mortality rate from 34 per 1,000 live births in 2013/14 to 20 per 1,000 live births in 2019/20 and child mortality (under 5) from 43 per 1,000 live births in 2013/14 to 23 per 1,000 live births by 2019/20 1.5 Reduce neonatal mortality from 15 per 1,000 live births in 2013/14 to 6 per 1,000 live births by 2019/20 1.6 Decrease child (under-5 years) diarrhoea case fatality rate from 3.5% in 2013/14 to 1.5% by 2019/20 1.7 Decrease child (under 5 years) severe acute malnutrition case fatality rate from 6.1% in 2013/2014 to 3% by 2019/20 1.8 Sustain immunisation coverage at 100% for children under 1 year by 2019/20 1.9 Decrease DTaP-IPV/HIB 3-Measles 1st dose drop-out rate from 3.5% in 2013/14 to 2% in 2019/20 and increase measles 2nd dose coverage from 85%in 2013/14 to 95% by 2019/20 1.10 Increase breast cancer screening from 20 000 in 2013/14 to 60 000 women by 2019/120	Maternal, infant and child mortality reduced

[1] One of the comments that were received from the stakeholders following an earlier analysis of the 2nd draft of the 2016/17 APP, was that the goal and objective statements were the same; it was recommended that the goal statements be shortened and the objective statements be smarter; this couldn't be done as the Strategic Plan couldn't be reviewed before the submission of the final APP 2016/17.

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
		1.11 Increase couple year protection rate from 24.9% in 2013/14 to 99% by 2019/20 1.12 Increase HPV vaccine coverage rate for 1st dose from 87.1% in 2013/14 to 90% by 2019/20 1.13 Increase HPV vaccine coverage rate for 2nd dose to 90% by 2019/20 1.14 Increase cervical cancer screening coverage from 41.7% of women in 2013/14 to 99% of women by 2019/20	
	We will reduce the incidence and prevalence of non-communicable diseases (NCDs) and the number of non-natural deaths by promoting healthy, safe lifestyles to reduce the prevalence of diabetes from 2.6% (2013/2014) to 0.2% (2019/20) and the prevalence of hypertension from 17.2% (2013/14) to 3.2% (2019/20) and support the decrease in number of people that die annually from non-natural deaths due to e.g., injury, accident or violence	1.1 Reduce case fatality rate due to violence and injury by 50% by 2019/20 1.2 Reduce percentage of obesity in women to 36%, men to 10% and children (under 5yrs) to 2% by 2019/20 1.3 Increase number of people counselled/ screened for high blood pressure and raised blood glucose levels to 550 000 and 280 000 respectively by 2019/20 1.4 Decrease hypertension prevalence rate from 17.2% in 2013/14 to 3.2% by 2019/20 1.5 Decrease prevalence of type 2 diabetes from 2.6% in 2013/14 to 0.2% by 2019/20 1.6 Increase clients screened for mental health to 100%, cataract surgery rate from 1408 per million in 2013/14 to 1500 per million ; malaria case fatality rate reduced to 1.7% by 2019/20	Maternal, infant and child mortality reduced
2. Reduced rate of new infections and burden of HIV & AIDS and TB	We will reduce the rate of new HIV and TB infections by increasing awareness, testing opportunities and access to the right products and services (medication, condoms, circumcision, ARV for pregnant women).	2.1 Reduce Mother to Child Transmission of HIV from 2% to 0.80% at six weeks after birth and from 3.1% to 2% at 18 months after birth, by increasing antiretroviral coverage among pregnant women living with HIV from 81% to 98% by 2019/20 2.2 Reduce rate of new HIV and STIs infections by 50% by 2019/20, and decrease percentage of young women infected from 19.6% in 2013/14 to 16% by 2019/20	HIV & AIDS and Tuberculosis prevented and successfully managed

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
		2.3 90% of all people receiving antiretroviral therapy will have viral suppression by 2019/10 2.4 90% of all people living with HIV will know their HIV status by 2019/20 2.5 Increase number of male condoms distributed annually from: 69 480 000 in 2013/14 to 309 100 000 by 2019/20 Increase number of female condoms distributed annually from 1 451 696 in 2013/14 to 5 000 000 by 2019/20 2.6 Increase number of men medically circumcised from 132 095 in 2013/14 to 335 408 by 2019/20 2.7 Increase number of people tested for HIV to 90% of population by 2019/20 2.8 Increase number of HIV exposed babies tested at 18 months to 90% by 2019/20 2.9 Increase number of people screened for TB from 440, 000 in 2013/14 to 5 million by 2019/20 2.10 Increase percentage of people screened for TB from 90% in 2013/14 to 95% of total population with HIV by 2019/20 2.11 Decrease the number of new TB infections by 50% by 2019/20 2.12 Increase number of men/women aged 15-49 tested for HIV from 1.8 million in 2013/14 to 4 million by 2019/20	
	We will prolong and improve the lives of people living with HIV, STIs and TB by ensuring that the right medication and services are available and increase awareness on how to use them.	2.13 Increase proportion of HIV positive population on ARV from 80% in 2013/14 to 90% by 2019/20 2.14 Increase the percentage of people cured of TB from 83% in 2013/14 to 85% by 2019/20 by reducing treatment defaulter rate from 5.1% to 1% 2.15 Increase TB treatment success rate from 84.5% in 2013/14 to 95% by 2019/20 2.16 Decrease HIV mortality rate from 31.9% in 2013/14 to 15% by 2019/20 2.17 Decrease TB death rate from 5.2% in 2013/14 to 3.5% by 2019/20	

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
		2.18 Increase the percentage of patients with MDR-TB initiated on treatment from 45% to 80% and MDR-TB treatment success rate from 35% to 65% by 2019/20 2.19 Increase number of clinical and district nurses trained to initiate MDR-TB treatment from 40 to 500 by 2019/20	
3. Increased equal and timely access to efficient and quality health care services, thereby preparing for roll-out of NHI	We will transform primary health care through broader access and better quality and getting closer to communities by 2019/20	3.1 Increase number of fully-fledged, functional Ward Based Outreach Teams from 130 to 533 in targeted wards by 2019/20 3.2 Ensure completeness of the DCST in all the 5 Health Districts to strengthen the 5 functional clinical specialist teams by 2019/20 3.3 Increase coverage of grade 1 learner's health screening in Quintile I – 5 public primary schools from 20% to 60% and grade 4, 8 and 10 learners' health screening (annualised) in Quintile 1 -2 from 10% to 20% respectively by 2019/2020 3.4 Fixed PHC clinics scoring above 70% on the ideal clinics dashboard; 90% of PHC facilities and district hospitals compliant with extreme and vital measures of national core standards and PHC facilities and district hospitals conducting national core standards self-assessment increase to 100% by 2019/20 3.5 Increase patient satisfaction rate to 85% by 2019/20 3.6 Increase quality and access in PHC facilities through 24 hours service provision in all CHCs, integration of mental health and rehabilitation services in 100% of PHC facilities by 2019/20	Re-engineering of Primary Health Care

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
	We will improve access to secondary, tertiary and central specialised care by improving efficiency, adding capacity, and improving the referral system to increase: patient satisfaction	4. Improve efficiency of hospitals by reducing average length of stay to less than 5 days, increasing bed utilisation to 80% and decreasing expenditure per PDE in hospitals by 2019/20 4.1 Reduce the number of primary care patient cases that are seen at regional, tertiary and central hospitals by 20% in 2019/20 4.2 Increase compliance to extreme and vital measures of core standards to 100% in 2019/20, and complete self- assessments in all hospitals by 2019/20 4.3 Patient experience of care survey will be assessed annually in all hospitals and will increase from an average of 68% in 2013/14 to 80% by 2019/20. 4.4 The percentage of complaints resolved within 25 working days will be over 95% in 2019/20 4.5 Percentage of regional and specialised hospitals with an annual Quality Improvement Plan after self-assessment will increase to 100% by 2019/20 4.6 Decrease the waiting times for defined elective surgeries, by 50% in 2019/20 4.7 Decrease average OPD and Pharmacy waiting times in regional and specialised hospitals by 60% in 2019/20 4.8 Reduce -surgical mortality rates by 33% , re-admission rates by 50%, infection rates, as measured by the number of nosocomial infections, to 50 per year across all hospitals and decrease inpatient crude death rate to 5.2%- by 2019/20 4.9 Increase average theatre utilization rate from 78% in 2013/14 to 90% by 2019/20	
	We will increase the availability of vital and essential medicines to 98% and 95% respectively across all levels of care.	4.10 Increase percentage of vital and essential medicines that are available and accessible from 82% in 2013/14 to 98% by 2019/20, and from 95% in 2013/14 to 98% by 2019/20 respectively across all levels of care	

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
		4.11 Improve availability of pharmaceuticals by increasing percentage of essential medicines that are directly delivered to facilities from 52% in 2013/14 to 70% in 2019/20 4.12 Increase access to chronic medication for stable patients through use of central chronic medicine dispensing and distribution centres and pick-up points from 0 in 2013/14 to 600,000 patients by 2019/2020 4.13 Improve quality of NHLS services delivered to GDoH by increasing turn-around times for laboratory test results by 33% by 2019/20	
	We will improve access to and the quality of EMS by improving the referral/call system to ensure correct usage, increasing the availability of vehicles and advancing employee skills to increase the percentage of P1 calls that are compliant with national targets such that 90% of urban calls for P1 patients are responded to within 15 minutes (currently 77%) and 100% P1 calls responded to within 40 minutes in rural areas	4.14 Improve EMS response time for P1 patients within 15 minutes in urban areas from 77% in 2013/14 to 90% by 2019/20 and within 40 minutes in rural areas to 100% by 2019/20 4.15 Improve inter-facility transfer (efficiency) rates of clients from 13.9% to 15% by 2019/20 4.16 Increase percentage of qualified EMS personnel per rostered ambulance to 90% by 2019/20	
4. Excellence in clinical and non-clinical functions	We will appoint, train and retain capable, accountable and motivated staff to ensure that our workforce matches demand, and continuously improve our employees' working conditions.	4.1 Develop a 5 year "Human Resources for Health Plan" on a province level in 2016/17 4.2 Increase the number of new nursing students to fulfil replacement annually to 1,000 by 2019/20 4.3 Increase training of health care professionals through continuous professional development from 5000 2013/14 to 7500 to 2019/20 4.4 Increase the number of nursing colleges accredited to offer the new nursing curriculum to 100% in 2019/20 4.5 Increase access to training opportunities for all staff Including heads of all institutions by 2019/20 4.6 Increase awareness of ethical conduct for all staff by offering a code-of-conduct training to 30% of our employees in 2019/20	Improved human resources for health Improved health management and leadership

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
		4.7 Increase employee satisfaction to 75 % by 2019/20 4.8 Improve relations between employer and employees in the workplace thus reducing grievances from 3.5 in 2013/14 to 2.0 per 1 000 employees by 2019/20 and misconduct cases from 11 in 2013/14 to 8.0 per 1 000 employees by 2019/20 4.9 Increase diversity, verification of qualifications and equity of our workforce thus increasing women in senior management positions from adequate (41%) to good (50%) by 2019/20 and increasing percentage of people with disabilities employed to 2% by 2019/20 4.10 Develop and approve a departmental organisational structure aligned to the 5-year strategic plan by March 2016 4.11 Implement Workload Indicators Staffing Norms in 100% of Facilities by 2019/20	
	We will increase the efficiency of our spending by generating more transparency on our cost through activity-based costing in all our central and tertiary hospitals as well as introducing more automation. We will improve revenue collection from qualifying paying patients to >R650 million We will support the economic development of local communities by sourcing more bread, vegetables, dairy products and linen	4.12 Receive unqualified audit opinion from Auditor-General by 2016/17 and obtain a clean audit by 2019/2020 4.13 Increase revenue collection from qualifying paying patients from R522 048 000 in 2013/14 to R 1, 700 000 000 by 2019/20 4.14 Improve cost-control by increasing percentage of facilities implementing activity based costing to 7 and decreasing the deviation from actual spend and forecast to less than 2% by 2019/20 4.15 Maintain percentage of linen contracts awarded to women cooperatives at 100% by 2019/20 4.16 Increase percentage of hospitals procuring/buying vegetables from local farmers to 90% by 2019/20 4.17 Increase percentage of hospitals procuring dairy products from local farmers to 80% by 2019/20 4.18 Increase percentage of hospitals procuring bread from small/medium scale bakeries to 70% by 2019/20 4.19 Increase conversion to electronic supply chain management system to 100% of hospital by 2020	Health care costs reduced

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVES STATEMENT	LINKAGE WITH MTSF 2014 - 2019
	We will increase the quality of and access to technology systems to boost our efficiency and performance, by increasing the number of health facilities with Health Information Systems to all 36 hospitals and 372 PHC facilities in 2019/20; and enhance broadband network access to all our health facilities in 2019/20	4.20 Develop and implement standard integrated patient-based information system in all 408 health facilities by 2019/20 4.21 Increase Broadband network access in the department such that 100% of PHC facilities and hospitals have broadband network access and 100% of total staff has email access by 2019/20 4.22 Develop and implement eHealth and mHealth solutions in 36 hospitals and 372 PHC facilities by 2019/20	Efficient Health Management Information System for improved decision making
	We will deliver new infrastructure and maintain existing infrastructure	4.23 Build 10 new clinics/community health centres and 2 additional new hospitals and refurbish 21 health care facilities by 2019/20, out of which 100% will comply to the gazetted norms and standards for facilities 4.24 Improve contract management by establishing Service Level Agreement (SLA) with Department of Infrastructure Development (DID) and increase the number of capital projects that are finished on time and within budget to 80% and 100% respectively by 2019/20 4.25 Sustain and improve maintenance in health care facilities and offices, by reducing the number of health care facilities rated as level 1 and 2 (in status quo terms) to zero by 2019/20 4.26 Increase the number of primary health facilities with own back-up generator and water tank to 80% by 2019/20	Improved health facility planning and infrastructure delivery

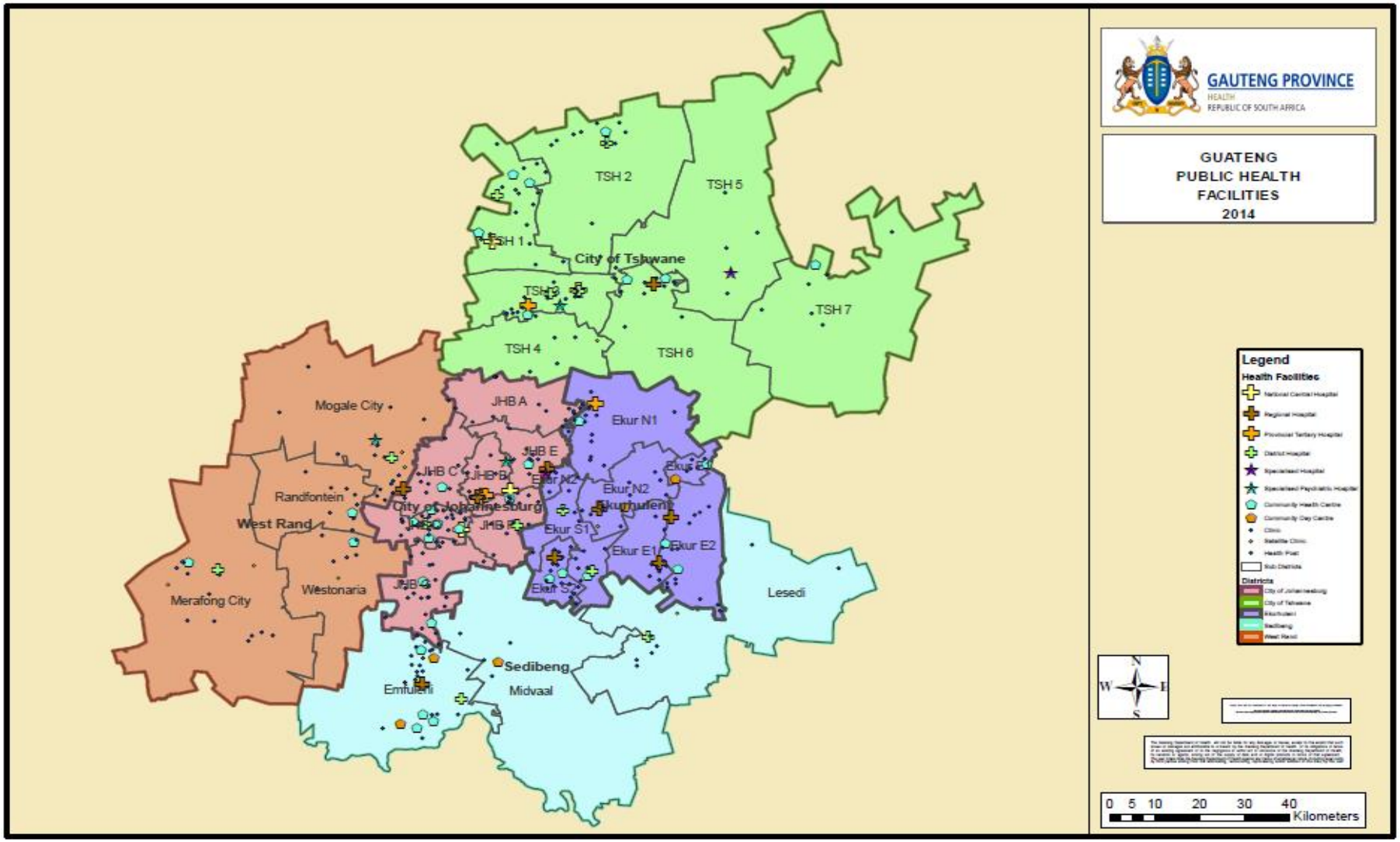
TABLE A2: IMPACT INDICATORS AND TARGETS

Impact Indicator	South Africa Baseline (2009)[2]	South Africa Baseline (2012)[3]	2019 Targets (South Africa)	2012 Baseline (Province)	2019 Target (Province) (consistent with SP 2020 targets)
Life expectancy at birth: Total	56.5 years	60.0 years (increase of 3,5 years)	63 years by March 2019 (increase of 3 years)	T: 62.5 years	T: 65.5 years
Life expectancy at birth: Male	54.0 years	57.2 years (increase of 3,5 years)	60.2 years by March 2019 (increase of 3years)	M: 61.7	M: 64.7
Life expectancy at birth: Female	59,0 years	62,8 years (increase of 3,8 years)	65,8 years by March 2019 (increase of 3 years)	F: 63.3	F: 66.3
Under-5 Mortality Rate (U5MR)	56 per 1,000 live-births	41 per 1,000 live-births (25% decrease)	23 per 1,000 live-births by March 2019 (20% decrease)	45 Per 1000 Live Births (1990)	23 Per 1000 Live Births
Neonatal Mortality Rate	-	14 per 1000 live births	6 per 1000 live births	24 Per 1000 Live Births (1990)	6 Per 1000 Live Births
Infant Mortality Rate (IMR)	39 per 1,000 live-births	27 per 1,000 live-births (25% decrease)	18 per 1000 live births	36 Per 1000 Live Births (1990)	20 Per 1000 Live Births
Child under 5 years diarrhoea case Fatality rate	-	4.20%	<2%	3.5% (2012/2013)	<2%
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	2.6% (2013/2014)	<5%
Maternal Mortality Ratio	304 per 100,000 live-births	269 per 100,000 live-births	Downward trend <100 per 100,000live-births by March 2019	144 Per 100 000 Live Births (2012)	<100 Per 100 000 Live Births

[2] [2] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012

[3] [3] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012

Gauteng's 5 districts and Public Health Facilities



4.5 SITUATIONAL ANALYSIS

4.5.1 DEMOGRAPHIC PROFILE

Population

Gauteng province is a densely populated urban area with 13.2 million people living in an area of 18 179 km² and a population density of 680/km², compared to the South African average of 42 per km². According to the 2015 mid-year population estimate, the Gauteng population has grown to 13.2 million and contributes to 24% of the country's population, with 19.7% (3.28 million) younger than 15 years and 26,3% (1,16 million) 60 years and over (Exhibit 1).

Gauteng's average monthly household care expenditure (HCE) is R5 661 – although this average masks major inequality (Exhibit 2). Gauteng has an expenditure derived Gini coefficient of 0.7[4] (Census 2011) compared to a South Africa value of 0.65. South Africa is in the top, 3% of inequality of all countries (Index Mundi).

Gauteng's rapid population growth is expected to continue, fueled in part by migration. Between 2011 and 2016, a projected 1.1 million migrants will move to Gauteng – three quarters of them from other provinces in South Africa, and the remainder from outside the country. These projections are consistent with the recent migration patterns: more than 1 million migrants moved to Gauteng between 2006 and 2011, and a similar number arrived between 2001 and 2006. In addition, 3% of Gauteng's population is comprised of orphans.

4.5.2. Socio-economic profile

The **social determinants of health** are the conditions relating to the social environment that affect the health of an individual. These conditions can be described as risk factors (i.e., the distribution of income, wealth, influence and power) rather than individual factors (such as behavioural risk factors or genetics) that influence the risk of disease. These conditions are shaped by the distribution of money, power and resources at global, national and local levels; and as such are shaped by public policies.

In 2010, the World Health Organisation (WHO) introduced a conceptual framework for social determinants of health (Exhibit 2). The framework is based on the notion that specific economic and social conditions influence individual and group differences in health status. The framework illustrates how social, economic and political mechanisms give rise to a set of **socioeconomic positions**, by which populations are divided according to income, education, occupation, gender, race/ethnicity, etc.

[4] The Gini coefficient is a measure of statistical dispersion intended to represent the income distribution of a nation's residents. This is the most commonly used measure of inequality. The coefficient varies between 0, which reflects complete equality and 1.

These socioeconomic positions in turn affect specific determinants of health status **(intermediary determinants)** which reflect people's place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions. Illness can also influence a person's social position, for example by compromising employment opportunities and reducing income. In the same way, certain epidemic diseases can also influence the functioning of social, economic and political institutions. This framework is particularly applicable in South Africa, which is still very much divided along social and economic lines, with huge disparities between the poor and the middle class.

EXHIBIT 1: 2015 MIDYEAR POPULATION ESTIMATES, JULY 2015

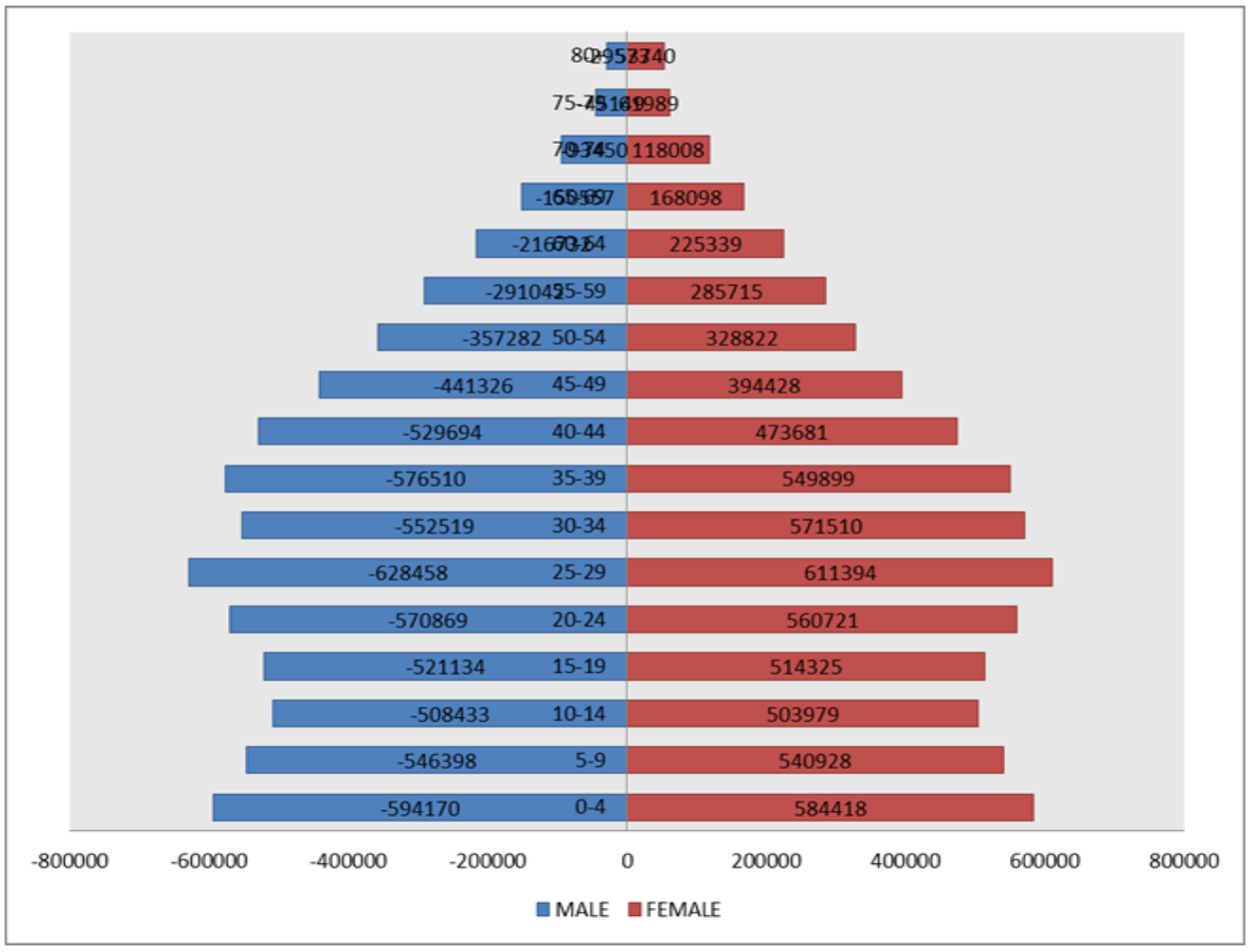
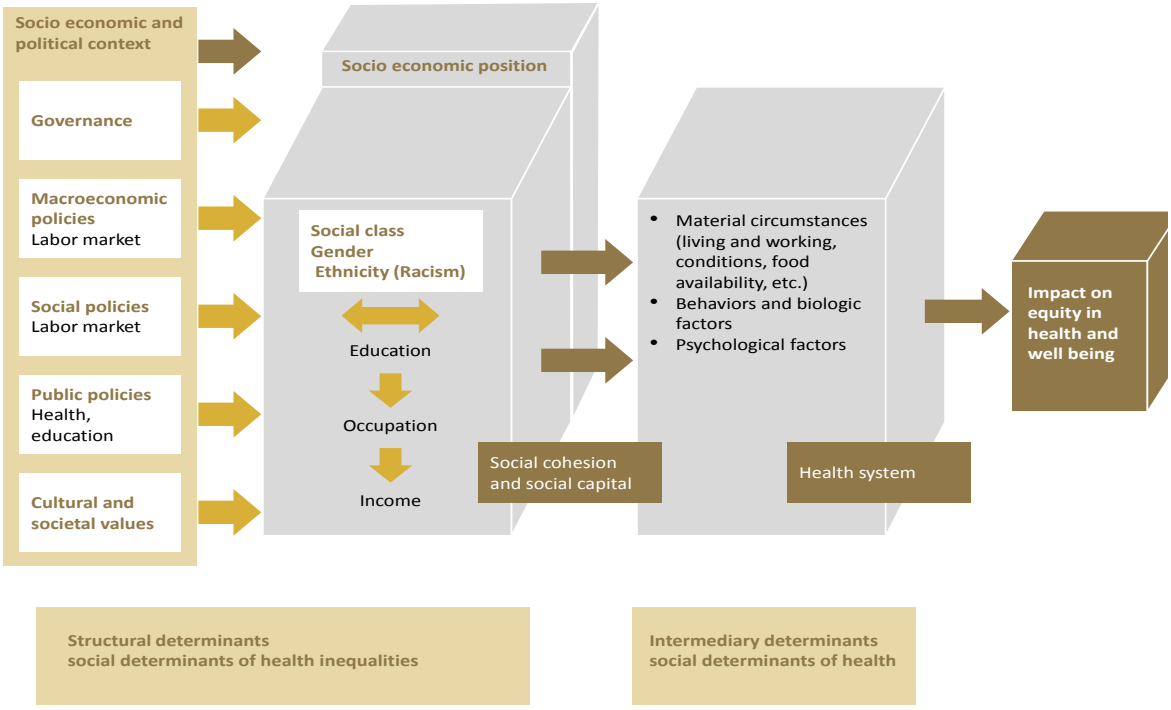


EXHIBIT: 2 SOCIAL DETERMINANTS OF HEALTH



SOURCE: WHO, 2011

Education, occupation and income

In 2014 the rate of unemployment in Gauteng was 22.4%, just below the national rate of 24.7%. Although Gauteng's unemployment rate is still unacceptably high, it has fallen slightly, from 24.8% in 2012[5]. Youth (19-34 years) unemployment is on the rise, currently standing at 36.4%. This is on a par with South Africa's youth unemployment rate of 36.1% for 2014. Gauteng's dependency ratio[6] is 39% (2011 Census), which is lower than average for SA, and has been steadily declining. The high rate of unemployment, combined with lower dependency rates increases probability of risky, unhealthy behaviours.

In 13% of Gauteng's households, food access is inadequate, while in 4.7% of households food access is severely inadequate (Household Survey 2013). In addition, 0.3% of households are headed by children.

Living conditions

A total of 19.8% of households in Gauteng live in informal dwellings (Household Survey 2013), with 78.6% living in formal dwellings and the remaining 1.5% in other tenure arrangements (including rent-free dwellings with multiple families), Gauteng has the second highest concentration of households abiding in informal set ups after North West Province, although there has been some

[5] one of the comments from the analysis of the 2nd draft APP 2016/17 was that old data has been used in the APP...the old data has been used as comparative analysis depicting the trends of a particular issue or condition

[6] Dependency ratios provide insights into the burden borne by those who are in the working age group (15–64) to support those aged 0–14 and 65+ years. The higher the dependency ratio, the more children and older people depend on the working age population.

decrease from 2008 where the number stood at 20.3%. The large numbers of informal and "other" dwellings have important implications for the GDoH, including increased risk of TB, pneumonia and other infections due to combinations of poor conditions and overcrowding.

Although Gauteng's water and sanitation levels is good overall, there are several gaps that have significant health implications; inadequate sanitation and water access aggravate infections such as diarrhoea and parasitic infections (including worms and bilharzia). In 2013, 90.2% of the households in Gauteng had access to adequate sanitation (Household Survey 2013). However, the proportion of households with easy access to water has declined slightly to 95.9% in 2013 (compared to 89.9% in South Africa overall); easy access to water is defined as water availability in dwellings, either off-site, or on-site (Household Survey 2013). Among Gauteng households, 2.2% perceive the quality of the water they drink as "not safe to drink" and 2.7% perceive their drinking water as "not clear" (Household Survey 2013). With respect to sanitation, 1.8% of the households in Gauteng have no access to a toilet facility or have been using bucket toilets – a figure which has remained more or less stable over the past 11 years (1.9% in 2002, 1.6% in 2009) (Household Survey 2013). The proportion of households with access to a flush or chemical toilet has increased to 86.5% in 2011 (Census, 2011).

According to the Household Survey, the percentage of households with mains electricity connections have decreased from 87.1% (2002) to 83.6% (2013), which is slightly below the national 85.3%.

Health system delivery

The percentage of Gauteng's population reliant on public healthcare has increased to 71% in 2013. The health spends per person in the public sector increased roughly in line with inflation by a rate of 6% per annum, to R3 033 in 2013. There is roughly double the number of people per bed in the public health system compared to the private system. On average a person using public health care will visit a health care facility, be it one of the 37 hospitals or 373 PHC facilities, 1.8 times per annum. The distribution of these facilities over the 5 key districts can be seen in t 1 below.

Table 1: **Reliance on public healthcare and public healthcare spend per capita (Health systems trust)**

	2008	**2009**	**2010**	**2011**	**2012**	**2013**
% reliance on public healthcare	66%	66%	69%	66%	71%	71%
Public spend per person (R)	NA	2392	2490	2882	3033	NA

4.5.3 Epidemiological profile

Life expectancy and birth rate

Gauteng's overall life expectancy has been improving according to the StatsSA 2013 MYE report. The province's life expectancy at birth stands at 61 years, up from 52 years in 2005; today, women born in Gauteng have a life expectancy of 63 years and men 58 years.

The crude birth rate (CBR) for Gauteng has decreased slightly, from 23.1 births per 1 000 people in 2009 to 22.4 births per 1 000 people in 2014 (Stats SA, 2014). The total fertility rate[7] has followed this pattern and is estimated to have decreased from 2.11 (2001-2006) to 2.07 (2006-2011), and it is projected to continue to decrease to 2.02 (2011-2016). This is well below the national fertility rate of 2.6 (2014), which decreased by 1% from 2.65 in 2009 (Stats SA, 2014). Teenage pregnancies are widespread in Gauteng, with reports indicating 4 200 girls in the provinces' schools were pregnant between 2008 and 2011.

Maternal, woman and child health

There has been a significant reduction in maternal deaths in the 2011-2013 triennium. Assessors classified sixty percent of maternal deaths to be possibly or probably preventable indicating mostly poor quality of care during the antenatal, intrapartum and postnatal periods. Three conditions have been identified that contribute to the two-thirds of preventable maternal deaths, namely non-pregnancy related infections, obstetric haemorrhage and complications of hypertension in pregnancy. Reduction of maternal deaths can be achieved quickest by taking action to reduce deaths due to HIV, haemorrhage and hypertension and involving all levels of the health care system from policy makers to health care professionals to the community. In order to achieve the reduction, clinicians need to provide quality care to all pregnant women (in all areas), safe caesarean sections, prevent unwanted pregnancies and engage the community to ensure the women know what to do at all times (5 C's). This is built upon a health system that has knowledgeable and skilled health care professionals, facilities that have the appropriate resources and an effective emergency service to rapidly transport patients to the appropriate level of care. To ensure continued functioning of this the service must continually be monitored and evaluated and where appropriate remedial action taken where appropriate.

Despite some progress, maternal, woman and child mortality rates remain unacceptably high and there was a large gap to close to achieve the Millennium Development Goals (MDGs). In particular, according to the National Department of Health's Health Data Advisory and Coordination Committee: Maternal mortality ratio in facility, a proxy indicator for the maternal mortality ratio (MMR), stands at 105 out of every 100 000 women in 2014. The 2015 MDG target for the MMR was 38/ 100 000. Under-five mortality rate in facility, a proxy indicator for under five mortality rate (u5MR), stands at 45 for every 1 000 live births. The 2015 MDG target for the u5MR was 20/1 000 live births; Infant

[7] Average number of children born to a woman over her lifetime

mortality in facility rate stands at 36/1000 live births, down from 40 in 2011. Neonatal mortality in facility rate stands at 11/1000 live births.

Tuberculosis (TB)

In Gauteng the outcomes for TB indicators are improving, although there is still room for further improvement. In 2014, the cure rate was 84.2% (up from 83.8% the previous year), the success rate 85.7% (up from 84.5% the previous year), the rate of defaulters down to 4.8% from 5.1% the previous year. The TB mortality rate in 2014 was 4.5%. However, 94% of patients diagnosed with TB were started on TB treatment in 2014 an indication of improvement from the previous financial year. The rate of multi-drug resistant TB (MDR –TB) cases increased by 16% over the last four years; however, the number of extensively drug resistant (XDR –TB) cases has decreased.

Table 2: MDR and XDR TB cases treated at Sizwe Tropical Disease Hospital

	2010	2011	2012	2013	2014
MDR-TB CASES	607	572	417	484	494
XDR-TB CASES	31	33	26	19	21

HIV, AIDS and STIs

The overall HIV prevalence for South Africa (SA), according to the 2013 National Antenatal Sentinel HIV Prevalence Survey (NASHIVPS, SA) report, in public health clinics was 29.5%, for the country.

In October 2013, a total of 6 760 pregnant first time antenatal bookers participated in the 2013 National Antenatal Sentinel HIV prevalence Survey in Gauteng province(Gauteng participants accounted for 20,4% of the country's survey participants). The majority (69%) were aged 15 to 29 years and 41% were between 15 to 24 years old. In 2013, according to the survey, Gauteng HIV prevalence among antenatal women was 28.6% which has decreased by 1.2% from 29.8% in 2009. The overall prevalence in the province has remained between 28% - 30% in the past 5 years as shown in Exhibit 3.

Only 2 out of the 5 districts recorded an increase in HIV prevalence. West Rand increased by 2.9% and Sedibeng by 0.3% from 2009 to 2013 respectively. Tshwane recorded the highest decrease by 2.3% from 25.7% in 2009 to 23.4% in 2013. The City of Johannesburg recorded a slight decrease from 28.9% in 2009 to 27.3% in 2013; and Ekurhuleni HIV prevalence decreased from 34.0% in 2009 to 33.5% in 2013. The HIV prevalence recorded in the 5 districts remains very high and the lowest was 23.4% in the City of Tshwane and the highest was 33.5% in Ekurhuleni. This is graphically shown in Exhibit 4 and 5 below.

EXHIBIT 3 HIV prevalence epidemic curve among antenatal women in Gauteng, 1990 - 2013[8]

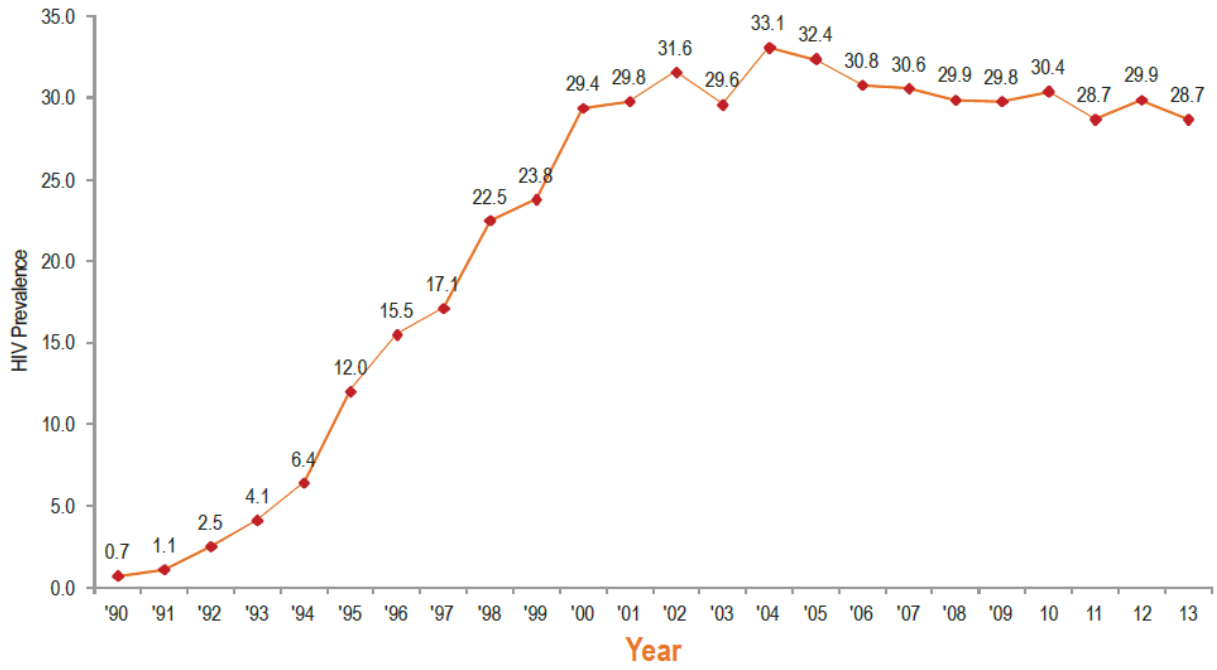
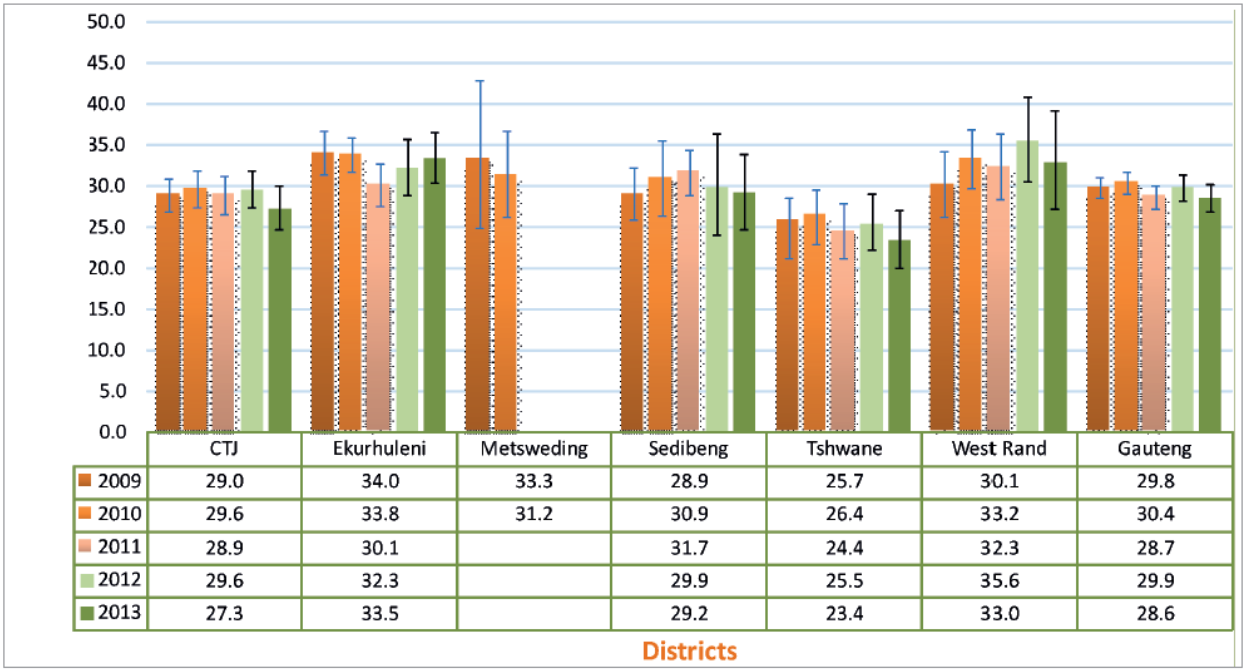


Exhibit 4: Change in HIV prevalence by districts from 2009 to 2013 in the Gauteng Province[9]

Districts	2009			2013			% Change in PREV
	%HIV+	95% (CI)	N	%HIV+	95% (CI)	N	
Co J	29.0	27.0 - 31.0	2489	27.3	24.7 - 30.1	2500	-1.7
Ekurhuleni	34.0	31.5 - 36.7	1896	33.5	30.4 - 36.6	1647.0	-0.5
Metsweding	33.3	24.9 - 43.0	120	Metsweding district merged with City of Tshwane			
Sedibeng	28.9	25.9 - 32.2	667	29.2	24.8 - 33.9	621	0.3
Tshwane	25.7	23.1 - 28.6	1466	23.4	20.1 - 27.1	1423	-2.3
West Rand	30.1	26.2 - 34.3	549	33.0	27.3 - 39.3	539	2.9
Gauteng	**29.8**	**28.6 - 31.1**	**7187**	**28.6**	**27.0 - 30.3**	**6730**	**-1.2**

[8] Source: 2013 National Antenatal Sentinel HIV prevalence Survey, SA
[9] Source: 2013 National Antenatal Sentinel HIV prevalence Survey, SA

Exhibit 5: Districts HIV prevalence 5 year trend analysis among antenatal women in Gauteng, 2009 to 2013[10]



	CTJ	Ekurhuleni	Metsweding	Sedibeng	Tshwane	West Rand	Gauteng
2009	29.0	34.0	33.3	28.9	25.7	30.1	29.8
2010	29.6	33.8	31.2	30.9	26.4	33.2	30.4
2011	28.9	30.1		31.7	24.4	32.3	28.7
2012	29.6	32.3		29.9	25.5	35.6	29.9
2013	27.3	33.5		29.2	23.4	33.0	28.6

Districts

Non-communicable diseases and healthy lifestyles

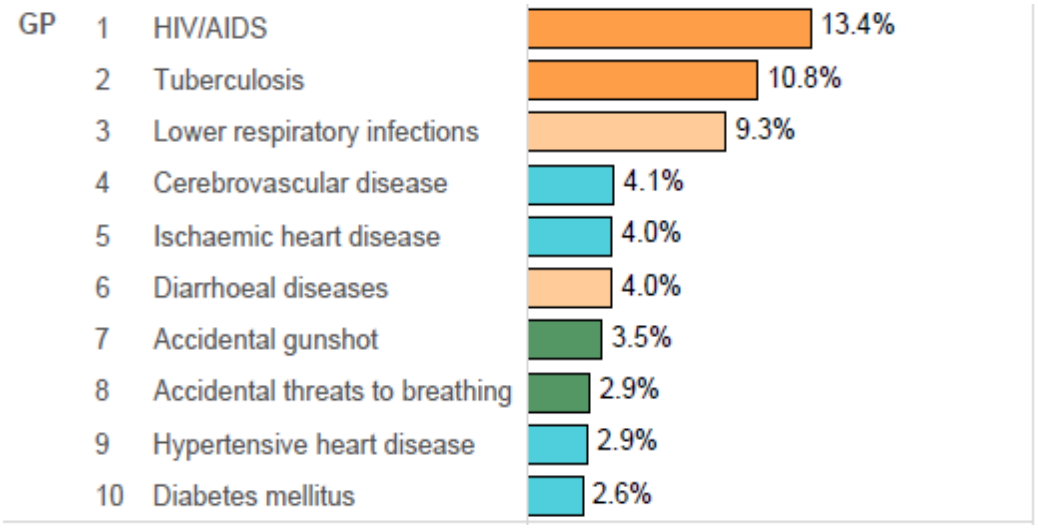
Two of the top causes of death in Gauteng are diabetes and hypertension related diseases, with respective incidence rates of 2.5% and 15.6% in 2013/14. One of the risk factors for diabetes and hypertension is obesity (measured by a body mass index > 25). Obesity is a growing problem in Gauteng, with 2013/14 prevalence rates of 36% among women, 10% of men and 2% of children under 5years. There is growing mobilisation against cervical cancer among women. Currently only 42% of women have been screened for cervical cancer, which is below the national rate of 54%. Gauteng's HPV vaccine coverage rates are high, with 87% of Grade 4 girls covered with the first dose. Gauteng's mental and physical disability prevalence has increased. The total number of disabled people in the province has grown by 8% over the last 2 years, increasing the need for aid/equipment provision (South African Household Survey, 2013)

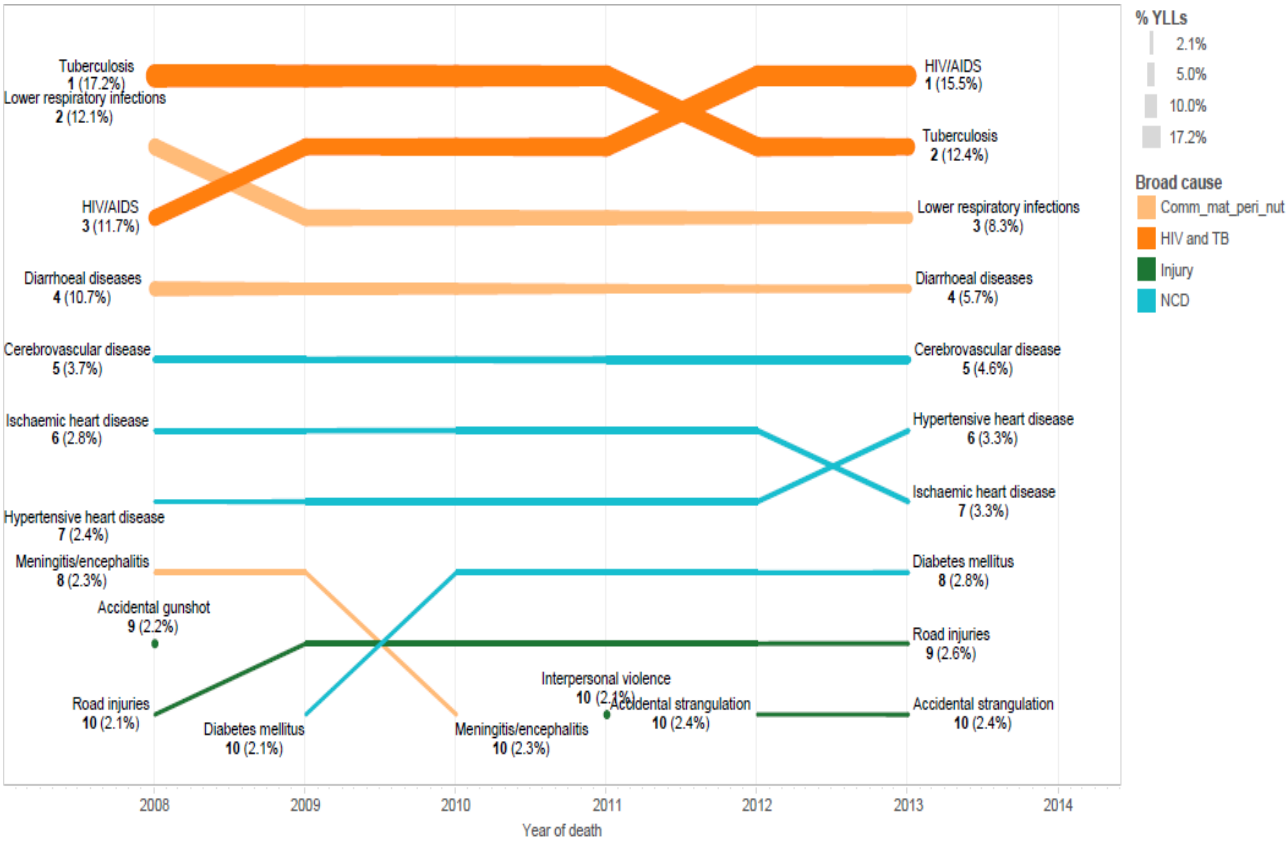
Trends in leading causes of premature mortality[11]

Tuberculosis remained the leading cause of premature mortality from 2008 to 2011. HIV and AIDS ranked 3rd in 2008 after lower respiratory infections, but moved to 2nd position in 2009, where it remained until it moved to 1st place in 2012. The lower respiratory infections have ranked 3rd in 2013. Meningitis/encephalitis dropped out of the top 10 in 2011. Diabetes mellitus moved from 10th to 8th place. Road injuries moved up from 10th to 9th position, and hypertensive heart disease moved from 7th position in 2008 to 6th place in 2013. In Gauteng, HIV and AIDS went up in the ranking in all districts between 2008 and 2013. Ischaemic heart disease increased in West Rand, Tshwane and Ekurhuleni. Cerebrovascular disease moved up in the ranking in Ekurhuleni, Johannesburg and Tshwane, and dropped in West Rand. The 2 graphics, Exhibit 6, from the District Health Barometer: Burden of Disease Burden 2014/15 depicts trends in premature mortality for the Gauteng Province.

[10] Source: 2013 National Antenatal Sentinel HIV prevalence Survey, SA
[11] Source: District Health Barometer: Burden of Disease 2014/15

EXHIBIT 6: Gauteng Province Trends in Premature Mortality (YLLs[12])





[12] YLLs (years of life lost) are a measure of premature mortality based on the age at death and therefore highlight the causes of death that should be targeted for prevention.

4.6 ORGANISATIONAL ENVIRONMENT

The Medium Term Strategic Framework for 2014-2019 focuses on strengthening the health system for better outcomes.

4.6.1. ORGANISATIONAL STRUCTURE AND HUMAN RESOURCE MANAGEMENT

In the last 5 years there has been changes in leadership positions and organizational structure, and as a result there's an updated organogram awaiting approval. Central to the changes was the merger of the department of health with social development in 2010/11, and the subsequent demerger in 2012/2013.

The Department has over the past 24 months been adapting the newly prescribed DPSA generic structure to a more suitable structure. The organisational structure that has been approved by the MEC is attached as Exhibit 8.

KEY STRUCTURAL CHANGES TO BE IMPLEMENTED IN THE NEXT 5 YEARS

Several additional structural changes will be implemented in the next 5 years, with the continued re-engineering of DHS and provincialisation. These include:

- At district level, additional paediatric and obstetric clinicians and gynaecologists will continue to be appointed to accelerate improvement on maternal and child health outcomes; and
- As a result of provincialisation, all Community Health Centres (CHC) will be transferred to the Provincial Health Districts. However, small clinics will be left to current management – either the Municipalities or Province. This will create additional workforce considerations.

WORKFORCE CHALLENGES

Over the last 5 years, funding constraints have resulted in a high number of vacancies. Vacancies are caused by two main factors:

Large numbers of people leaving the Department's employ – driven by both a high retirement rate in an aging workforce, and high turnover (low years of service). Inability to meet the growing demand for healthcare professionals – both challenges in attracting new recruits, and lack of funds to adequately expand the organisation. Despite growth in absolute numbers in the Department, the ratio of non-clinical and clinical workers to the proportion of the population relying on public healthcare has decreased by 1% over the last 4 years (Exhibit 9).

The Department has been plagued by high vacancy rates, so the current inability to grow an understaffed department in line with the population it serves is a big challenge. As seen in Exhibit 7, high vacancy rates are prevalent across both clinical and non-clinical services as well as all service types. Clinical services suffer the most from high vacancy rates.

Analysing the age distribution by departments leads to some important insights, namely:

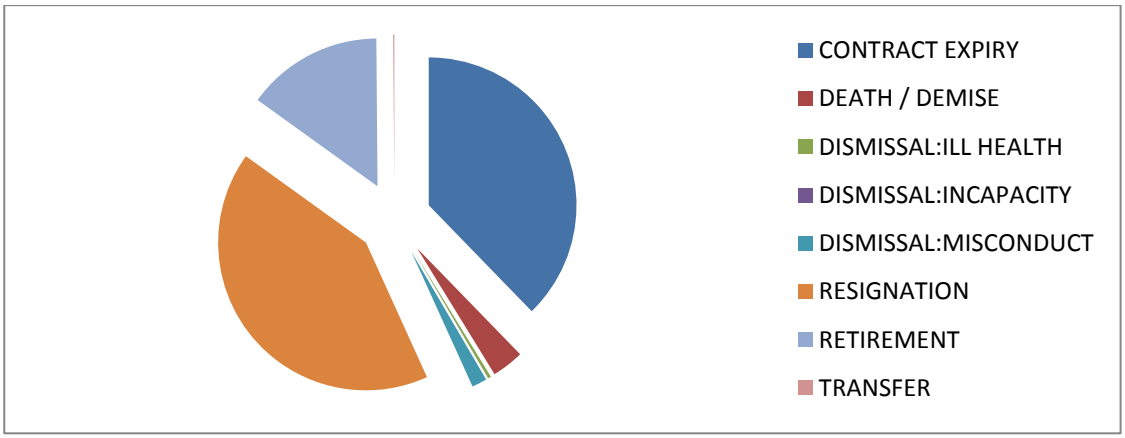
Administration, support and allied support are losing their youngest workers, with each experiencing a significant decrease in the 20-24-year age bracket over the last 4 years, management age distribution is narrow, with 53% of the workforce in the 50-55 and 60+ categories. These age brackets are the only ones that have shown growth in representation over the last 4 years. The highest age specific growth rate in nursing is for the 55-59 years category.

The continuous reduction of the health sector workforce can be unpredictable and uncontrollable but is normal and this is attributed to resignations, completion of training, retirements, sickness and death. An analysis of attrition rates over the 2014/15 financial year indicates that 42% (3312) of employees resigned, 38% (2996) their contract expired, 15% (1187) were retirements, 4% (278) deaths and insignificant percentage to different categories of dismissal (2%): ill health, (26), misconduct (131), incapacity (1) and finally transfers (10). Below is a graphic presentation of all the above in Exhibit 7. All clinical professionals trained in South Africa are required to do one year of community service in the public sector after which many professionals leave the GDoH.

Attrition is expected to continue to be a problem however the following interventions will serve to mitigate the risk:

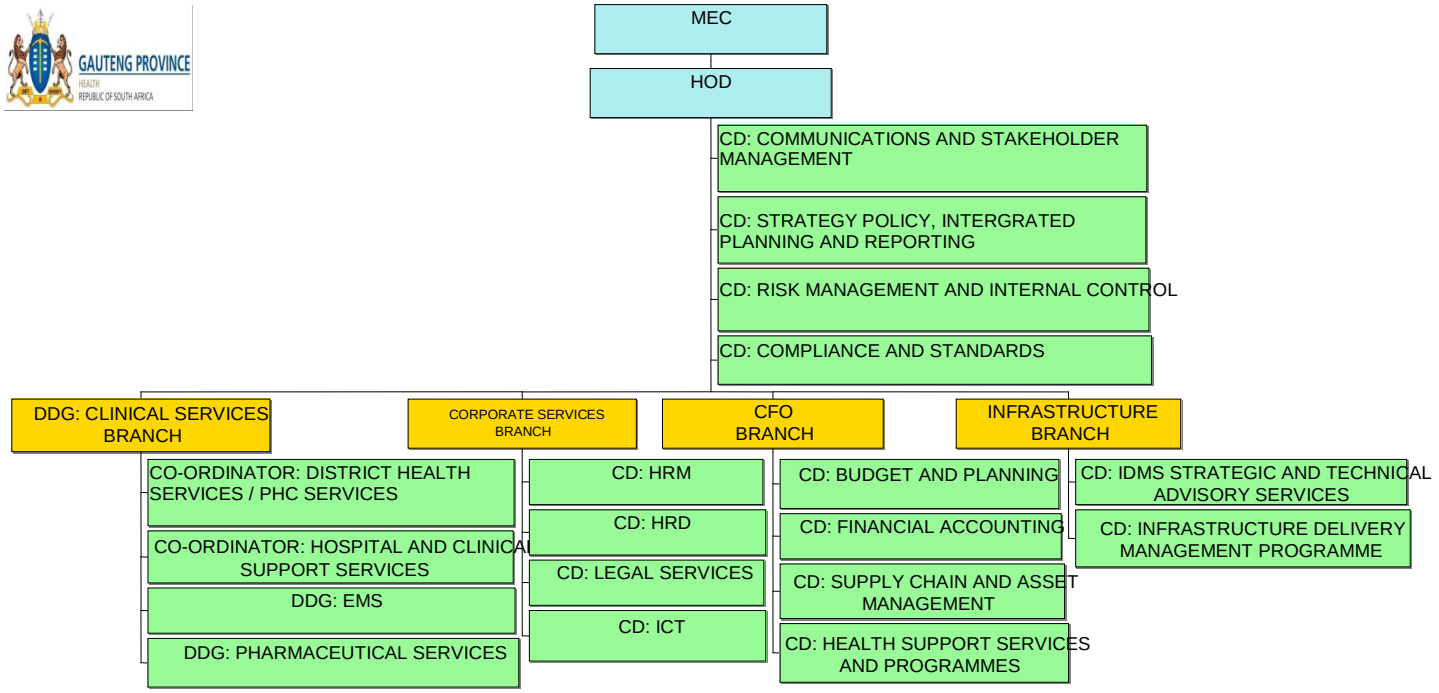
- Improve attitude in the workforce;
- Introduce a programme to attract youth to work in the department;
- Promote succession planning and continue efforts to bring back retired nurses;
- Introduction of work load norms planned to be finalised by national by 2016; and
- Be more strategic in hiring candidates who suit company culture as well as job description.

EXHIBIT 7: SERVICE TERMINATION CATEGORY DESCRIPTION 2014/15



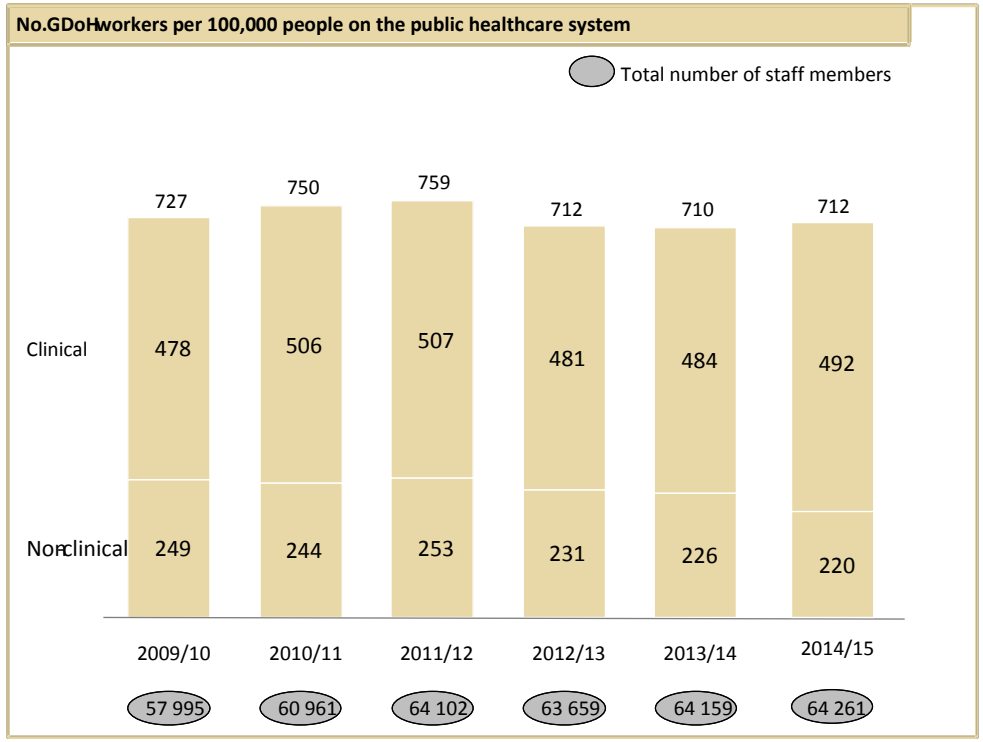
SOURCE OF DATA: PERSAL TERMINATION REPORT PERIOD 20140401-20150331

EXHIBIT 8: 2015 GAUTENG DEPARTMENT OF HEALTH ORGANISATIONAL STRUCTURE



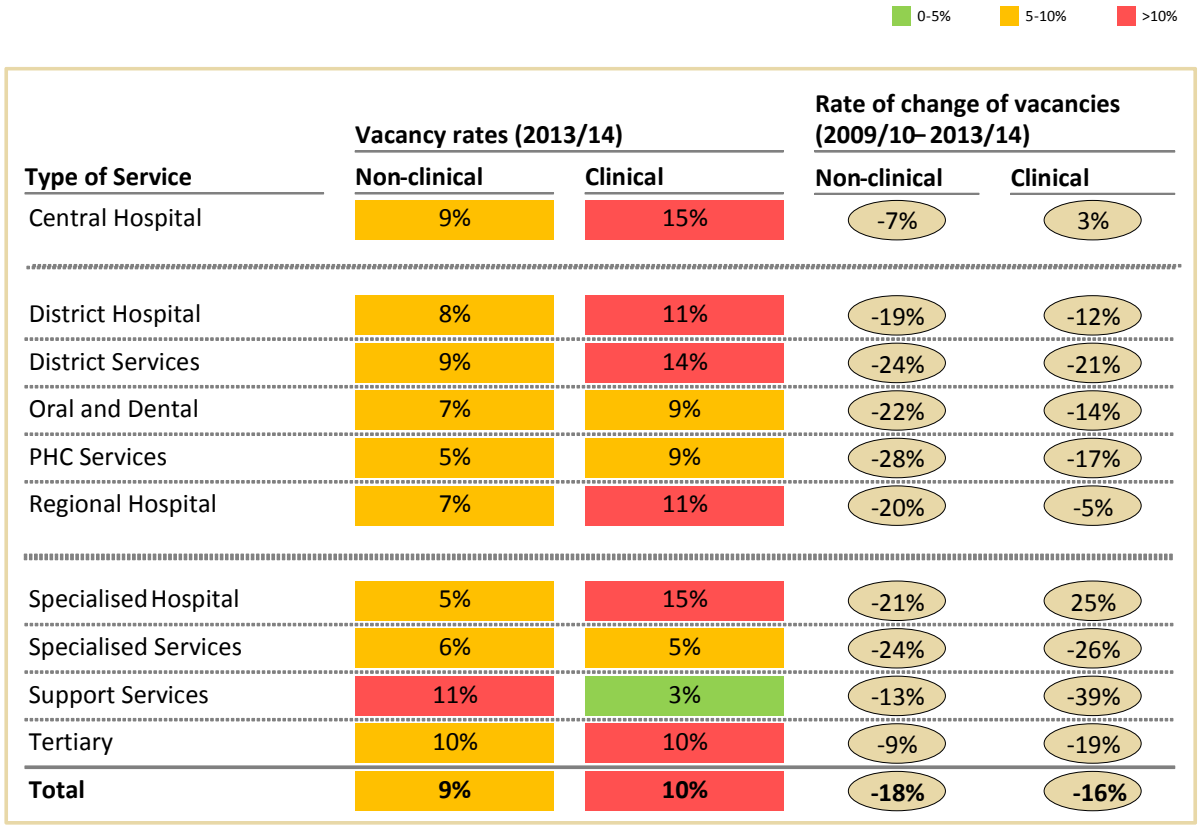
Blue: MEC and HOD
Yellow: DDGs
Green: Chief Directors

EXHIBIT 9 NUMBER OF GDOH WORKERS PER 100,000 PEOPLE ON THE PUBLIC HEALTHCARE SYSTEM



SOURCE: HR department, GDoH

EXHIBIT: 10 GDOH VACANCY RATES



Type of Service	Vacancy rates (2013/14) Non-clinical	Vacancy rates (2013/14) Clinical	Rate of change of vacancies (2009/10– 2013/14) Non-clinical	Rate of change of vacancies (2009/10– 2013/14) Clinical
Central Hospital	9%	15%	-7%	3%
District Hospital	8%	11%	-19%	-12%
District Services	9%	14%	-24%	-21%
Oral and Dental	7%	9%	-22%	-14%
PHC Services	5%	9%	-28%	-17%
Regional Hospital	7%	11%	-20%	-5%
Specialised Hospital	5%	15%	-21%	25%
Specialised Services	6%	5%	-24%	-26%
Support Services	11%	3%	-13%	-39%
Tertiary	10%	10%	-9%	-19%
Total	**9%**	**10%**	**-18%**	**-16%**

SOURCE: HR department, GDoH

Key reasons for personnel leaving the workforce, often cited in exit interviews, include:

- Conflict with managers;
- Retirement of personnel;
- High workloads;

- Frustration around insufficient resources provided to perform the job; and
- Inability to adapt to the working environment.

TABLE A 2: PUBLIC HEALTH PERSONNEL AS AT 31 JANUARY 2016

Categories	Number employed As at 31/01/16	% of total employed	Number per 100,000people	Number per 100,000 uninsured people[13]	Vacancy rate	% of total personnel budget	Annual cost per category[14]
Medical Officers[15]	3407	5.2%	25.8	34.4	13.9%	12.77%	1 881 888 098
Medical specialists	2422	3.7%	18.3	24.5	8.1%	13.49%	1 988 033 672
Dentists	306	0.5%	2.3	3.1	7.1%	1.13%	166 363 297
Dental specialists	184	0.3%	1.4	1.9	5.8%	0.95%	139 587 789
Professional nurses	14052	21.4%	106.5	141.9	10.9%	27.13%	3 998 037 165
Enrolled Nurses	6754	10.3%	51.2	68.2	5.9%	6.58%	969 539 427
Enrolled Nursing Auxillaries	6501	9.9%	49.2	65.7	5.7%	5.12%	754 330 719
Student nurses	3185	4.8%	24.1	32.2	34.8%	2.05%	302 033 805
Pharmacists	830	1.3%	6.3	8.4	19.2%	1.98%	291 760 687
Physiotherapists	265	0.4%	2.0	2.7	17.5%	0.46%	67 919 859
Occupational therapists[16]	347	0.5%	2.6	3.5	15.9%	0.56%	83 223 287
Radiographers	731	1.1%	5.5	7.4	11.8%	1.38%	203 989 356
Emergency Care Practitioners	1525	2.3%	11.6	15.4	2.3%	1.65%	243 313 050
Nutritionists	257	0.4%	1.9	2.6	15.0%	0.49%	71 470 381
Dieticians							
Community Care Givers (even though not part of the GDoH staff establishment)							
TOTAL	**65713**	100%				100%	

Data Source: PERSAL

[13] Populations should be those of resident people

[14] the province is not able to provide cost per staff members and have decided to utilise staff category.

[15] Interns and community service should be included.

[16] this group comprises health therapists (physiotherapists, speech therapists, occupational therapists, clinical psychologists, environmental health practitioners, dental therapists) and specialised auxiliary service staff

4.6.2 Improve Financial Management

TURNAROUND STRATEGY: The departmental turnaround strategy was designed to address major challenges that impact on health system effectiveness. It covered eight focal areas, namely: financial management, human resources, district health services, hospital management, medico-legal services, health information, communication, social mobilisation and health infrastructure. There has been a significant improvement made during the implementation of the Turnaround Strategy. The key outcomes of the Turnaround Strategy indicate a collaborative effort with the Administrator, which was Gauteng Provincial Treasury (GPT) and the Gauteng Department of Health across the eight core challenges areas reflecting the work performed

In order to maintain and sustain the systems developed during implementation of the Turnaround Strategy; the Department will ensure that:

- Monthly HOD's Turnaround Strategy meeting are conducted;
- Forums and decision making frameworks are maintained;
- ICT initiatives organisation wide supported and prioritised;
- Hospitals and Central Office communication and collaboration across all spheres are improved;
- MPAT and Office of Health Standards Compliance (OHSC) dashboards are owned and implemented by GDOH; and reviewed every six months by Gauteng Provincial Treasury.

Interventions towards a clean audit

- The Department formed a partnership with SAICA (South African Institute of Chartered Accountants) whereby experienced Chartered Accountants have been deployed to the four academic and three tertiary hospitals to provide assistance and guidance in the following areas to assist with obtaining a clean Audit outcome.
  - Revenue and Receivables;
  - Payment of suppliers within 30 Days;
  - Reducing accruals; and
  - Any audit related matter.
- Detail instructions and clear guidelines have been issued to address the verification of staff credentials when appointments are made

4.6.3 Strengthen Information Management

Gauteng health services will be modernized through effective management of information system and the development and implementation of e-health strategies towards creating a paperless environment. All hospitals and 27% of PHC facilities will have broadband access in 2016/17 financial year. Upgrading of ICT infrastructure will continue to enable connection of all clinics and hospitals to the internet broadband network. The Department will continue with development of an integrated Health Information System, as part of e-health records system, including scanning and indexing of patient records at central, tertiary and regional hospitals to reduce waiting times and loss of records. In addition, the department will implement the Patient Archiving Communication System (PACS) system in all institutions across all four clusters, and interface with the National Health Information System and the National Health Laboratory Services (NHLS).

4.6.4 Infrastructure Delivery

The department will continue to invest in health infrastructure through improved health infrastructure design, delivery and maintenance and ensuring compliance with statutory requirements in all health facilities. The Department is committed to implementing the green agenda through tri-generation in three hospitals, dual fire diesel/gas boilers in all hospitals, roof-top solar panels in PHC facilities and green building design over the next five years, in partnership with Department of Infrastructure and Development (DID). Maintenance of health facilities will be improved through efficient implementation of e-maintenance in all institutions.

The Department will commence building 10 new clinics and Community Health Centres (CHCs) for completion in 2018/19, in order to address population growth in the province. The department's focus will also be on major re-build or refurbishment of facilities including Jubilee, Sebokeng, OR Tambo Memorial, Kalafong and Dr Yusuf Dadoo and Khayalami Hospitals and 11 mortuaries in the next MTEF period. In addition, the three new hospitals (Lillian Ngoyi, Soshanguve and Daveyton Hospitals) will be under construction in the 2016/17 financial year with expected completion in 2018/19. The refurbishing of laundries which commenced in 2015/16 will be completed in 2017/18 financial year.

4.6.5 Supply Chain Management

The department will continue to strengthen its Supply Chain Management (SCM) systems focusing on organizational design, contract management, the Procure to Pay system to enhance clearing of accruals towards payment of suppliers within 30 days. The department is continuing with its decision that any invoice that is for a prior period must undergo an audit process. This audit process ensures that only valid and authentic invoices are paid. Procurement is part of the Turnaround Strategy for Health, and results are visible particularly in the area of financial and SCM reforms. Contracts are being subjected to market price analysis, and their terms are analyzed to identify areas where the department can negotiate better contracts that result in improved service delivery as well as savings. The analysis of all contracts will be continued, along with improved contract management, more accurate forecasting related to demand and early detection of low stock levels with appropriate interventions. The implementation of the Procurement Transformation Initiative, in conjunction with the Chief Procurement Office at National Treasury, has begun and will continue in 2016/17. This initiative will transform the procurement process through end-to-end management of the procurement of specific critical items.

The Department will support cooperatives and SMMEs as providers of linen and other hospitals related needs. The platform for women cooperatives to supply linen to the department will be created. The department will strengthen the management of laundries and develop departmental guidelines on transformation, modernisation and re-industrialisation.

4.6.6. Medico - legal Services

Legal services provide immediate legal intervention and advice to minimize the risk in the management of an adverse event and to avoid potential litigation.

The Department will ensure management of medical ligations and provision of high quality legal advisory services. Therefore, external expertise and certified mediators have been solicited to assist in mediation process. This has proven effective and a cost saving intervention in many cases. Institutions are reporting immediately on adverse events and the public at large are requesting mediation in the Department. Thus far, 10 cases have been successfully resolved through mediation.

4.7 LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

Acts, rules and regulations

- Intergovernmental Relations Framework Act, 13 of 2005;
- Broad Based Black Economic Empowerment Act, 53 of 2003;
- The National Health Act, 61 of 2003;
- Mental Health Care Act, 17 of 2002;
- Unemployment Insurance Contributions Act, 4 of 2002;
- Promotion of Access to Information Act, 2 of 2000;
- Promotion of Administrative Justice Act, 3 of 2000;
- Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000;
- Preferential Procurement Policy Framework Act, 5 of 2000;
- Protected Disclosures Act, 26 of 2000;
- National Health Laboratory Service Act, 37 of 2000;
- Council for Medical Schemes Levy Act, 58 of 2000;
- Public Finance Management Act, 1 of 1999;
- Tobacco Products Control Amendment Act, 12 of 1999;
- State Information Technology Act, 88 of 1998;
- Competition Act, 89 of 1998;
- Copyright Act, 98 of 1998;
- Sterilisation Act, 44 of 1998;
- Employment Equity Act, 55 of 1998;
- Skills Development Act, 97 of 1998;
- Medical Schemes Act, 131 of 1998;
- Public Service Commission Act, 46 of 1997;
- Basic Conditions of Employment Act, 75 of 1997;
- Public Service Regulations, 2001, as amended
- Labour Relation Act, (Act no 66 of 1995) as amended
- The Constitution of South Africa (Act No 108 of 1996), as amended
- Intergovernmental Fiscal Relations Act, 97 of 1997;
- Medicines and Related Substances Act, 101 of 1965 (as amended in 1997);
- Choice on Termination of Pregnancy Act, 92 of 1996;
- Public Service Act, Proclamation 103 of 1994;
- Occupational Health and Safety Act, 85 of 1993;
- Trade Marks Act, 194 of 1993;
- Designs Act, 195 of 1993;
- SA Medical Research Council Act, 58 of 1991;
- Control of Access to Public Premises and Vehicles Act, 53 of 1985;
- Child Care Act, 74 of 1983;
- Allied Health Professions Act, 63 of 1982;
- Dental Technicians Act, 19 of 1979;
- Nursing Act, 50 of 1978;
- Patents Act, 57 of 1978;
- International Health Regulations Act, 28 of 1974;
- Pharmacy Act, 53 of 1974;
- Health Professions Act, 56 of 1974;
- Occupational Diseases in Mines and Works Act, 78 of 1973;
- Hazardous Substances Act, 15 of 1973;
- Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972;
- Conventional Penalties Act, 15 of 1962;

- State Liability Act, 20 of 1957; and
- Merchandise Marks Act, 17 of 1941.
- Treasury Regulation

Specific provincial health legislation

National legislation and policy is further supported by the following provincial legislation:

- The Gauteng Ambulance Services Act, 2002;
- The Gauteng District Health Services Act, 2000; and
- The Hospital Ordinance Act, 1958 (as amended in 1999).

Other policy imperatives guiding the work of the GDH include the following:

- National Development Plan 2030;
- Gauteng Vision 2055;
- GCR game changers
- GPG 10 Pillar Programme
- Provincial government's five year strategic programme of action;
- National Health MTSF;
- Provincial medium Term Strategic Framework;
- The Batho Pele principles of social service delivery and the Service Delivery Charter;
- Policy and Procedure on the Revolving Door Enabler document;
- Public Health and Welfare Sector Bargaining Council (PHWSBC);
- PSCBC Resolution 9 of 2001; and
- PSCBC Resolution 3 of 1999.

4.8 OVERVIEW OF THE 2015/16 BUDGET AND MTEF ESTIMATES

TABLE A3: SUMMARY OF PAYMENTS AND ESTIMATES BY PROGRAMME: HEALTH

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Administration	501 362	584 151	565 081	561 194	743 226	898 088	616 895	669 961	712 296
2. District Health Services	8 555 956	8 357 432	9 563 046	11 420 847	11 615 588	11 344 993	12 598 039	13 543 039	14 636 378
3. Emergency Medical Services	1 147 231	936 278	847 561	1 086 491	1 086 491	1 064 844	1 197 221	1 275 082	1 351 587
4. Provincial Hospital Services	4 619 534	5 154 324	5 987 314	6 698 750	6 726 998	6 663 256	6 910 146	7 372 610	7 814 966
5. Central Hospital Services	9 762 819	10 237 795	11 584 642	11 783 047	12 034 408	12 637 071	12 609 627	13 317 200	14 055 189
6. Health Sciences And Training	807 070	829 485	861 931	916 549	912 929	889 266	976 452	1 025 163	1 086 672
7. Health Care Support Services	196 544	194 870	211 542	260 328	259 796	235 912	268 747	281 538	298 430
8. Health Facilities Management	1 243 831	1 121 466	1 384 095	1 447 973	1 957 652	1 957 652	2 017 930	2 425 334	2 544 870
Total payments and estimates	**26 834 347**	**27 415 801**	**31 005 212**	**34 175 179**	**35 337 088**	**35 691 082**	**37 195 057**	**39 909 926**	**42 500 389**

SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**23 870 650**	**25 157 666**	**28 390 262**	**31 263 266**	**32 346 651**	**32 658 699**	**33 443 757**	**35 731 393**	**38 197 994**
Compensation of employees	15 244 542	17 096 854	18 654 909	20 409 051	20 834 706	20 777 919	22 205 177	23 614 733	25 043 335
Goods and services	8 625 127	8 059 289	9 735 281	10 854 214	11 511 944	11 880 780	11 238 580	12 116 660	13 154 659
Interest and rent on land	981	1 523	72	–	–	–	–	–	–
Transfers and subsidies to:	**2 016 510**	**1 423 046**	**1 570 752**	**1 501 024**	**1 457 653**	**1 471 477**	**1 342 692**	**1 423 056**	**1 508 435**
Provinces and municipalities	1 083 525	607 677	672 042	681 326	657 443	657 443	675 326	709 103	751 650
Departmental agencies and accounts	28 267	16 117	17 183	17 919	17 919	17 919	18 869	19 812	21 001
Higher education institutions	500	958	–	1 864	1 864	1 864	1 963	2 061	2 185
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	34	33 393	–	–	–	–	–	–	–
Non-profit institutions	817 505	640 453	652 703	721 610	686 983	636 983	544 030	583 410	618 414
Households	86 679	124 448	228 824	78 305	93 444	157 268	102 504	108 669	115 185
Payments for capital assets	**941 464**	**832 163**	**1 031 499**	**1 410 889**	**1 532 784**	**1 554 756**	**2 408 608**	**2 755 477**	**2 793 960**
Buildings and other fixed structures	528 282	415 135	378 954	869 741	869 741	869 741	1 235 355	1 630 974	1 595 444
Machinery and equipment	413 182	416 840	652 545	541 148	663 043	685 015	1 173 253	1 124 503	1 198 516
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	188	–	–	–	–	–	–	–
Payments for financial assets	**5 723**	**2 926**	**12 699**	**–**	**–**	**6 150**	**–**	**–**	**–**
Total economic classification	**26 834 347**	**27 415 801**	**31 005 212**	**34 175 179**	**35 337 088**	**35 691 082**	**37 195 057**	**39 909 926**	**42 500 389**

4.8.2 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

The department's expenditure increased from R26.8 billion in 2012/13 to R31 billion in 2014/15. This is due to the burden of disease, which resulted in accelerated expenditure mainly in district health services and central hospitals, and the payment of accruals from previous financial years.

The total appropriation increases from R34.2 billion in 2015/16 to R37.7 billion in 2016/17 financial year. The increase is mainly due to inflation (CPI), cost of living adjustments, OSD and filling of critical posts, and the carry-through effect of additional funding allocated to the department in 2014/15 for non-negotiable budget line items as well as the adjustment carry through costs towards payment of municipal services.

Comparing the 2015/16 and 2016/17 financial years, the Administration budget shows a substantial increase of 10 per cent. This is as a result of increase in the computer services budget; in 2016/17, the department allocated R27 million towards the continued enhancement of ICT upgrade and modernisation of the health system such as replacement of servers in institutions in the department.

The budget of Programme 2: District Health Services increases by 10 per cent from 2015/16 to 2016/17. Over the 2016 MTEF, this programme received an earmarked allocation for accelerating the provision and improvement of PHC services; ward-based outreach teams; district clinical specialist teams; and integrated school health services, and to provide funding for Human Papillomavirus (HPV) Vaccine to enable the department to prevent cervical cancer in grade 4 school girls. The National Health Insurance Grant (NHI) is terminated from the 2017/18 as a transfer allocation to the province it has not been effective as expected in preparing for the roll out and a more targeted approach is considered to make it more efficient for the planned roll out.

The budget for Programme 3: Emergency Medical Services increases by 20 percent from R1 billion in 2015/16 to R1.2 billion in 2016/17. The growth makes provision for replacing ageing emergency vehicles so that the department can continue to provide effective and efficient emergency medical services.

Over the four year period 2015/16 to 2018/19, the budget of Programme 4: Provincial Hospital Services increases by R1.1 billion or 17 per cent. This is due to additional funding for higher municipal tariffs at institutions and non-negotiable line items.

The budget in Programme 5: Central Hospital Services increases significantly by 20 per cent, from R11.7 billion in 2015/16 to R14.0 billion in 2018/19. This is due to the enhancement of tertiary services, adequately funding non-negotiable items and budget pressures from increases in the prices of medical commodities and the payment of municipal services.

Over the MTEF period 2016/17 to 2018/19, the budget of Programme 6: Health Science and Training increases by R110 million or 11 per cent to provide for student intake, employee bursary holders and the South African Cuban Doctor programme to address the shortage of doctors in the country.

The budget of Programme 7: Health Care Support Services increases by R29 million or 11 per cent from 2016/17 to 2018/19 to provide for the laundry services and pre-packed food services.

Programme 8: Health Facilities Management is funded through the equitable share and Health Facility Revitalisation Grant for improving and maintaining health facility infrastructure. From 2016/17 to 2018/19, the allocation for the programme increases by 26 per cent.

The compensation of employees budget increased by 8,8 per cent from R20.4 billion in 2015/16 to R22.2 billion in 2016/17 financial year as a result of cost of living adjustments, OSD for qualifying employees and overtime and employment of critical staff.

The allocation for goods and services has increased by 4 percent from R10.8 billion in 2015/16 to R11.2 billion in 2016/17. The increase is due to funding for re-engineering of PHC and additional funding for non-negotiable items such as medical supplies and higher municipal tariffs.

The budget for transfer payments decreased by 13 percent from R1.5 billion in 2015/16 to R1.3 billion in 2016/17. The transfers are to cater for transfer payments to municipalities for primary health care, HIV and AIDS and emergency medical services. The budget for transfer payments to non-profit organisations decreases from R721 million in 2015/16 to R544 million in 2016/17. This slight decrease is as a result of the absorption of the Alexandra clinic and a decision taken by the department to terminate contract with Life Esidimeni. Transfers to departmental agencies and accounts increases from R17.9 million in 2015/16 to R21.0 million in 2018/19 as a result of payments to the Health and Welfare Sector Training Authority (HWSETA) for skills development and training of health professionals on behalf of the department.

An additional allocation of R184 million is allocated in the 2016/2017 towards payment for Municipal Services. Over the 2016 MTEF an amount of R587 million has been allocated for Municipal services. Further R158 million has been allocated towards medicine and medical supplies over the 2016 MTEF. These allocations were allocated in programmes 2, 4 and 5, i.e. District Health Services, Provincial Hospital Services and Central Hospital Services respectively.

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

Expenditure	2012/13 (MTEF (actual)	2013/14 (MTEF (actual)	2014/15 (MTEF (actual)	2015/16 (MTEF estimates)	2016/17 (MTEF Projection	2017/18 (MTEF Projection	2018/19 (MTEF Projection
Current prices[1]							
Total[2]	26,834,347	27,415,801	31,005,212	35,337,088	37,195,057	39,080,497	42,500,389
Total per person	2,360	2,234	2,501	2,736	2,880	3,026	3,291
Total per uninsured person	2,985	2,828	3,166	3,464	3,646	3,830	4,166
CPI	5.60%	5.80%	5.50%	5.20%	6.20%	5.80%	5.80%
Index (Multiplier)	80.2	84.8	89.5	94.2	100.0	105.8	111.9
Constant (2016/17) prices[3]							
Total	21,521,146	23,248,599	27,749,665	33,287,537	37,195,057	41,347,166	47,557,935
Total per person	2,943	2,634	2,795	2,905	2,880	2,860	2,941
Total per uninsured person	2,394	2,398	2,834	3,263	3,646	4,053	4,661
% of Total spent on							
DHS[4]	32%	30%	31%	33%	34%	35%	34%
PHS[5]	25%	19%	19%	19%	19%	19%	18%
CHS[6]	29%	37%	37%	34%	34%	33%	33%
All personnel	57%	62%	60%	59%	60%	60%	59%
Capital[2]	**941,464**	**832,163**	**1,031,499**	**1,532,784**	**2,369,434**	**2,479,058**	**2,793,960**
Health as % of total public expenditure	0.03%	0.03%	0.03%	0.03%	0.04%	0.04%	0.04%

PART B: PROGRAMMES AND SUB PROGRAMME PLANS

BUDGET PROGRAMME 1: ADMINISTRATION

1.1 PROGRAMME PURPOSE

The purpose of this programme is to conduct strategic management and overall administration of the Department of Health through the sub-programmes:

- Office of the MEC, which is rendering advisory, secretarial and office support services; and
- Management: Policy formulation, overall management and administration support of the Department and the respective regions and institutions within the Department.

The changes to the 5 year strategic plan are described under financial management and Human Resource Management strategic objective statements as per attached Annexure A.

1.2 PRIORITIES

Improved Quality of Health Care

- Implement the Lean Management project in all hospitals and clinics to reduce waiting times;
- Conduct gap assessment and develop quality improvement plans in all hospitals to improve quality of care;
- Increase performance of all facilities against the national core standards and compliance through certification by Office of Health Standards Compliance;
- Conduct patient satisfaction surveys at all health institutions;

Improve financial management and accountability

- Improve Department audit outcomes;
- Develop and implement standardised governance and financial systems processes and procedures;
- Develop an activity-based costing system;
- Increase revenue enhancement capacity and debt collection;
- Strengthen risk management and internal control environment; and
- Develop departmental guidelines on transformation, modernisation and re-industrialisation.

Effective management information system

- Develop and implement efficient integrated patient-based Management Information System to improve decision making, including patient records and patient data management;
- Upgrade ICT infrastructure, health information system and ensure connectivity in all health facilities; and Build multi-skilled health information personnel.

Improved Human Resource for Health

- Implement PHC Normative Guide informed by the Workload Indicators of Staffing Needs (WISN) in all PHC facilities;
- Strengthen Labour Relation Processes and Systems to achieve legislated turnaround times;
- Ensure compliance with performance management system;
- Implement Employment Equity (EE), Gender, youth and disability mainstreaming;
- Build capacity of HR management in institutions and districts; and
- Conduct annual staff satisfaction survey.

Strengthen the provision and management of legal services

- Ensure effective management of medical litigations; and
- Provision of high-quality legal advisory services.

1.3 PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

TABLE ADMIN 1 & 2: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

Strategic objective statement	Programme Performance indicator	Frequency of reporting	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Estimates			Strategic Plan Target
				2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Decrease average OPD and Pharmacy waiting times in regional and specialised hospitals by 60% in 2019/20	1. Number of hospitals implementing Lean Management project	Quarterly	No	#	#	4/36	32/36	36/36	36/36	36/36	36
	2. Number of clinics implementing Lean Management project	Quarterly	No	#	#	#	#	372/372[17]	372/372	372/372	
Implement eHealth and mHealth solutions in 36 hospitals	3. Number of mHealth applications developed	Quarterly	No	0	2	4	2	4	8	10	
	4. Number of hospitals with PACS	Quarterly	No	#	4/36	0	19/36	36/36	36/36	36/36	36
Increase revenue collection from qualifying paying patients from R522 048 000 in 2013/14 to R1, 700 000 000 in 2019/20	5. Rand value of revenue collected	Quarterly	R	R506.939m	R527.709m	R524.051m	R555.727m	R 1 b	R 1.3 b	R1.5 b	R1.7b
Increase diversity, verification of qualifications and equity of our	6. Percentage of women in senior management posts (106) senior managers)	Quarterly	%	37.38%	40.5%	44%	43% (46/106)	45% (52/116)	47% (54/116)	48% (56/116)	50% (58/106)

[17] According to DHIS and confirmed by District managers the total number of clinics and CHCs in the province in November 2015 is 372.

Strategic objective statement	Programme Performance indicator	Frequency of reporting	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Estimates			Strategic Plan Target
				2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
workforce thus increasing women in senior management positions from adequate (41%) to good (50%) by 2019/20 and increasing percentage of people with disabilities employed to 2% by 2019/20	7. Percentage of people with disabilities employed	Quarterly	%	0.8%	0.74%	0.72%	2%	1.8% 350/65517	1.8% 350/65517	1.8% 350/65517	2%
	8. Percentage of newly appointed staff members with verified qualifications	Quarterly	%	#	#	20%	40%	60%	80%	80%	100%
Improve relations between employer and employees in the workplace thus reducing grievances from 3.5 in 2013/14 to 2.0 per 1 000 employees by 2019/20 and misconduct cases from 11 in 2013/14 to 8.0 per 1 000 employees by 2019/20	9. Percentage of grievances cases resolved within 30 days	Quarterly	%	6.3%	3.5%	3.4%	80%	100% 300/300	100% 250/250	100% 200/200	100%
	10. Percentage of misconduct cases resolved within 90 days	Quarterly	%	11.8%	11.0%	10.8%	90%	100% 600/600	100% 500/500	100% 400/400	100%
	11. Percentage of precautionary suspensions uplifted within 60 days	Quarterly	%	#	#	#	100%	100% 12/12	100% 7/7	100% 3/3	100%
Receive unqualified audit opinion from Auditor-General by 2016/17 and a clean audit by 2019/20	12. Audit opinion from Auditor General	Annually	Categorical (QPR)	Qualified	Qualified	Qualified	Unqualified	Unqualified	Unqualified	Unqualified	Clean

Strategic objective statement	Programme Performance indicator	Frequency of reporting	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Estimates			Strategic Plan Target
				2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase the Broadband network access in the department such that 100% of PHC facilities and hospitals have broadband network access and 100% of total staff has email access by 2019/20	13. Percentage of Hospitals with Broadband access[18]	Quarterly	% (QPR)	#	#	#	50% (18/36)	100% (36/36)	100% (36/36)	100% (36/36)	100%
	14. Percentage of fixed facilities with broadband access	Quarterly	% (QPR)	#	#	#	1% (2)	27% (100/372)	54% (200)	60% (223)	100%

 # Refers to new indicator where baseline data was not collected in that financial year

1.4: QUARTELY TARGETS

TABLE ADMIN 3: QUARTERLY TARGETS

INDICATOR	Frequency of reporting (quarterly, bi-annual, annual)	Indicator type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1.Number of hospitals implementing Lean Management project	Quarterly	No	36/36	36	36	36	36
2.Number of clinics implementing Lean Management project	Quarterly	No	372/372	372	372	372	372
3.Number of mhealth applications developed	Quarterly	No	4	2	2	4	4
4.Number of hospitals with PACS	Quarterly	No	36/36	36	36	36	36

[18] Shaded areas are nationally customised health sector indicators

INDICATOR	Frequency of reporting (quarterly, bi-annual, annual)	Indicator type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
5.Rand value of revenue collected	Quarterly	R	R 1 b	R 250 m	R500m	R750 m	R 1 b
6.Percentage of women in senior management posts (106) senior managers)	Quarterly	%	45% (52/116)	45%	45%	45%	45%
7.Percentage of people with disabilities employed	Quarterly	%	1.8% 350/65517	1.8%	1.8%	1.8%	1.8%
8.Percentage of newly appointed staff members with verified qualifications	Quarterly	%	60%	60%	60%	60%	60%
9.Percentage of grievances cases resolved within 30 days	Quarterly	%	90%	90% 300/300	90%	90%	90%
10. Percentage of misconduct cases resolved within 90 days	Quarterly	%	95%	95% 600/600	95%	95%	95%
11. Percentage of precautionary suspensions uplifted within 60 days	Quarterly	%	100%	100% 12/12	100%	100%	100%
12. Audit opinion from Auditor General[19]	Annually	Categorical (QPR)	Unqualified				Unqualified
13. Percentage of Hospitals with Broadband access	Quarterly	% (QPR)	100% (36/36)	100%	100%	100%	100%
14. Percentage of fixed PHC[20] facilities with broadband access	Quarterly	% (QPR)	27% (100/372)	27% (100)	27% (100)	27% (100)	27% (100)

[19] Shaded areas are nationally customised health sector indicators
[20] 2015: 372fixed clinics and 35 CHCs

1.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE ADMIN 4: EXPENDITURE ESTIMATES: ADMINISTRATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Office Of The MEC	11 519	10 970	15 066	18 360	18 345	16 582	19 389	20 358	21 580
2. Management	489 843	573 181	550 015	542 834	724 881	881 506	597 506	649 603	690 716
Total payments and estimates	**501 362**	**584 151**	**565 081**	**561 194**	**743 226**	**898 088**	**616 895**	**669 961**	**712 296**

SUMMARY OF PROVINCIAL EXPENDITURES ESTIMATES BY ECONOMIC CLASSIFICATION: ADMINISTRATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**471 731**	**565 776**	**514 261**	**551 271**	**725 591**	**836 452**	**606 146**	**658 159**	**699 788**
Compensation of employees	241 568	274 797	301 841	370 768	370 768	337 791	395 762	415 549	442 621
Goods and services	229 792	290 748	212 420	180 502	354 822	498 661	210 384	242 610	257 166
Interest and rent on land	371	231	–	–	–	–	–	–	–
Transfers and subsidies to:	**16 136**	**1 897**	**2 158**	**2 092**	**2 092**	**3 868**	**2 203**	**2 313**	**2 450**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	7	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	15 131	–	–	–	–	–	–	–	–
Households	998	1 897	2 158	2 092	2 092	3 868	2 203	2 313	2 450
Payments for capital assets	**12 761**	**16 449**	**42 191**	**7 831**	**15 543**	**56 582**	**8 546**	**9 488**	**10 058**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	12 761	16 449	42 191	7 831	15 543	56 582	8 546	9 488	10 058
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**734**	**29**	**6 471**	**–**	**–**	**1 186**	**–**	**–**	**–**
Total economic classification	**501 362**	**584 151**	**565 081**	**561 194**	**743 226**	**898 088**	**616 895**	**669 961**	**712 296**

1.6 PERFORMANCE AND EXPENDITURE TRENDS

The baseline of the programme has increased by 10 percent from R561.1 million in 2015/16 to R616.8 million in 2016/17. This is as a result of increase in the computer services budget; in 2016/17, the department allocated R27 million towards improving ICT systems by upgrading IT infrastructure across a number of hospitals and moving towards electronic patient records.

1.7 RISK MANAGEMENT

RISK	MITIGATING FACTORS
Delays/late payments to suppliers (30 day payment period)	• Continuous Pre-payment audit process for accruals; • Decentralize scanning of documents and implementation of E- Invoicing (XML files); • Procurement demand plans to be aligned to the budget; • Develop and implement institutional procurement units capacity building programme.
• Irregular, fruitless & wasteful expenditure • Financial losses due to Litigation	• Implementation of Consequence Management for non -compliance to policies and procedures • Develop and Implement procurement plans aligned with budget • Implement an electronic inventory system (SAP) • Implement Activity Based Costing Budgeting in hospitals • Establishment of the Ethics Committee and Continue with the Ethics training and Code of Conduct
Fraud and corruption	• Approval and implementation of the Integrity Management Policy • Implementation of Public Administration Management Act. (PAMA) • Implementation of Public Administration Integrity Management Framework (PAIMF) • Continuous training on ethics and the Code of Conduct • To continue with annual disclosure of interest • Updating and monitoring of Fraud Risk Register • Roll out of Fraud Prevention Plan
In-effective human resource management and inadequate Human Capital Management	• Prioritise allocation of human resources to districts and PHC facilities • Improve and align individual health worker's performance to organisational performance and strategic goals • Strengthen institutional human resources capacity through uniform organogram aligned to Department of Public Service and Administration (DPSA) guidelines • Improve turnaround times for the filling of funded vacant posts • Develop and implement Succession Planning Policy and implement competency assessments • Finalise and implement norms and standards (WISN) • Improve human resource practices such as leave management and Remunerated Work outside the Public Service (RWOPS) etc. • Conduct departmental satisfaction survey and implement recommendations
Poor Information Communication Technology (ICT) Management	• Review ICT organisational structure • Rolled-out. Standard Operating Procedures • Implement ICT policy and plan • Upgrade ICT infrastructure at various sites

BUDGET PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

2.1 PROGRAMME PURPOSE

The purpose of the programme is to render primary health care services, district hospital services, comprehensive HIV and AIDS care and nutrition and priority health programmes including sub-programmes:

- District Management;
- Community health clinics;
- Community health centres
- Community based services; and
- Other community services.

The changes to the 5 year strategic plan are described in all District Health Services sub- programmes goal statement and strategic objective statements as per attached Annexure A.

2.2 PRIORITIES

- **Universal Coverage through implementation of National Health Insurance (NHI)**
    - Expansion of National Health Insurance implementation across the province
    - Implement the Ideal Clinic Initiative Project interventions in all the health districts in the province.
    - Strengthen Re-engineering of Primary Health Care
        - Expansion of functional Ward Based Outreach Teams (WBOTs) across all the health districts in the province to provide preventative care and collect community based information;
        - Implementation of District Clinical Specialist Teams (DCSTs), with a special focus on maternal, infant and child health;
        - Establishment of District Mental Health Specialist Teams; and
        - Integrated School Health Services.
- **Strengthen partnerships** with civil society and other external stakeholders and interdepartmental collaboration and communication, through governance structures such as District Health Council and Ntirhisano initiatives.
- Expanding the **Centralised Chronic Medicine Dispensing and Distributions** across the province

2.3 SERVICE DELIVERY PLATFORM FOR DHS

TABLE DHS1: DISTRICT HEALTH SERVICE FACILITIES BY HEALTH DISTRICT IN 2014/15

Health district	Facility type	No.	Population[3]	Population per facility[3] or per hospital bed	PHC Headcount or Inpatient Separations	Per capita utilisation[3]
City of Jo'burg	Non fixed clinics[1]	0	**4,763,168**			1.8
	Fixed clinics operated by Local Government	80				
	Fixed Clinics[2] operated by Provincial Government	27				
	Fixed clinics operated by NGOs	1				
	Total fixed Clinics	108				
	CHCs	10				
	Sub-total clinics + CHCs	118				
	District hospitals	2				
West Rand	Non fixed clinics[1]	11	860,613			2.3
	Fixed clinics operated by Local Government	0				
	Fixed Clinics[2] operated by Provincial Government	44				
	Fixed clinics operated by NGOs	0				
	Total fixed Clinics	44				
	CHCs	3				
	Sub-total clinics + CHCs	47				
	District hospitals	2				
Ekurhuleni	Non fixed clinics[1]	7	3,284,630			1.9
	Fixed clinics operated by Local Government	79				
	Fixed Clinics[2] operated by Provincial Government	5				
	Fixed clinics operated by NGOs	0				
	Total fixed Clinics	84				
	CHCs	7				
	Sub-total clinics + CHCs	91				
	District hospitals	1				
Sedibeng	Non fixed clinics[1]	13	**922,050**			2.2
	Fixed clinics operated by Local Government	24				
	Fixed Clinics[2] operated by Provincial Government	11				
	Fixed clinics operated by NGOs	0				
	Total fixed Clinics	35				
	CHCs	4				
	Sub-total clinics + CHCs	39				
	District hospitals	2				
Tshwane	Non fixed clinics[1]	11	**3,165,746**			1.6
	Fixed clinics operated by Local Government	23				
	Fixed Clinics[2] operated by Provincial Government	42				
	Fixed clinics operated by NGOs	0				
	Total fixed Clinics	65				
	CHCs	8				
	Sub-total clinics + CHCs	73				
	District hospitals	4				
Province	**Non fixed clinics[1]**	**42**	**12,996,207**			1.8
	Fixed clinics operated by Local Government	**206**				
	Fixed Clinics[2] operated by Provincial Government	**129**				
	Fixed clinics operated by NGOs	**1**				
	Total Fixed Clinics	**335**				
	CHCs	**32**				
	Sub-total clinics + CHCs	**372**				
	District hospitals	**11**				

1. Non fixed clinics should include mobile and satellite clinics (exclude visiting points).
2. Fixed clinics operated by Provincial Government must include gateway clinics.
3. PHC facility headcounts and hospital inpatient separations should be used for per capita utilisation.
4. Include state aided hospitals that provide Level 1 care
5. Boekenhout, Refentse and Ethafeni render MOU services but are not classified as CHCs
6. The province has 5 fixed clinics classified as CDCs: 3 in Sedibeng and 2 in Ekurhuleni

2.4 SITUATIONAL ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

TABLE DHS 2: SITUATIONAL ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

Programme Performance Indicator	Indicator Type	Province wide value 2014/15	2014/15 City of Jo'burg	2014/15 West Rand	2014/15 Ekurhuleni	2014/15 Sedibeng	2014/15 Tshwane
1. Percentage of fixed PHC facilities scoring above 70% on the ideal clinic dashboard	% (QPR)	1 (0.26%)	0	0	0	0	1
2. Client Satisfaction Survey rate	% (QPR)	#	#	#	#	#	#
3. Client Satisfaction rate	% (QPR)	#	#	#	#	#	#
4. OHH registration visit coverage (Annualised)	% (QPR)	104.9%	54.4%	57.6%	83.8%	52.74%	47.3%
5. Number of Districts with District Clinical Specialist Teams (DCSTs)	No (QPR)	5/5	1	1	1	1	1
6. PHC Utilisation rate	No (QPR)	1.8	1.8	2.1	1.9	2.1	1.6
7. Complaints resolution rate	% (QPR)	88.7%	80.7%	75.6%	80.1%	79.5%	93.7%
8. Complaint resolution within 25 working days rate	% (QPR)	95.2%	94%	97.9%	96.9%	99%	95.6%

 # depicts a new performance indicator not measured before

**** National NHI indicators removed as per National Health Department Directive**

2.4.1 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES

TABLE DHS 3: STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium Term Targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Fixed PHC clinics scoring above 70% on the ideal clinics dashboard; 90% of PHC facilities and district hospitals compliant with extreme and vital measures of national core standards and PHC facilities and district hospitals conducting national core standards self-assessment increase to 100% by 2019/20	1. Percentage of fixed PHC facilities scoring above 70% on the ideal clinic dashboard	% (QPR)	#	#	1 (0.26%)	5 (1.32%)	100% (372/272)	100% (372/272)	100% (372/272)	5,3%
	2. PHC Utilisation rate	No (QPR)	2	1.8	1.8	2.5	2.8	3.0	3,0	
	3. Complaints resolution rate	% (QPR)	85%	85%	85%	90%	95%	100%	100%	
	4. Complaint resolution within 25 working days rate	% (QPR)	94%	74.3%	95.2%	80%	82%	87%	90%	
	5. OHH registration visit coverage (annualised)	% (QPR)	#	87.2%	93.9%	70%	80%	90%	95%	
Increase patient satisfaction rate to 85% by 2019/20	6. Client Satisfaction Survey rate	% (QPR)	#	#	#	100%	100%	100%	100%	
	7. Client Satisfaction rate	% (QPR)	#	#	#	68%	70%	72%	80%	85%
Ensure completeness of the DCSTs in all the 5 Health Districts to strengthen the 5 functional clinical specialist teams by 2019/20	8. Number of Districts with District Clinical Specialist Teams (DCSTs)	No (QPR)	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium Term Targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase quality and access in PHC facilities through 24 hours service provision in all CHCs, integration of mental health and rehabilitation services in 100% of PHC facilities by 2019/20	9. Number CHCs providing 24 hour services	No	26/35	26/35	27/35	28/35	35/35	35/35	35/35	35
	10. Percentage of PHC facilities with integrated mental health services	%	65%	65% (242/372)	75% (279/372)	85% (316/372)	100% 372/372	100% 372/372	100% 372/372	
	11. Proportion of assistive devices issued	No	#	#	#	44%	50%	52%	55%	
Increase the number of fully-fledged, functional Ward Based Outreach Teams from 103 to 533 by 2019/20	12. Number of fully-fledged, functional Ward Based Outreach Teams	No	#	130/533	388/533	300/533	533/533	533/533	533/533	533

 # depicts a new performance indicator not measured before

**** National NHI indicators removed as per National Directive**

2.4.2 QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

TABLE DHS 4: QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

INDICATOR	Frequency of reporting	Indicator type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. Percentage of fixed PHC facilities scoring above 70% on the ideal clinic dashboard	Quarterly	% (QPR)	100% 372/272	100%	100%	100%	100%
2. Client Satisfaction Survey rate	Quarterly	% (QPR)	100% 372/372	100%	100%	100%	100%
3. Client Satisfaction rate	Annually	% (QPR)	70%	70%	70%	70%	70%
4. OHH registration visit coverage (annualised)	Quarterly	% (QPR)	80%	80%	80%	80%	80%
5. Number of Districts with District Clinical Specialist Teams (DCSTs)	Quarterly	No (QPR)	5/5	5	5	5	5
6. PHC Utilisation rate	Quarterly	% (QPR)	2.8	2.8	2.8	2.8	2.8
7. Complaints resolution rate	Quarterly	% (QPR)	95%	95%	95%	95%	95%
8. Complaint resolution within 25 working days rate	Quarterly	% (QPR)	82%	82%	82%	82%	82%
9. Number CHCs providing 24 hour services	Quarterly	No	35/35	32	33	34	35
10. Proportion of assistive devices issued	Quarterly	No	50%	46%	47%	48%	50%
11. Percentage of PHC facilities with integrated mental health services	Quarterly	%	100% (372/372)	100%	100%	100%	100%
12. Number of fully-fledged, functional Ward Based Outreach Teams	Quarterly	No	508/508	400	508	508	508

2.5 PROGRAMME: DISTRICT HOSPITALS

Purpose of the Sub - Programme
Rendering of a hospital service at district level.

TABLE DHS 5: SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS

Programme Performance Indicators	Indicator Type	2014/15 Province wide value	2014/15 City of Jo'burg	2014/15 West Rand	2014/15 Ekurhuleni	2014/15 Sedibeng	2014/15 Tshwane	National Average 2013/14
1. National Core Standards self-assessment rate[21]	%	100%	100%	100%	100%	100%	100%	
2. Quality improvement plan after self-assessment rate	%	75%	0%	100%	100%	100%	75%	
3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	%	0%	0%	0%	0%	0%	0%	
4. Client Satisfaction Survey Rate	%	100%	50%	100%	100%	100%	100%	
5. Client Satisfaction rate	%	66.5%	64.5%	67%	62%	67%	68%	
6. Average Length of Stay	No	4.3	3.6	4.8	4.3	3.5	4.9	
7. Inpatient Bed Utilisation Rate	%	60.6%	45.1%	66.7%	69%	69.5%	62.4	
8. Expenditure per PDE	No	R2386	-	-	-	-	-	
9. Complaints resolution rate	%	100%	98.5%	72%	76.3%	81.1%	88%	
10. Complaint Resolution within 25 working days rate	%	98.5%	100%	96.3%	100%	102.7.1%	97.6%	

depicts a new performance indicator not measured before

[21] Shaded areas are nationally customised health sector indicators

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

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

Strategic Objectives Statement	Programme Performance Indicators	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan target 2019/20
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
90% of PHC facilities and district hospitals compliance with extreme and vital measures of national core standards and PHC facilities and district hospitals conducting national core standards self-assessment increase to 100% by 2019/20	1. National Core Standards self-assessment rate[22]	% (QPR)	#	#	100% (11/11	100% (11/11	100% (11/11)	100% (11/11)	100% (11/11)	80%
	2. Quality improvement plan after self-assessment rate	% (QPR)	#	#	75% (8/11)	80% (9/11)	85% (9/11)	90% (10/11)	80% (10/11)	100%
	3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	% (QPR)	#	#	0% (0 of 11)	27% (3 of 11)	20% (2 of 11)	27% (3 of 11)	36% (4 of 11)	90%
Increase patient satisfaction rate to 85% by 2019/20	4. Client Satisfaction Survey Rate	% (QPR)	#	#	100% (11/11	100% (11/11	100% (11/11	100% (11/11	100% (11/11	
	5. Client Satisfaction rate	% (QPR)	66%	69%	66.5%	75%	78%	80%	100%	85%
Improve efficiency of hospitals by reducing average length of stay to less than 5 days increasing bed utilisation to 80% and decreasing expenditure per PDE in hospitals by 2019/20	6. Average Length of Stay	No (QPR)	3.2	4.9	4.3	4	4.5	4.5	4.5	<5
	7. Inpatient Bed Utilisation Rate	% (QPR)	66.3%	85%	60.6%	80%	80%	80%	80%	80%
	8. Expenditure per PDE	No (QPR)	R2 032	R2186	R2386	R2500	R2650	R2750	R2850	
Percentage of complaints resolved within 25 working days will be over 95% by 2019/20	9. Complaints resolution rate	% (QPR)	95.6%	83%	100%	80%	85%	90%	95%	
	10. Complaint Resolution within 25 working days rate	% (QPR)	87.4%	81%	98.5%	68%	85%	90%	95%	<95%

depicts a new performance indicator not measured before

[22] Shaded areas are nationally customised health sector indicators

2.5.2 QUARTERLY TARGETS FOR DISTRICT HOSPITALS

TABLE DHS 7: QUARTERLY TARGETS FOR DISTRICT HOSPITALS

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. National Core Standards self-assessment rate (District Hospitals)[23]	Quarterly	% (QPR)	100% (11/11)	100% (11/11)	100%	100%	100%
2. Quality improvement plan after self-assessment rate (District Hospitals)	Quarterly	% (QPR)	85% (9/11)	85% (9/11)	85% (9/11)	85% (9/11)	85% (9/11)
3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (District Hospitals)	Quarterly	% (QPR)	20% (2 of 11)	20% (2 of 11)	20% (2 of 11)	20% (2 of 11)	20% (2 of 11)
4. Client Satisfaction Survey Rate (District Hospitals)	Quarterly	% (QPR)	100%	100% (11/11)	100%	100%	100%
5. Client Satisfaction rate (District Hospitals)	Quarterly	% (QPR)	78%	78%	78%	78%	78%
6. Average Length of Stay (District Hospitals)	Quarterly	No (QPR)	4.5	4.5	4.5	4.5	4.5
7. Inpatient Bed Utilisation Rate (District Hospitals)	Quarterly	% (QPR)	80%	80%	80%	80%	80%
8. Expenditure per PDE (District Hospitals)	Quarterly	No (QPR)	R2650	R2650	R2650	R2650	R2650
9. Complaints resolution rate (District Hospitals)	Quarterly	% (QPR)	85%	85%	85%	85%	85%
10. Complaint Resolution within 25 working days rate (District Hospitals)	Quarterly	% (QPR)	85%	85%	85%	85%	85%

[23] Shaded areas are nationally customised health sector indicators

2.6 SUB-PROGRAMME: HIV AND AIDS, STI & TB CONTROL

PURPOSE OF THE PROGRAMME

HIV and AIDS: Rendering a primary health care service in respect of HIV and AIDS campaigns and Special Projects.

PRIORITIES

Intensify HIV and AIDS Programme: prevention

- Reduce new HIV infection by 50% through a combination of prevention strategies, targeting vulnerable and populations at high risk of HIV infection;
- Implement the UNAIDS 90-90-90 strategy;
- Strengthen the multisector response to HIV, TB and STIs; and
- Strengthen the comprehensive management of patients with TB and HIV co-infection**.**

Tuberculosis prevention and management

- Improve case finding and treatment initiation following TB diagnosis;
- Improve TB success rate and reduce defaulter rate;
- Integrate prevention, diagnosis and treatment of TB and HIV; and
- Provide training of TB staff on NIMDR to increase uptake of DRTB.

TABLE DHS 8: SITUATION ANALYSIS INDICATORS FOR HIV & AIDS, STIs AND TB CONTROL

Programme Performance Indicator	Indicator Type	Province wide value 2014/15	Tshwane 2014/15	Jo'burg 2014/15	West Rand 2014/15	Ekurhuleni 2014/15	Sedibeng 2014/15
Adults remaining on ART - Total	No (QPR	726 472	143 439	287642	63590	179894	51907
Total Children (under 15 years) remaining on ART – Total	Yes (QPR)	#	#	#	#	#	#
TB/HIV co-infected client on ART rate	% (QPR)	#	#	#	#	#	#
Client tested for HIV (incl ANC) (Sum of: HIV test child 19-59 months HIV test child 5-14 years HIV test client 15-49 years (excl. ANC) HIV test client 50 years and older (excl. ANC) Antenatal client HIV 1st test Antenatal client HIV re-test)	No (QPR)	2 333858	646 691	704 438	176 884	595 252	210 593
TB symptom 5yrs and older screened rate	% (QPR)	10.29%	9.2%	9.2%	6%	14.4%	10.1%
Male condom distribution coverage	No (QPR)	131 315 310	42 167 401	44 596 148	9 631 780	28 462 315	6 467 666
Medical male circumcision performed - Total	No	139 093	23 580	65 696	12 296	29 299	8 222
TB client treatment success rate	% (QPR)	85.7%	87.4%	85.3%	85.3%	88.2%	81%
TB client lost to follow up rate	% (QPR)	4.9%	4.6%	5.1%	3.4%	4.4%	8.2%
TB client death Rate	% (QPR)	4.5%	4.2%	3.8%	6.8%	4%	6.2%
TB MDR confirmed treatment initiation rate	% (QPR)	56.5% (Sizwe)	N/A	N/A	N/A	N/A	N/A
TB MDR treatment success rate	% (QPR)	51.5% (Sizwe)	N/A	N/A	N/A	N/A	N/A

2.6.1 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HAST

TABLE DSH9: STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HAST

Strategic Objective Statement	Programme Performance Indicator	Frequency of Reporting	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan Target
				2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase proportion of HIV positive population on ARV from 80% in 2013/14 to 90% by 2019/20	1. Adults remaining on ART – Total[24]	Quarterly	No (QPR)	532 996	591 981	726472	746 678	829 643	921 825	1 024 250	
	2. Total Children (under 15 years) remaining on ART – Total	Quarterly	No (QPR)	#	#	#	29,867	38,521	42,758	47,461	
	3. TB/HIV co-infected client on ART rate	Quarterly	% (QPR)	#	#	#	75%	85%	88%	90%	
Increase the number of men/women aged 15 - 49 tested for HIV from 1,8 million in 2013/14 to 4 million by 2019/20	4. Client tested for HIV (incl. ANC) (Sum of: HIV test child 19-59 months HIV test child 5-14 years HIV test client 15-49 years (excl. ANC) HIV test client 50 years and older (excl. ANC) Antenatal client HIV 1st test Antenatal client HIV re-test)	Quarterly	No (QPR)	1422153	3 257 478	2333858	2 119 906	3 592 943	4 693 487	5 194 625	4 million
Reduce mother to child transmission of HIV from 2% to 0.80% at 6 weeks after birth and from 3.1% to less than 2% at 18 months after birth by increasing antiretroviral among pregnant women living with HIV from 81% to 98% by 2019/20	5. Transmission rate from mother to child	Quarterly	%	2.4 %	2%	1.3%	<1.5%	<1.5%	<1.5%	<1%	<5%

[24] Shaded areas are nationally customised health sector indicators

Strategic Objective Statement	Programme Performance Indicator	Frequency of Reporting	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan Target
				2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase percentage of people screened for TB from 90% in 2013/14 to 95% of total population with HIV by 2019/20	6. TB symptom 5yrs and older screened rate[25]	Quarterly	% (QPR)	#	#	10.29% (1.02 m)	30%	31% (5m/16m)	90% (5.5 m)	90% (6 m)	95%
Increase number of male condoms distributed annually from 69 480 000 to 309 100 000 by 2019/20 Increase number of female condoms distributed annually from 1 451 696 to 5 000 000 by 2019/20	7. Male condom distribution coverage[26]	Quarterly	No (QPR)	131 000 000	69 480 378	131 315 310	191 782 721	210 960 993	234 472 801	257 920 081	309 m
	8. Female condom distribution Rate (Annualised) [27]	Quarterly	No	1 300 000	1 451696	4838281	4 097 926	4.6 m	4.8 m	5 m	5 m
Increase number of men medically circumcised from 132 095 in 2013/14 to 335 408 by 2019/20	9. Medical male circumcision performed - Total	Quarterly	No (QPR)	94 059	132 095	139093	151 082	209190	151 082	151 082	335408
Increase TB treatment success rate from 84.5% in 2013/14 to 95% by 2019/20	10. TB client treatment success rate	Quarterly	% (QPR)	83.1%	84.5%	85.7%	86%	90%	95%	95%	95%

[25] Indicator measured in numbers; Rate not calculated[25]
[26] Indicator measured in numbers - coverage not calculated
[27] Indicator measured in numbers - rate not calculated

Strategic Objective Statement	Programme Performance Indicator	Frequency of Reporting	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan Target
				2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase the percentage of people cured of TB from 83% in 2013/14 to 85% by 2019/20 by reducing treatment defaulter rate from 5.1% to 1%	11. TB client lost to follow up rate	Quarterly	% (QPR)	#	5.10%	4.8%	<5%	5.10%	4%	4%	1%
Decrease TB death rate from 5.2% in 2013/14 to 3.5% by 2019/20	12. TB client death Rate	Annual	% (QPR)	#	<5%	4.5%	<5%	<5%	<5%	<5%	3.5%
Increase % of patients with MDR-TB started on treatment from 45% in 2013/14 to 80% by 2019/20 and success rate from 35% in 2013/14 to 65% by 2019/20	13. TB MDR confirmed treatment initiation rate	Annual	% (QPR)	#	60%	64.5%	70%	60%	80%	95%	80%
	14. TB MDR treatment success rate	Annual	% (QPR)	#	40%	51.5%	50%	55%	65%	70%	65%

2.6.2 TABLE DHS 10: QUARTERLY TARGETS FOR HAST

TABLE DHS 10: QUARTERLY TARGETS FOR HAST

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. Adults remaining on ART – Total[28]	**Quarterly**	No (QPR)	829 643	767 419	788 160	808 901	829 643
2. Total Children (under 15 years) remaining on ART – Total	Quarterly	No (QPR)	38,521	32 150	34 274	36 398	38 521
3. TB/HIV co-infected client on ART rate	Quarterly	% (QPR)	85%	21%	42%	63%	85%
4. Client tested for HIV (incl. ANC) (Sum of: HIV test child 19-59 month HIV test child 5-14 years HIV test client 15-49 years (excl. ANC) HIV test client 50 years and older (excl. ANC) Antenatal client HIV 1st test Antenatal client HIV re-test)	Quarterly	No (QPR)	3 592 943	2 488 165	2 856 424	3 224 683	3 592 943
5. Transmission rate from mother to child	Quarterly	%	<1.5%	<1.5%	<1.5%	<1.5%	<1.5%
6. TB symptom 5yrs and older screened rate	Quarterly	No (QPR)	5 m	1.5 m	3 m	4 m	5 m
7. Male condom distribution Coverage	Quarterly	No (QPR)	210 960 993	52 740 248	105 480 497	158 220 745	210 960 993
8. Female condom distribution Rate (Annualised)	Quarterly	No	4.6 m	1 150 000	2 300 000	3 450 000	4 600 000
9. Medical male circumcision performed - Total	Quarterly	No (QPR)	209190	72297	144594	176892	209190
10. TB client treatment success rate	Quarterly	% (QPR)	90%	90%	90%	90%	90%
11. TB client lost to follow up rate	Quarterly	% (QPR)	5.1%	5.1%	5.1%	5.1%	5.1%
12. TB client death Rate	Annual	% (QPR)	<5%	-	-	-	<5%
13. TB MDR confirmed treatment initiation rate	Annual	% (QPR)	60%	-	-	-	60%
14. TB MDR treatment success rate	Annual	% (QPR)	55%	-	-	-	55%

[28] Shaded areas are nationally customised health sector indicators

2.7 SUB-PROGRAMME: MATERNAL, NEONATAL, CHILD, YOUTH ANDWOMEN'S HEALTH AND NUTRITION

PURPOSE OF THE PROGRAMME

The purpose of this programme is to render Maternal, Neonatal, Child, Youth and Women's Health and Nutrition services aimed at specific target groups and combines direct and indirect nutrition interventions to address malnutrition

PRIORITIES

Decreasing maternal, infant and child mortality through:

- Strengthen and promote access to comprehensive sexual reproductive health and rights (SRHR) programmes with specific focus on family planning and quality contraceptive services through rollout of long acting reversible contraceptives (LARC);
- Increase knowledge of reproductive biology and promote responsible behaviours of adolescents regarding contraception, safer sex and prevention of sexually transmitted infection;
- Prevention, early detection and management of breast and cervical cancers;
- Social Behaviour Change Communication Strategy (SBCCS) through advocacy and health promotion for early antenatal care attendance / booking within the 14 weeks of pregnancy – provide antenatal care every day and advocate for appropriate care and support for pregnant and lactating women in the work place;
- Improve access to skilled birth attendance by allocating midwifery-obstetric ambulances to every healthcare facility where deliveries take place and establishing maternity waiting homes where necessary;
- Strengthen human resources for maternal and child health by providing training on essential steps in management of obstetric emergencies (ESMOE/helping babies breathe (HBB)/ management of small and sick neonates (MSSN) and integrated management of childhood illness (IMCI) for midwives and doctors;
- Intensifying midwifery education and training;
- Improving child survival by promoting and supporting exclusive breastfeeding for six months, providing facilities for lactating mothers (boarder mothers) in healthcare facilities where children are admitted;
- Promoting Kangaroo Mother Care (KMC) for low-birth infants and establishing human milk banks in healthcare facilities; and
- Strengthen Integrated School Health Programme (ISPH) by expanding services to grade 8 learners.

TABLE DHS 11: SITUATION ANALYSIS INDICATORS FOR MCWH & N

Programme Performance Indicator	Indicator Type	2014/15 Province wide value	2014/15 City of Jo'burg	2014/15 West Rand	2014/15 Ekurhuleni	2014/15 Sedibeng	2014/15 Tshwane	2013/14 National Average
1. Antenatal 1st visit before 20 weeks rate[29]	% (QPR)	48.6%	46.1%	57.6%	49%	56.9%	46.4%	
2. Mother postnatal visit within 6 days rate	% (QPR)	85.4%	99.8%	61.7%	78.6%	71.6%	85.7%	
3. Antenatal client initiated on ART rate	% (QPR)	87.4%	86.9%	98.3%	85.4%	90.0%	86.2%	
4. Infant 1st PCR test positive around 6 weeks rate	% (QPR)	1.3%	0.9%	1.8%	1.3%	1.8%	1.8%	
5. Immunisation coverage under 1 year (annualised)	% (QPR)	109.2%	108.7%	111.6%	111.0 %	104.5 %	108.7 %	94%
6. Measles 2nd dose coverage (annualised)	% (QPR)	94.7%	90.4%	118.1%	101.1 %	96.5%	88.6%	85%
7. DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	% (QPR)	-0.5%	-2.0%	-1.8%	2.0%	5.7%	-2.5%	8%
8. Child under 5 years diarrhoea case fatality rate	% (QPR)	2.9%	4.9%	2.9%	3.4%	2.5%	1.8%	
9. Child under 5 years pneumonia case fatality rate	% (QPR)	2.1%	2.7%	1.3%	2.3%	3.1%	1.6%	
10. Child under 5 years severe acute malnutrition case fatality rate	% (QPR)	9.3%	5.0%	5.7%	15.1%	11.3%	8.2%	
11. School Grade 1 screening coverage (annualised)	% (QPR)	35.1%	18.3%	55.4%	47.2%	29.6%	39.5%	
12. School Grade 8 screening coverage (annualised)	% (QPR)	13.0%	2.5%	28.3%	13.5%	17.5%	18.6%	
13. Couple year protection rate (annualised)	% (QPR)	32.1%	30.4%	34.2%	31.9%	32.9%	34.1%	
14. Cervical cancer screening Coverage (Annualised)	% (QPR)	43.6%	45.6%	41.8%	47.5%	39.2%	38.2%	
15. Human Papilloma Virus Vaccine 1st dose coverage	% (QPR)	87.8%	89.5%	87.0%	88.2%	86.8%	86.0%	

[29] Shaded areas are nationally customised health sector indicators

Programme Performance Indicator	Indicator Type	2014/15 Province wide value	2014/15 City of Jo'burg	2014/15 West Rand	2014/15 Ekurhuleni	2014/15 Sedibeng	2014/15 Tshwane	2013/14 National Average
16. Human Papilloma Virus Vaccine 2nd dose coverage	% (QPR)	77.7%	87.8%	85.1%	59.7%	74.5%	81.6%	
17. Vitamin A dose 12 - 59 months coverage (annualised)	% (QPR)	56.5%	57.4%	67.0%	63.4%	66.7%	43.2%	
18. Infant exclusively breastfed at HepB 3rd dose rate	% (QPR)	25.8%	23.9%	24.3%	22.0%	32.7%	31.8%	
19. Maternal mortality in facility ratio (annualised)	Per 100 000 live births (QPR)	112.6/ 100000	90.4	128.6	169.3	122.3	63.7	
20. Inpatient early neonatal death rate	per 1000 (QPR)	9.6/1000	9.2	5.4	10.2	9.1	10.9	

# denotes a new indicator not measured in the previous financial year

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

TABLE DHS 12 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR MCWH & N

Strategic Objective Statement	Programme Performance Indicators	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase number of mothers whose first antenatal visit is before 20 weeks from 43.7% in 2013/2014 to 70% by 2019/20	1. Antenatal 1st visit before 20 weeks rate[30]	% (QPR)	37.8%	43.7%	48.6%	55%	60%	65%	70%	70%
Increase number of mothers visited within 6 days of delivery of their babies from 86.5% in 2013/14 to 90%	2. Mother postnatal visit within 6 days rate)	% (QPR)	#	86.5%	85.4%	87%	90%	99%	99%	90%

[30] Shaded areas are nationally customised health sector indicators

Strategic Objective Statement	Programme Performance Indicators	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
by 2019/20										
Reduce mother to child transmission of HIV from 2% to 0,80% at six weeks after birth and from 3,1% to less than 2% at 18 weeks by increasing antiviral coverage among pregnant women living with HIV from 81% to 98% by 2019/20	3. Antenatal client initiated on ART rate	% (QPR)	#	63.10%	87.4%	90%	90%	99%	99%	98%
	4. Infant 1st PCR test positive around 10 weeks rate	% (QPR)	2.4%	<5%	1.3%	<1,5%	<1,5%	<1,5%	<1,5%	0.80%
Sustain immunisation coverage at 100% for children under 1 year by 2019/20	5. Immunisation coverage under 1 year (annualised)	% (QPR)	107.9%	109%	109.2%	90%	92%	97%	98%	100%
Decrease DTaP-IPV/HIB 3-Measles 1st dose drop-out rate from 3.5% to 2% and increase measles 2nd dose coverage from 85% to 95% by 2019/20	6. Measles 2nd dose coverage (annualised)	% (QPR)	#	#	94.7%	90%	95%	95%	95%	95%
	7. DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	% (QPR)	#	#	0.5%	<10%	<10%	<10%	5%	2%
Decrease child (under-5 years) diarrhoea case fatality rate from 3.5% in 2013/14 to 1.5% by 2019/20	8. Child under 5 years diarrhoea case fatality rate	% (QPR)	3.3%	3%	2.9%	3%	2.5%	<2%	<2%	1.5%
Decrease child (under 5 years) severe acute malnutrition case fatality rate from 6.1% in 2013/14 to 3% by 2019/20	9. Child under 5 years pneumonia case fatality rate	% (QPR)	2.3%	2.5%	2.1%	2.5%	<2%	<2%	<2%	
	10. Child under 5 years severe acute malnutrition case fatality rate	% (QPR)	12.1%	12%	9.3%	7	<10%	5%	5%	3%
Increase coverage of grade 1 learner's health screening in Quintile I – 5 public primary schools from 20% to 60% and grade 4, 8 and 10 learners' health screening (annualised) in Quintile 1 -2	11. School Grade 1 screening coverage (annualised)	% (QPR)	#	33.8%	35.1%	40%	40%	45%	45%	60%
	12. School Grade 8 screening coverage	% (QPR)	#	19.7%	13.0%	20%	15%	20%	20%	20%

Strategic Objective Statement	Programme Performance Indicators	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term Targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
from 10% to 20% respectively 2019/2020	(annualised)									
Increase couple year protection rate from 24.9% in 2013/14 to 80% by 2019/20	13. Couple year protection rate (annualised)	% (QPR)	26.1%	28.3%	32.1%	50%	60%	90%	99%	99%
Increase cervical cancer screening coverage from 41.7% in 2013/14 to 70% of women by 2019/20	14. Cervical cancer screening Coverage (Annualised)	% (QPR)	45%	44.1%	43.6%	55%	60%	99%	99%	99%
Increase HPV vaccine coverage rate from 87.1% for 1st dose to 90% by 2019/20	15. Human Papilloma Virus Vaccine 1st dose coverage	% (QPR)	#	#	87.8%	87%	90%	90%	90%	90%
Increase HPV vaccine coverage rate for 2nd dose to 90% by 2019/20	16. Human Papilloma Virus Vaccine 2nd dose coverage	% (QPR)	#	#	77.7%	80%	80%	80%	90%	90%
Decrease child (under 5 years) severe acute malnutrition case fatality rate from 6.1% in 2013/14 to 3% by 2019/20	17. Vitamin A dose 12 - 59 months coverage (annualised)	% (QPR)	47,1%	45,6%	56.5%	60%	60%	65%	70%	
	18. Infant exclusively breastfed at HepB 3rd dose rate	% (QPR)	#	#	25.8%	50%	60%	65%	70%	
Reduce in-facility maternal mortality ratio from 143 in 2013/14 to 80 per 100,000 live births by 2019/2020	19. Maternal mortality in facility ratio (annualised)	Per 100 000 live births (QPR)	121,45	142,52	112.6	137	112.6	<100	<100	80/100 000
Reduce neonatal mortality from 15/1,000 live births in 2013/14 to 6/1,000 live births by 2019/20	20. Inpatient early neonatal death rate	Per 1000 (QPR)	12,6	11,6	9.6	13	13	13	10	6/1 000 live births

Refers to new indicator where baseline data was not collected in that financial year

2.7.2 DHS13: QUARTERLY TARGETS FOR MCWH&N

TABLE DHS13: QUARTERLY TARGETS FOR MCWH&N

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2016/17	TARGET			
				Q1	Q2	Q3	Q4
1. Antenatal 1st visit before 20 weeks rate [31]	Quarterly	% (QPR)	60%	60%	60%	60%	60%
2. Mother postnatal visit within 6 days rate	Quarterly	% (QPR)	90%	90%	90%	90%	90%
3. Antenatal client initiated on ART rate	Annually	% (QPR)	90%	90%	90%	90%	90%
4. Infant 1st PCR test positive around 6 weeks rate	Quarterly	% (QPR)	<1,5%	<1,5%	<1,5%	<1,5%	<1,5%
5. Immunisation coverage under 1 year (annualised)	Quarterly	% (QPR)	92%	92%	92%	92%	92%
6. Measles 2nd dose coverage (annualised)	Quarterly	% (QPR)	95%	95%	95%	95%	95%
7. DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	Quarterly	% (QPR)	<10%	<10%	<10%	<10%	<10%
8. Child under 5 years diarrhoea case fatality rate	Quarterly	% (QPR)	2.5%	2.5%	2.5%	2.5%	2.5%
9. Child under 5 years pneumonia case fatality rate	Quarterly	% (QPR)	<2%	<2%	<2%	<2%	<2%
10. Child under 5 years severe acute malnutrition case fatality rate	Quarterly	% (QPR)	<10%	<10%	<10%	<10%	<10%
11. School Grade 1 screening coverage (annualised)	Quarterly	% (QPR)	40%	20%	25%	30%	40%
12. School Grade 8 screening coverage (annualised)	Quarterly	% (QPR)	15%	5%	7%	10%	15%
13. Couple year protection rate (annualised)	Quarterly	% (QPR)	60%	60%	60%	60%	60%

[31] Shaded areas are nationally customised health sector indicators

INDICATOR	Frequency of Reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2016/17	TARGET			
				Q1	Q2	Q3	Q4
14. Cervical cancer screening Coverage (Annualised)	Quarterly	% (QPR)	60%	60%	60%	60%	60%
15. Human Papilloma Virus Vaccine 1st dose coverage	Annually	% (QPR)	90%	-	-	-	90%
16. Human Papilloma Virus Vaccine 2nd dose coverage	Annually	% (QPR)	80%	-	80%	-	
17. Vitamin A dose 12 - 59 months coverage (annualised)	Quarterly	% (QPR)	60%	60%	60%	60%	60%
18. Infant exclusively breastfed at HepB 3rd dose rate	Quarterly	% (QPR)	60%	60%	60%	60%	60%
19. Maternal mortality in facility ratio (annualised)	Annually	Per 100 000 live births (QPR)	112	-	-	-	112
20. Inpatient early neonatal death rate	Annually	per 1000 (QPR)	13	-	-	-	13

2.8 SUB-PROGRAMME: DISEASE PREVENTION AND CONTROL

The sub-programme focuses on disease prevention and reduction of morbidity and mortality associated with communicable as well as non-communicable diseases. Disease prevention activities are aimed at creating awareness about the disease, education to emphasise disease control, training of health professionals for improved disease management and surveillance to prevent and reduce disease outbreak incidences.

PRIORITIES

- Develop and implement a Social Behaviour Change Communication Strategy; ensuring healthy lifestyle campaigns take priority;
- Roll out Integrated Chronic Disease Management Model in all 5 districts;
- Develop and implement Communicable disease control monitoring and evaluation plan;
- Increase performance of cataract surgery in all hospitals;
- Recruit and sustain optometrists and health promoters; and
- Implement the malaria elimination strategy.

TABLE DHS 14: SITUATIONAL ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL

Programme Performance Indicator	Indicator Type	Province wide value 2014/15	Tshwane	Johannesburg	West Rand	Ekurhuleni	Sedibeng
Clients screened for hypertension	No (QPR)	#	#	#	#	#	#
Clients screened for diabetes	No (QPR)	#	#	#	#	#	#
Clients screened for mental health illnesses	% (QPR)	#	#	#	#	#	#
Cataract surgery rate annualised	Rate per 1 million (QPR)	1 127/million[32]	1 60/million	1 126/mil	1 452/million	619/million	1 104/million
Malaria case fatality rate	% (QPR)	1.1%	2.5%	0%	2.0%	2.2%	0%

Refers to new indicator where baseline data was not collected in that financial year

2.8.1 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DPC

TABLE DHS 15 PERFORMANCE INDICATORS FOR DISEASE PREVENTION AND CONTROL

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium-term targets			Strategic Plan 2020
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase number of clients screened for high blood pressure and raised blood glucose levels to 550 000 and 280 000 respectively by 2019/20	1. Clients screened[33] for hypertension	No (QPR)	#	#	#	58 800	474 000	500 000	500 000	550 000
	2. Clients screened for diabetes[34]	No (QPR)	#	#	#	58 800	400 000	400 000	400 000	280 000

[32] The Provincial final CSR was calculated using 80% uninsured population as allocated by National Department of Health

[33] Shaded areas are nationally customised health sector indicators

[34] Data for this indicator will only be collected from the 3rd August 2015, the current projections were for Diabetes client 18 years and older new

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium-term targets			Strategic Plan 2020
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase clients screened for mental health to 100%; cataract surgery rate from 1408 per million in 2013/14 to 1500 per million and malaria case fatality rate reduced to 1.7% by 2019/20	3. Clients screened for mental health	% (QPR)	#	#	#	2%	50%	60%	100%	
	4. Cataract surgery rate (annualised)	Rate per 1 million (QPR)	1261/ mil	1408/mil	1 127/mil	1300/mil	1300/mil	1500/mil	1500/mil	
	5. Malaria case fatality rate	% (QPR)	1.1%	1.1%	1.4%	<0.3%	1.7%	1.7%	1.7%	

Refers to new indicator where baseline data was not collected in that financial year

2.8.2 QUARTERLY TARGETS FOR DISEASE PREVENTION AND CONTROL

TABLE DHS 16: QUARTERLY TARGETS FOR DISEASE PREVENTION AND CONTROL

INDICATOR	Frequency of reporting	Indicator type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. Clients screened for hypertension	Quarterly	No (QPR)	474 000	119 500	239 000	358 500	474 000
2. Clients screened for diabetes	Quarterly	No (QPR)	400 000	100 000	200 000	300 000	400 000
3. Client screened for Mental Health	Quarterly	% (QPR)	50%	50%	50%	50%	50%
4. Cataract Surgery Rate annualised	Quarterly	No (QPR)	1300/mil	1500/mil	1500/mil	1500/mil	1500/mil
5. Malaria case fatality rate	Quarterly	% (QPR)	1.7%	-	-	-	1.7%

2.9 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE DHS 17: EXPENDITURE ESTIMATES BY: DISTRICT HEALTH SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. District Management	512 337	411 698	428 363	475 621	466 764	476 487	499 666	516 955	547 972
2. Community Health Clinics	1 884 134	1 640 842	1 664 910	2 123 604	2 113 377	2 058 872	2 280 109	2 386 339	2 529 520
3. Community Health Centres	1 184 942	1 087 137	1 329 667	1 739 259	1 751 445	1 535 279	1 743 676	1 873 050	1 985 433
4. Community Based Services	919 224	888 127	1 168 605	1 307 107	1 474 746	1 487 457	1 607 616	1 601 598	1 697 693
5. HIV/Aids	2 134 359	2 459 887	2 709 860	3 086 733	3 086 733	3 086 733	3 451 142	3 982 788	4 481 627
6. Nutrition	49 412	26 339	42 109	50 339	50 339	50 339	52 604	55 234	58 548
7. Coroner Services	126 421	145 177	173 799	194 933	194 933	189 596	204 971	215 220	228 133
8. District Hospitals	1 745 127	1 698 225	2 045 733	2 443 251	2 477 251	2 460 230	2 758 255	2 911 856	3 107 452
Total payments and estimates	**8 555 956**	**8 357 432**	**9 563 046**	**11 420 847**	**11 615 588**	**11 344 993**	**12 598 039**	**13 543 039**	**14 636 378**

SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION: DISTRICT HEALTH SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**7 415 386**	**7 551 460**	**8 777 412**	**10 503 621**	**10 664 557**	**10 440 325**	**11 476 238**	**12 463 523**	**13 492 091**
Compensation of employees	4 243 315	4 663 026	5 163 930	5 665 974	5 936 631	5 862 663	6 476 312	7 040 469	7 482 426
Goods and services	3 172 071	2 888 427	3 613 482	4 837 647	4 727 926	4 577 662	4 999 926	5 423 053	6 009 664
Interest and rent on land	–	7	–	–	–	–	–	–	–
Transfers and subsidies to:	**1 080 394**	**731 303**	**663 494**	**795 147**	**771 751**	**728 310**	**845 963**	**816 169**	**865 139**
Provinces and municipalities	506 498	288 758	310 721	327 388	327 380	327 380	344 531	361 769	383 475
Departmental agencies and accounts	10	1	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	560 418	421 917	328 990	456 324	432 936	382 936	482 058	434 085	460 131
Households	13 468	20 627	23 783	11 434	11 434	17 994	19 374	20 315	21 534
Payments for capital assets	**58 989**	**74 206**	**120 643**	**122 079**	**179 280**	**174 774**	**275 838**	**263 348**	**279 149**
Buildings and other fixed structures	1 510	1 537	13 554	–	–	–	–	–	–
Machinery and equipment	57 479	72 511	107 089	122 079	179 280	174 774	275 838	263 348	279 149
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	158	–	–	–	–	–	–	–
Payments for financial assets	**1 187**	**463**	**1 497**	**–**	**–**	**1 584**	**–**	**–**	**–**
Total economic classification	**8 555 956**	**8 357 432**	**9 563 046**	**11 420 847**	**11 615 588**	**11 344 993**	**12 598 039**	**13 543 039**	**14 636 378**

2.10 RELATING EXPENDITURE TRENDS TO STRATEGIC GOALS

The total budget of the programme increases by 17 per cent from R12.5 billion in 2016/17 to R14.6 billion in 2018/19. HIV and AIDS Sub-Programme has increased by 13 per cent from R3 billion in 2015/16 to R3.4 billion in 2016/17 due to CD4 count threshold required to initiate ARTs increasing from 300-500. The district hospitals' budget grows substantially by 13 per cent from 2015/16 to 2016/17 to fund the new Bronkhorstspruit hospital.

Over the 2016 MTEF, the allocation of the Comprehensive HIV, AIDS and TB Grant decreases to make provision for direct funding as a result of function shift to National Health for NHLS. In addition, the department transferred R91 million to the national department for port health services.

The budget for compensation of employees increases by 16 percent from R6.4 billion in 2016/17 to an estimated R7.4 billion in the 2018/19 financial year. This budget takes into account items such as payment of OSD to nurses, doctors, specialists and therapists as well as improvement of conditions of Service (ICS)

Over the 2016 MTEF, the budget for goods and services increases from R4.9 billion in 2016/17 to an estimated R6 billion in the 2018/19 financial year. An amount of R27.3 million is earmarked for HPV vaccine in 2018/2019 to enable the department to provide the vaccine to prevent cervical cancer to grade 4 school girls.

The overall budget for transfers and subsidies increases from R795 million in 2015/16 to R845 million in 2016/17 mainly to cater for transfers to municipalities. There is an increase in payments to non-profit institutions from R456.3 million in 2015/16 to R482 million in 2016/17; this is due to the increase in mental health non-profit institutions from Programme 4: Provincial Hospital Services, Sub-Programme: Psychiatric Hospitals to Sub-Programme: Community Based Services to accommodate some of the patients from Life Esidimeni.

The NHI funding is earmarked for Tshwane Health District, with allocation increasing slightly from R7.2 million in 2015/16 to R7.5 million in 2016/17. This grant will cease from 2017/18 as a direct transfer from National Health.

2.11 RISK MANAGEMENT

RISK	MITIGATING FACTORS
Fragmented Primary Health Care (PHC) at EMS, Metros and Sedibeng Districts	• Implement the national directive so that Municipal facilities are taken over by Provincial entities in order to provincialise and rationalize services
PHC Re-engineering: integration of services (verticalisation vs integration)- - HAST	• Training of clinical staff and WBOT teams • Robust monitoring and reporting systems – reduce indicators • Enforce PHC supervision • Enhance buy-in of staff into implementation of integrated health services • Improve advocacy and community awareness regarding change in patient level and at community level • Advanced planning for restructuring (staff and patient flow) at institutional level
Increased number of HIV and AIDS and Tuberculosis (TB) infections	• Continuous implementation of current preventative measures • Job creation through EPWP • Collaboration with all relevant stakeholders on HIV and AIDS prevention Strategies
High influx rate into Gauteng	• Malaria awareness campaigns in “hotspots” & “hotpops”
Non-availability / Shortages on pharmaceutical items, etc.).	• Finalize and implement re-engineering process • Decentralise procurement of non-pharmaceutical items • Implement National Inventory system • Develop an Integrated Patient Management System • Develop and Implement Communication Strategy • Roll-out Central Chronic Medicine Distribution and Dispensing Plan (CCMDD)

BUDGET PROGRAMME 3: EMERGENCY MEDICAL AND PATIENT TRANSPORT SERVICES

3.1 PROGRAMME PURPOSE

To render pre-hospital Emergency Medical Services, including Inter-hospital Transfers and Planned Patient Transport services

- **Emergency Medical Services**
  Emergency Medical Services includes: Ambulance Services, Special Operations, Communications and Air Ambulance services
- **Planned patient transport**
  Planned Patient Transport includes: Local Outpatient Transport (within the boundaries of a given town or local area) and Inter-City/Town Outpatient Transport (Into referral centres)

The changes to the 5 year (2015/16-19/20 strategic plan objective statement is described as per Annexure A.

3.2 PRIORITIES

- Improve all facilities to reach minimum infrastructure operational standards and requirements;
- Strategically position EMS bases and resources in order to achieve set response times;
- Promote proactive programmes to drive demand for services down in various communities including using social media platforms;
- Improve comprehensive EMS services, staffed by qualified paramedics with the necessary equipment, integrated with Hospital bed bureau management; and
- Complete integration of computer aided, call taking and dispatching system.

TABLE EMS1: SITUATION ANALYSIS INDICATORS FOR EMS AND PATIENT TRANSPORT

Programme Performance Indicator	Frequency of Reporting	Type	2014/15 Province wide value	2014/15 City of Jo'burg	2014/15 West rand	2014/15 Ekurhuleni	2014/15 Sedibeng	2014/15 Tshwane	National Average 2013/14
1. EMS P1 urban response under 15 minutes rate[35]	Quarterly	% (QPR)	78.7%	82.7%	67.1%	84.3%	52.8%	68.4%	
2. EMS P1 rural response under 40 minutes rate	Quarterly	% (QPR)	84.8%	#	#	#	#	88.7%	
3. EMS inter - facility transfer rate	Quarterly	% (QPR)	18.8%	22.3%	21.6%	11.7%	38.5%	17.6%	

3.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR EMS AND PATIENT TRANSPORT

TABLE EMS3 and EMS4: PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR EMS AND PATIENT TRANSPORT

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ actual performance			Estimated performance	MTEF projection			Strategic Plan target 2020
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Improve EMS response time for P1 patients within 15 minutes in urban areas from 77% to 90% and within 40 minutes in rural areas to 100%	1. EMS P1 urban response under 15 minutes rate	% (QPR)	52%	76.7%	78.7%	85%	99% (19822/ 19962)	99%	99%	90%
	2. EMS P1 rural response under 40 minutes rate	% (QPR)	95%	74.5%	84.8%	100%	99% (300/304)	99%	99%	100%
Improve inter-facility transfer rates of clients from 13.9% to 15% by 2019/20	3. EMS inter - facility transfer rate	% (QPR)	#	13.9%	18.8%	12%	13% (103950/ 799683)	14%	15%	15%

Refers to new indicator where baseline data was not collected in that financial year

[35] Shaded areas are nationally customised health sector indicators

3.4 QUARTERLY TARGETS FOR EMS

TABLE EMS 3: QUARTERLY TARGETS FOR EMS

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. EMS P1 urban response under 15 minutes rate	Quarterly	% (QPR)	99% (19822/19962)	99%	99%	99%	99%
2. EMS P1 rural response under 40 minutes rate	Quarterly	% (QPR)	100% (304/304)	100%	100%	100%	100%
3. EMS inter - facility transfer rate	Quarterly	% (QPR)	13% (110342/799683)	10.5%	11%	11.5%	13%

3.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE EMS 4: EXPENDITURE ESTIMATES: EMERGENCY MEDICAL SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Emergency Transport	916 242	798 148	723 165	927 527	949 527	936 617	1 036 179	1 105 988	1 172 347
2. Planned Patient Transport	230 989	138 130	124 396	158 964	136 964	128 227	161 042	169 094	179 239
Total payments and estimates	**1 147 231**	**936 278**	**847 561**	**1 086 491**	**1 086 491**	**1 064 844**	**1 197 221**	**1 275 082**	**1 351 587**

TABLE EMS 5: SUMMARY OF BY ECONOMIC CLASSIFICATIONPROVINCIAL EXPENDITURE ESTIMATES: EMERGENCY MEDICAL SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**556 692**	**537 280**	**467 718**	**704 500**	**675 560**	**634 992**	**755 126**	**797 417**	**845 262**
Compensation of employees	262 330	313 509	330 910	425 710	425 710	395 576	465 538	494 127	523 774
Goods and services	294 362	223 771	136 808	278 790	249 850	239 416	289 588	303 290	321 488
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies to:	**577 474**	**320 218**	**362 136**	**353 938**	**332 063**	**332 063**	**333 295**	**349 835**	**370 825**
Provinces and municipalities	577 027	318 919	361 321	353 938	330 063	330 063	330 795	347 335	368 175
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	447	1 299	815	–	2 000	2 000	2 500	2 500	2 650
Payments for capital assets	**13 063**	**78 780**	**17 669**	**28 053**	**78 868**	**97 778**	**108 800**	**127 830**	**135 500**
Buildings and other fixed structures	–	510	–	–	–	–	–	–	–
Machinery and equipment	13 063	78 270	17 669	28 053	78 868	97 778	108 800	127 830	135 500
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**2**	**–**	**38**	**–**	**–**	**11**	**–**	**–**	**–**
Total economic classification	**1 147 231**	**936 278**	**847 561**	**1 086 491**	**1 086 491**	**1 064 844**	**1 197 221**	**1 275 082**	**1 351 587**

3.6 PERFORMANCE AND EXPENDITURE TRENDS

The increase in compensation of employees over the MTEF is as a result of the filling of critical EMS posts, absorption of emergency care technicians trained at Leone College and OSD, implications and the provincialisation of West Rand EMS. The budget for machinery and equipment increases by R80 million from 2015/16 to 2016/17. The department will continue to invest in the recapitalisation and replacement of ambulances with the aim of improving response times of P1 patients.

3.7 RISK MANAGEMENT

RISK	MITIGATING FACTORS
Occupational Specific Dispensation implications and salary disparities	• Cost analysis of provincialisation in Metro's • Review organogram in relation to municipal structure to alleviate disparity of salaries • Filling of critical posts and appropriate funding in line with recapitalisation plan
Inadequate ambulance fleet, furniture and equipment	• Align equipment procurement plan with recapitalisation
Lack of purpose built EMS stations, and by default space was allocated in clinics, hospitals and government institutions	Ensure purpose built EMS bases that have the following • Health care waste storage and disposal; • Sluice rooms and laundry; • Rest and recreational areas; and • Paraplegic access and facilities.

BUDGET PROGRAMME 4: PROVINCIAL HOSPITALS (REGIONAL AND SPECIALISED)

4.1 PROGRAMME PURPOSE

Delivery of hospital services, which are accessible, appropriate, effective and provide general specialist services, including a specialized rehabilitation service, as well as a platform for training health professionals and research through sub-programmes:

- **General (Regional) hospitals**
  Rendering of hospital services at a general specialist level and a platform for training of health workers and research;
- **Specialised Rehabilitation Hospital**
  Rendering a comprehensive interdisciplinary rehabilitation service for people with various forms of disabilities as a result of injury and/or disease affecting mainly the musculoskeletal, central and peripheral nervous systems and other related systems. Providing a training platform for health professionals, health care workers and for research promotion and development
- **Tuberculosis hospitals**
  To convert present Tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions, which allow for isolation during the intensive phase of treatment, as well as the application of the standardized multi-drug resistant (MDR) protocols;
- **Psychiatric /mental hospitals**
  Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for the training of health workers and research;
- **Oral health training hospitals**
  Rendering an affordable and comprehensive oral health service and training, based on the primary health care approach.

The changes to the 5 year strategic plan are described under regional and specialized hospitals Goal statement and strategic objectives statements as per attached Annexure A.

4.2 PRIORITIES

- Implementation of Lean Management Project and other programmes to reduce waiting times;
- Compliance with national Core Standards;
- Strengthen bed bureau management;
- Intensify implementation of the Mental Health Act at secondary level of care;
- Strengthen decentralized MDR-TB management at Sizwe TB Hospital; and
- Implement revitalisation of hospital services.

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

(Edenvale, Leratong, Sebokeng, Tambo Memorial, Rahima Moosa, New Natalspruit, Far East Rand, Pholosong, Mamelodi)

Strategic Objective Statement	Performance indicators	Frequency of Reporting	Indicator Type	Audited/ Actual performance				Medium-term targets			Strategic Plan Target 2020
				2012/13	2013/14	2014/15	Estimated performance 2015/16	2016/17	2017/18	2018/19	
Percentage of regional and specialised hospitals with an annual Quality Improvement Plan (QIP) after self-assessment will increase to 100% by 2019/20	National Core Standard self-assessment rate (Regional Hospitals)	Quarterly	% (QPR)	#	100% 9/9	100% 9/9	100% 9/9	100% 9/9	100% 9/9	100% 9/9	100%
	Quality Improvement plan after self-assessment rate (Regional Hospitals)	Quarterly	% (QPR)	#	25% (2/9)	60% (5/9)	70% (6/9)	40% (3/9)	100% (9/9)	100% (9/9)	100%
Increase compliance to extreme and vital measures of core standards to 100% in 2019/20, and complete self- assessments in all hospitals	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (Regional Hospitals)	Quarterly	% (QPR)	#	#	0%)	33% (3/9)	33% (3/9)	33% (3/9)	33% (3/9)	100%
Patient experience of care survey will be assessed annually in all regional and specialised hospitals and will increase from an average of 68% in 2013/14 to 80% by 2019/20	Patient Satisfaction Survey Rate (Regional Hospitals)	Quarterly	% (QPR)	#	#	#	100% (9/9)	100% (9/9)	100% (9/9)	100% (9/9)	100%
	Patient Satisfaction rate (Regional Hospitals)	Annual	% (QPR)	67%	68%	67.3%	70%	70%	71%	73%	80%
Improve efficiency of hospitals by reducing average length of stay to less than 5 days increasing bed utilisation to 80% and decreasing expenditure per PDE in hospitals by 2019/20	Average Length of Stay	Quarterly	No (QPR)	4.1	4.9	5	4.8	4.85	4.9	4,95	<5 days
	Inpatient Bed Utilisation Rate	Quarterly	% (QPR)	80%	85%	82.4%	80%	82% (300/400)	83%	84%	80%
	Expenditure per patient day equivalent (PDE) (Regional Hospitals)	Quarterly	R (QPR)	R 1964	R2110	R2304	R2250	R3000	R3000	R3000	
Increase complaints resolved within 25 working days to over 95% in 2019/20	Complaints resolution rate (Regional Hospitals)	Quarterly	% (QPR)	#	#	#	86%	88%	88%	90%	
	Complaint Resolution within 25 working days rate (Regional Hospitals)	Quarterly	% (QPR)	90%	89.7%	99.9%	80%	82%	85%	85%	>95%

Refers to new indicator where baseline data was not collected in that financial year

TABLE PHS2: QUARTERLY TARGETS FOR REGIONAL HOSPITALS

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
National Core Standards self-assessment rate (Regional Hospitals)	Quarterly	% (QPR)	100% 9/9	100%	100%	100%	100%
Quality improvement plan after self-assessment rate (Regional Hospitals)	Quarterly	% (QPR)	40% (3/9)	40%	40%	40%	40%
Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (Regional Hospitals)	Quarterly	% (QPR)	33% (3/9)	33%	33%	33%	33%
Patient Satisfaction Survey Rate (Regional Hospitals)	Quarterly	% (QPR)	100% (9/9)	`100%	100%	100%	100%
Patient Satisfaction rate (Regional Hospitals)	Annual	% (QPR)	70%	-	-	-	70%
Inpatient Bed Utilisation Rate (Regional Hospitals)	Quarterly	% (QPR)	82% (300/400)	82%	82%	82%	82%
Average Length of Stay (Regional Hospitals)	Quarterly	No (QPR)	4.85	4.85	4.85	4.85	4.85
Expenditure per PDE (Regional Hospitals)	Quarterly	R (QPR)	R3000	R3000	R3000	R3000	R3000
Complaints resolution rate (Regional Hospitals)	Quarterly	% (QPR)	88%	88%	88%	88%	88%
Complaint Resolution within 25 working days rate (Regional Hospitals)	Quarterly	% (QPR)	82%	82%	82%	82%	82%

4.4 TABLE PHS3: PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR SPECIALISED HOSPITALS

Strategic Objective Statement	Performance indicators	Indicator Type	Audited/ Actual performance				Medium-term targets			Strategic Plan Target 2020
			2012/13	2013/14	2014/15	Estimate 2015/16	2016/17	2017/18	2018/19	
Percentage of regional and specialised hospitals with an annual Quality Improvement Plan (QIP) after self-assessment will increase to 100% by 2019/20	National Core Standard self-assessment rate (Specialised Hospitals)[36]	% (QPR)	#	100% (9/9)	100% (9/9)	100% (9/9)	100% (9/9) 9/9	100% (9/9)	100% (9/9)	100% (9/9)
	Quality Improvement plan after self-assessment rate (Specialised Hospitals)	% (QPR)	#	25% (2/9)	60% (5/9)	70% (6/9)	40% (3/9)	100% (9/9)	100% (9/9)	100% (9/9)
Increase compliance to extreme and vital measures of core standards to 100% in 2019/20, and complete self-assessments in all hospitals	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (Specialised Hospitals)	% (QPR)	#	#	0%	33%	41%	41%	56%	
Patient experience of care survey will be assessed annually in all regional and specialised hospitals and will increase from an average of 68% in 2013/14 to 80% by 2019/20	Patient Satisfaction Survey Rate (Specialised Hospitals)	% (QPR)	#	#	#	100%	100%	100%	100%	100% (9/9)
	Client satisfaction Rate (Specialised Hospitals)	% (QPR)	67%	68%	67.5%	68%	70%	71%	80%	
The percentage of complaints resolved within 25 working days to over 95% in 2019/20	Complaint resolution rate (Specialised Hospitals)	% (QPR)	#	#	#	86%	88%	88%	90%	
	Complaint Resolution within 25 working days rate (Specialised Hospitals)	% (QPR)	#	90%	100%	95%	80%	82%	90%	85%
Improve efficiency of hospitals by reducing average length of stay, increasing bed utilisation to 80% and decreasing expenditure per PDE	Inpatient Bed Utilisation Rate (Specialised Hospitals)	%	#	#	73.5% Siswe	75%	77%	78%	78%	80%

[36] Shaded areas are nationally customised health sector indicators

TABLE PHS4: QUARTERLY TARGETS FOR SPECIALISED HOSPITALS

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
National Core Standard self-assessment rate (Specialised Hospitals)	Quarterly	% (QPR)	100% (9/9)	100% (9/9)	100%	100%	100%
Quality Improvement plan after self-assessment rate (Specialised Hospitals)	Quarterly	% (QPR)	40% (3/9)	40%	40%	40%	40%
Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (Specialised Hospitals)	Quarterly	% (QPR)	41% (3/9)	41%	41%	41%	41%
Patient Satisfaction Survey Rate (Specialised Hospitals)	Quarterly	% (QPR)	100%	100%	100%	100%	100%
Patient satisfaction Rate (Specialised Hospitals)	Quarterly	% (QPR)	70%	70%	70%	70%	70%
Complaint resolution rate (Specialised Hospitals)	Quarterly	% (QPR)	88%	88%	88%	88%	88%
Complaint Resolution within 25 working days rate (Specialised Hospitals)	Quarterly	% (QPR)	82%	82%	82%	82%	82%
Inpatient Bed Utilisation Rate (Specialised Hospitals)	Quarterly	%	77%	77%	77%	77%	77%

4.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE PHS 5: EXPENDITURE ESTIMATES: PROVINCIAL HOSPITAL SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. General Hospitals	3 187 646	3 642 601	4 241 858	4 726 917	4 707 404	4 735 434	4 912 317	5 211 158	5 523 828
2. Tuberculosis Hospitals	156 718	157 939	205 810	399 882	403 482	320 382	383 629	395 593	419 329
3. Psychiatric/Mental Hospital	893 466	919 845	1 069 675	1 057 859	1 082 920	1 078 899	1 038 185	1 161 974	1 231 692
4. Dental Training Hospitals	329 030	375 909	407 374	438 201	456 201	449 550	503 869	528 131	559 819
5. Other Specialised Hospitals	52 674	58 030	62 597	75 892	76 992	78 991	72 146	75 754	80 299
Total payments and estimates	**4 619 534**	**5 154 324**	**5 987 314**	**6 698 750**	**6 726 998**	**6 663 256**	**6 910 146**	**7 372 610**	**7 814 966**

SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION: PROVINCIAL HOSPITAL SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**4 330 570**	**4 867 144**	**5 570 168**	**6 350 610**	**6 383 038**	**6 305 439**	**6 698 615**	**7 060 031**	**7 483 633**
Compensation of employees	3 257 583	3 856 710	4 251 671	4 756 275	4 792 275	4 759 176	5 109 585	5 361 120	5 682 787
Goods and services	1 072 798	1 010 189	1 318 425	1 594 335	1 590 763	1 546 263	1 589 030	1 698 911	1 800 846
Interest and rent on land	189	245	72	–	–	–	–	–	–
Transfers and subsidies to:	**253 975**	**231 469**	**342 996**	**271 014**	**261 159**	**269 113**	**71 854**	**159 682**	**169 263**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	3	18	4	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	241 843	218 536	323 713	265 286	254 047	254 047	61 972	149 324	158 284
Households	12 129	12 915	19 279	5 728	7 112	15 066	9 882	10 357	10 979
Payments for capital assets	**33 393**	**53 831**	**72 742**	**77 126**	**82 801**	**87 659**	**139 677**	**152 897**	**162 071**
Buildings and other fixed structures	–	–	631	–	–	–	–	–	–
Machinery and equipment	33 393	53 814	72 111	77 126	82 801	87 659	139 677	152 897	162 071
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	17	–	–	–	–	–	–	–
Payments for financial assets	**1 596**	**1 880**	**1 408**	**–**	**–**	**1 045**	**–**	**–**	**–**
Total economic classification	**4 619 534**	**5 154 324**	**5 987 314**	**6 698 750**	**6 726 998**	**6 663 256**	**6 910 146**	**7 372 610**	**7 814 966**

4.6 PERFORMANCE AND EXPENDITURE TRENDS

A major portion of the budget is allocated to general hospitals providing level two services, and to ensure that regional hospitals comply with statutory obligations. From 2015/16, the allocation to the programme is also funded through the Health Professions Training and Development Grant with the aim of expanding the teaching and training platform in various institutions.

The budget for compensation of employees' grows from R4.7 billion in the 2015/16 to R5.6 billion in 2018/19, in order to make provision for all salary-related costs. Non-profit institution budget has decreased due to the departmental decision to terminate Life Esidimeni contract. This reduction of non-profit institution budget has been re-allocated within the sub-programme to fund psychiatric hospitals which will accommodate some of the patients from Life Esidimeni and to non- profit institutions providing mental health services in programme 2: District Health Services, sub-programme: Community Based Services. Re-allocated amounts within the programme were reprioritised to compensation of employees, goods and services and machinery and equipment to operationalise the services.

4.7 RISKS MANAGEMENT

RISK	MITIGATING FACTORS
Inaccurate and unreliable data at facilities level	• Develop and implement electronic departmental health information system
High staff turnover in mental health services	• Re alignment of the staff establishment and upgrading of executive management posts at specialised psychiatric hospitals
Termination of Life Esidimeni contract	• Open and register new non-governmental organisations • Increase beds and placement in the existing non-governmental organisations • Renovate specialized Hospitals for medium to long term care
Long backlogs for patients requiring dentures and elective oral surgery	• Inclusion of dental hospitals in the ring fenced surgical backlog fund
Medical malpractices	• Develop and Implement the Human Resource (HR) Plan in line with Norms and Standards • Finalisation and implementation of the Referral Policy • Implementation of Consequence Management for non - compliance to policies and procedures • Strengthen adverse events reporting system • Develop a strategy to minimize medical malpractice • Develop and Implement the Asset management Plan • Establish the Ethics Committee and continue with ethics training

BUDGET PROGRAMME 5: CENTRAL AND TERTIARY HOSPITALS

5.1 PROGRAMME PURPOSE

Provide a highly specialised health care service, a platform for training health workers and a place of research, and to serve as specialist referral centres for regional hospitals and neighbouring provinces.

The changes to the 5 year strategic plan are described under tertiary and central hospitals goal statement and strategic objective statements as per attached Annexure A.

5.2 SUB-PROGRAMME: TERTIARY HOSPITALS

5.2.1 PRIORITIES

- Implement national policies on conditional grants and revitalisation of hospital services;
- Implement MoUs with universities;
- Render and implement tertiary services;
- Implement Activity Based Costing including the ward-based management approach;
- Implement the Electronic Record Management System;
- Comply with National Core Standards; and
- Implement Lean Management and other programmes to reduce waiting times.

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

TABLE C&THS 1: PERFORMANCE INDICATORS FOR TERTIARY HOSPITALS (Kalafong, Helen Joseph and Tembisa)

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium-term targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Percentage of regional and specialised hospitals with an annual Quality Improvement Plan (QIP) after self-assessment will increase to 100% by 2019/20	1. National Core Standards self-assessment rate[37] (tertiary hospitals)	% (QPR)	#	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	
	2. Quality Improvement Plan after self-assessment rate (tertiary hospitals)	% (QPR)	#	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100%
Increase compliance to extreme and vital measures of core standards to 100% in 2019/20, and complete self- assessments in all hospitals	3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (tertiary hospitals)	% (QPR)	#	0%	0%	33% (1/3)	100% 3/3	100% (3/3)	100% (3/3)	100%
Patient experience of care survey will be assessed annually in all central and tertiary hospitals and will increase from an average of 68% in 2013/14 to 80% by 2019/20	4. Patient Satisfaction Survey Rate (tertiary hospitals)	% (QPR)	#	#	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	
	5. Patient Satisfaction rate (tertiary hospitals)	% (QPR)	67%	68%	66%	75%	78%	80%	82%	80%
Improve efficiency of hospitals by reducing average length of stay to less than 5 days increasing bed utilisation to 80% and decreasing expenditure per PDE in hospitals by 2019/20	6. Average Length of Stay (tertiary hospitals)	No (QPR)	5.3	5.8	5.8	5.4	5.45	5.5	5.5	<5
	7. Inpatient Bed Utilisation Rate (tertiary hospitals)	% (QPR)	77%	82,2%	82.3%	82%	82%	82%	82%	80%
	8. Expenditure per patient day equivalent (PDE) (tertiary hospitals)	R (QPR)	R2950	R2338	R2409	R2625	R2760	R2900	R2900	
The percentage of complaints resolved within 25 working days will be over 95% in 2019/20	9. Complaint Resolution rate (tertiary hospitals)	% (QPR)	#	#	90.5%	85.6%	95%	95%	100%	
	10. Complaint Resolution within 25 working days rate (tertiary hospitals)	% (QPR)	87.9%	65.9%	93.6%	68%	80%	85%	100%	>95%

[37] Shaded areas are nationally customised health sector indicators

5.2.3 QUARTERLY TARGETS FOR TERTIARY HOSPITALS

TABLE C&THS 2: QUARTERLY TARGETS FOR TERTIARY HOSPITALS

INDICATOR	Frequency of Reporting	Indicator Type	TARGETS				
			ANNUAL TARGET 2016/17	Q1	Q2	Q3	Q4
1. National Core Standards self-assessment rate (tertiary hospitals)	Quarterly	% (QPR)	100% (3/3)	100%	100%	100%	100%
2. Quality improvement plan after self-assessment rate (tertiary hospitals)	Quarterly	% (QPR)	100% (3/3)	100%	100%	100%	100%
3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards(tertiary hospitals)	Quarterly	% (QPR)	100% (3/3)	100%	100%	100%	100%
4. Patient Satisfaction Survey Rate (tertiary hospitals)	Quarterly	% (QPR)	100% (3/3)	100%	100%	100%	100%
5. Patient Satisfaction rate (tertiary hospitals)	Annual	% (QPR)	78%	70%	74%	76%	78%
6. Average Length of Stay (tertiary hospitals)	Quarterly	No (QPR)	5.45	5.45	5.45	5.45	5.45
7. Inpatient Bed Utilisation Rate (tertiary hospitals)	Quarterly	% (QPR)	82%	82%	82%	82%	82%
8. Expenditure per PDE (tertiary hospitals)	Quarterly	R (QPR)	R2760	R2760	R2760	R2760	R2760
9. Complaints resolution rate (tertiary hospitals)	Quarterly	% (QPR)	95%	95%	95%	95%	95%
10. Complaint Resolution within 25 working days rate (tertiary hospitals)	Quarterly	% (QPR)	80%	80%	80%	80%	80%

5.3 SUB- PROGRAMME: CENTRAL HOSPITALS

5.3.1 PRIORITIES

- Implement national policies on conditional grants and revitalisation of hospital services;
- Implement MoUs with universities;
- Render and implement tertiary services;
- Implement Activity Based Costing including the ward-based management approach;
- Implement the Electronic Record Management System;
- Comply with National Core Standards; and
- Implement Lean Management and other programmes to reduce waiting times.

5.2.2 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR CENTRAL HOSPITALS

TABLE C&THS 3: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR CENTRAL HOSPITALS

Strategic Objectives Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium-term targets			Strategic plan Target
			2012/13 #	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Percentage of tertiary and centralised hospitals with an annual Quality Improvement Plan (QIP) after self-assessment will increase to 100% by 2019/20	1. National Core Standards self-assessment rate[38]	% (QPR)	#	100% (4/4)	100% (4/4)	100% (4/4)	100% 4/4	100% 4/4	100% 4/4	
	2. Quality Improvement Plan after self-assessment rate	% (QPR)	#	100% (4/4)	100% (4/4)	100% (4/4)	100% 4/4	100% 4/4	100% 4/4	
Increase compliance to extreme and vital measures of core standards to 100% in 2019/20, and complete self- assessments in all hospitals	3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	% (QPR)	#	0%	0%	75% (3/4)	100% (4 /4)	100% (4/ 4)	100% (4/ 4)	
Patient experience of care survey will be assessed annually in all tertiary and centralised hospitals and will increase from an average of 68% in 2013/14 to 80% by 2019/20.	4. Patient Satisfaction Survey Rate	% (QPR)	#	#	100% (4/4)	100% (4/4)	100% (4/4)	100% (4/4)	100% (4/4)	
	5. Patient Satisfaction Rate	% (QPR)	#	#	66.8%	66%	75%	78%	80%	80%
Improve efficiency of hospitals by reducing average length of stay to less than 5 days increasing bed utilisation to 80% and decreasing expenditure per PDE in hospitals by 2019/20	6. Average Length of Stay	No (QPR)	#	#	#	6	5.6	5.7	5.7	<5
	7. Inpatient Bed Utilisation Rate	% (QPR)	#	78.4%	76.9%	80%	78%	78%	78%	80%
	8. Expenditure per patient day equivalent (PDE)	R (QPR)	#	R2870#	R3507	R3000	R3500	R4000	R4000	
The percentage of complaints resolved within 25 working days will be over 95% in 2019/20	9. Complaints resolution rate	% (QPR)	#	#	75%	80%	80%	80%	85%	
	10. Complaint Resolution within 25 working days rate	% (QPR)	#	63.9%	96%	90%	90%	90%	95%	>95%

Refers to new indicator where baseline data was not collected in that financial year

[38] Shaded areas are nationally customised health sector indicators

5.3.3 QUARTERLY TARGETS FOR CENTRAL HOSPITALS

TABLE C&THS 4: QUARTERLY TARGETS FOR CENTRAL HOSPITALS

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. National Core Standards self-assessment rate (Central hospital(s))	Quarterly	% (QPR)	100% (4/4)	100%	100%	100%	100%
2. Quality improvement plan after self-assessment rate (Central hospital(s))	Quarterly	% (QPR)	100% (4/4)	100%	100%	100%	100%
3. Percentage of Hospitals compliant with all extreme and vital measures of the national core standards (Central hospital(s))	Quarterly	% (QPR)	100% (4 /4)	100%	100%	100%	100%
4. Patient Satisfaction Survey Rate (Central hospital(s))	Quarterly	% (QPR)	100% (4/4)	100%	100%	100%	100%
5. Patient Satisfaction rate (Central hospital(s))	Annually	% (QPR)	75%	75%	75%	75%	75%
6. Average Length of Stay (Central hospital(s))	Quarterly	No (QPR)	5.6	5.6	5.6	5.6	5.6
7. Inpatient Bed Utilisation Rate (Central hospital(s))	Quarterly	% (QPR)	78%	78%	78%	78%	78%
8. Expenditure per PDE (Central hospital(s))	Quarterly	R (QPR)	3500	3500	3500	3500	3500
9. Complaints resolution rate (Central hospital(s))	Quarterly	% (QPR)	80%	80%	80%	80%	80%
10. Complaint Resolution within 25 working days rate (Central hospital(s))	Quarterly	% (QPR)	90%	90%	90%	90%	90%

TABLE C &THS 5: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR STEVE BIKO ACADEMIC HOSPITAL

Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
1. National Core Standards self-assessment score	% (QPR)	100%	100%	100%	100%	100%	100%	100%
2. Patient Satisfaction Rate	% (QPR)	67%	69%	70.8%	80%	80%	85%	90%
3. Average Length of Stay	No (QPR)	5.5 days	6.5	8.2	6	6	6	6
4. Inpatient Bed Utilisation Rate	% (QPR)	77%	78.3%	79.2%	80%	80%	80%	80%
5. Expenditure per patient day equivalent (PDE)	R (QPR)	R3 899	R3 899	R4301	R4 000	R4 500	R4500	R4500
6. Complaints resolution rate	% (QPR)	#	#	83%	85%	85%	87%	90%
7. Complaint Resolution within 25 working days rate	% (QPR)	97%	81.8%	106.5%	95%	95%	97%	100%

Refers to new indicator where baseline data was not collected in that financial year

TABLE C&THS 6: QUARTERLY TARGETS FOR STEVE BIKO ACADEMIC HOSPITAL

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. National Core Standards self-assessment score	Quarterly	% (QPR)	100%	100%	100%	100%	100%
2. Patient Satisfaction rate	Annually	% (QPR)	80%				80%
3. Average Length of Stay	Quarterly	No (QPR)	6	6	6	6	6
4. Inpatient Bed Utilisation Rate	Quarterly	% (QPR)	80%	80%	80%	80%	80%
5. Expenditure per PDE	Quarterly	R (QPR)	R4 500	R4 500	R4 500	R4 500	R4 500
6. Complaints resolution rate	Quarterly	% (QPR)	85%	85%	85%	85%	85%
7. Complaint Resolution within 25 working days rate	Quarterly	% (QPR)	95%	95%	95%	95%	95%

TABLE C & THS 7: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR DR GEORGE MUKHARI ACADEMIC HOSPITAL

Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated Performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
1. National Core Standards self-assessment score	% (QPR)	#	64%	71%	78%	80%	82%	82%
2. Patient Satisfaction Rate	% (QPR)	67%	66%	66%	75%	78%	80%	82%
3. Average Length of Stay	No (QPR)	7.3	7.6	8.4	6.8	6.6	6.5	6.5
4. Inpatient Bed Utilisation Rate	% (QPR)	72%	69.8%	78.9%	76%	78%	80%	80%
5. Expenditure per patient day equivalent (PDE)	R (QPR)	R2456	R2758	R3067	R3500	R3800	R4000	R4000
6. Complaints resolution rate	% (QPR)	#	#	#	92%	95%	98%	100%
7. Complaint Resolution within 25 working days rate	% (QPR)	97%	84%	91.8%	83%	93%	95%	100%

Refers to new indicator where baseline data was not collected in that financial year

TABLE C&THS 8: QUARTERLY TARGETS FOR DR GEORGE MUKHARI ACADEMIC HOSPITAL

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. National Core Standards self-assessment score	Quarterly	% (QPR)	80%	80%	80%	80%	80%
2. Patient Satisfaction rate	Annually	% (QPR)	78%	-	-	-	78%
3. Average Length of Stay	Quarterly	No (QPR)	6.6	6.6	6.6	6.6	6.6
4. Inpatient Bed Utilisation Rate	Quarterly	% (QPR)	78%	78%	78%	78%	78%
5. Expenditure per PDE	Quarterly	R (QPR)	R3800	R3800	R3800	R3800	R3800
6. Complaints resolution rate	Quarterly	% (QPR)	95%	95%	95%	95%	95%
7. Complaint Resolution within 25 working days rate	Quarterly	% (QPR)	93%	93%	93%	93%	93%

TABLE C &THS 9: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
1. National Core Standards self-assessment score	% (QPR)	100%	100%	100%	100%	100%	100%	100%
2. Patient Satisfaction Rate	% (QPR)	67%	65%	63.3%	75%	78%	80%	85%
3. Average Length of Stay	No (QPR)	3.9	7.1	7.1	6.2	6.2	6.2	6,2
4. Inpatient Bed Utilisation Rate	% (QPR)	83%	84.1%	82.3%	85%	78%	78%	80%
5. Expenditure per patient day equivalent (PDE)	R (QPR)	R2640	R986	R1101	R3 000	R3 000	R3 000	R3000
6. Complaints resolution rate	% (QPR)	#	#	#	100%	100%	100%	100%
7. Complaint Resolution within 25 working days rate	% (QPR)	97%	61%	99.7%	98%	96%	96%	100%

Refers to new indicator where baseline data was not collected in that financial year

TABLE C&THS 10: QUARTERLY TARGETS FOR CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

INDICATOR	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
			Q1	Q2	Q3	Q4
1. National Core Standards self-assessment score	% (QPR)	100%	100%	100%	100%	100%
2. Patient Satisfaction rate	% (QPR)	78%				78%
3. Average Length of Stay	No (QPR)	6.2	6.2	6.2	6.2	6.2
4. Inpatient Bed Utilisation Rate	% (QPR)	78%	78%	78%	78%	78%
5. Expenditure per PDE	R (QPR)	R 3000	R3 000	R3 000	R3 000	R3 000
6. Complaints resolution rate	% (QPR)	100%	100%	100%	100%	100%
7. Complaint Resolution within 25 working days rate	% (QPR)	96%	96%	96%	96%	96%

TABLE C & THS 11: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
1. National Core Standards self-assessment score	% (QPR)	100%	100%	100%	100%	100%	100%	100%
2. Patient Satisfaction Rate	% (QPR)	61.8%	63.8%	67%	75%	78%	80%	85%
3. Average Length of Stay	No (QPR)	5.5 days	7.6	7.9	5.8	5.8	5.8	5.8
4. Inpatient Bed Utilisation Rate	% (QPR)	77%	81.2%	77.7%	79%	79%	79%	79%
5. Expenditure per patient day equivalent (PDE)	R (QPR)	R3101	R1866	R2640	R3101	R3101	R 2 822	R3200
6. Complaints resolution rate	% (QPR)	100%	100%	100%	100%	100%	100%	100%
7. Complaint Resolution within 25 working days rate	% (QPR)	97%	47.5%	86.7%	75%	75%	80%	85%

Refers to new indicator where baseline data was not collected in that financial year

TABLE C&THS12: QUARTERLY TARGETS FOR CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. National Core Standards self-assessment score	Quarterly	% (QPR)	100%	100%	100%	100%	100%
2. Patient Satisfaction rate	Annually	% (QPR)	78%				78%
3. Average Length of Stay	Quarterly	No (QPR)	5.8	5.8	5.8	5.8	5.8
4. Inpatient Bed Utilisation Rate	Quarterly	% (QPR)	79%	79%	79%	79%	79%
5. Expenditure per PDE	Quarterly	R (QPR)	R3101	R3101	R3101	R3101	R3101
6. Complaints resolution rate	Quarterly	% (QPR)	100%	100%	100%	100%	100%
7. Complaint Resolution within 25 working days rate	Quarterly	% (QPR)	75%	75%	75%	75%	75%

5.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE C&TH 8: EXPENDITURE ESTIMATES: CENTRAL AND TERTIARY SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Central Hospitals	7 799 913	8 079 935	9 198 127	8 831 896	9 079 757	9 806 452	9 537 174	10 024 750	10 565 193
2. Provincial Tertiary Hospital Services	1 962 906	2 157 860	2 386 515	2 951 151	2 954 651	2 830 619	3 072 453	3 292 449	3 489 996
Total payments and estimates	**9 762 819**	**10 237 795**	**11 584 642**	**11 783 047**	**12 034 408**	**12 637 071**	**12 609 627**	**13 317 200**	**14 055 189**

TABLE C&TH 9: SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**9 531 085**	**10 061 298**	**11 293 793**	**11 492 336**	**11 735 197**	**12 369 160**	**12 085 295**	**12 759 419**	**13 457 980**
Compensation of employees	6 422 987	7 176 189	7 817 483	8 229 196	8 361 044	8 561 055	8 716 095	9 214 422	9 757 287
Goods and services	3 107 677	2 884 069	3 476 310	3 263 140	3 374 153	3 808 105	3 369 200	3 544 997	3 700 693
Interest and rent on land	421	1 040	–	–	–	–	–	–	–
Transfers and subsidies to:	**22 747**	**36 182**	**49 073**	**22 684**	**22 684**	**28 021**	**20 807**	**22 391**	**23 732**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	12	48	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	22 747	36 170	49 025	22 684	22 684	28 021	20 807	22 391	23 732
Payments for capital assets	**207 190**	**139 849**	**239 300**	**268 027**	**276 527**	**238 198**	**503 525**	**535 390**	**573 477**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	207 190	139 836	239 300	268 027	276 527	238 198	503 525	535 390	573 477
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	13	–	–	–	–	–	–	–
Payments for financial assets	**1 797**	**466**	**2 476**	**–**	**–**	**1 692**	**–**	**–**	**–**
Total economic classification	**9 762 819**	**10 237 795**	**11 584 642**	**11 783 047**	**12 034 408**	**12 637 071**	**12 609 627**	**13 317 200**	**14 055 189**

5.5 PERFORMANCE AND EXPENDITURE TRENDS

The programme budget increases from R11.8 billion in 2015/16 to R12.6 billion in the 2016/17 financial year. The largest portion of the budget is allocated to the Sub-programme: Central Hospitals. The programme is funded mainly through the conditional grant: the National Tertiary Services and the Health Professions Training and Development Grants.

Over the MTEF, the programme budget grows by 11.6 per cent or R1.4 billion; this is to ensure that non-negotiable budget line items such as medicine and medical supplies are adequately funded. In 2016/17, the department will continue to provide funding for operationalization of the three tertiary hospitals i.e. Helen Joseph, Kalafong and Tembisa.

The budget for compensation of employees increases from R8.2 billion in 2015/16 to R8.7 billion in the 2016/17 financial year, due to Improvement of Conditions of Service provision made for health professionals. Comparing the budgets of 2015/16 and 2016/17, goods and services increases by 3 percent to ensure that non-negotiable and municipal services items are funded adequately.

5.6 RISK MANAGEMENT

RISK	MITIGATING FACTORS
No co-payment by MEDUNSA for joint appointees	Approve and implement Memorandum of Understanding with Universities
Inability to function in the event of a disaster. (business disruption)	• Finalisation and implementation of a Business Continuity Plan • Standardisation of BCP at all institutions • Training and enforcement on policies, legislation and procedures (e.g. Disaster Management Act and OHS Act etc.). • Development and implementation of Live Plan (system that will cover internal and external)
Dilapidated health infrastructure	• Develop and implement Service Level Agreement between Department and Department of Infrastructure Development
Insufficient, irrelevant, inaccurate and incomplete Performance Reports (Portfolio of Evidence) (performance information).	• Develop and implement monitoring and evaluation framework and Information Management Plan • Train all relevant officials on Predetermined Objectives • Approve institutional organisational structures • Conduct quarterly reviews

Inability to function in the event of a disaster. (business disruption)	• Finalisation and implementation of a Business Continuity Plan • Standardisation of Business Continuity Plan • at all institutions • Training and enforcement on policies, legislation and procedures (e.g. Disaster Management Act and Occupational Health and Safety Act etc.) • Development and implementation of Live Plan (system that will cover internal and external)
Medical malpractices	• Develop and Implement the Human Resource Plan in line with norms and standards • Finalisation and implementation of the Referral Policy • Implementation of Consequence Management for non - compliance to policies and procedures • Strengthen adverse events reporting system • Develop a strategy to minimize medical malpractice • Develop and Implement the Asset management Plan • Establishment of the Ethics Committee and continue with ethics training

BUDGET PROGRAMME 6: HEALTH SCIENCES AND TRAINING

6.1 PROGRAMME PURPOSE

Rendering of training and development opportunities for clinical and non-clinical employees of the Department of Health through sub-programmes:

- **Nurse training college:** Training of nurses at undergraduate and post-basic level. Target group includes actual and potential employees;
- **Emergency medical services**: (EMS) training college: Training of rescue and ambulance personnel. Target group includes actual and potential employees;
- **Bursaries:** Provision of bursaries for health science training programmes at undergraduate and postgraduate levels. Target group includes actual and potential employees; and
- **Training (other):** Provision of skills development interventions for all occupational categories in the Department. Target group includes actual and potential employees.

Programme six is strategically positioned to plan, produce, manage and fund the education, training and development needs of internal and external Gauteng Department of Health together with the provision of health wellness and occupational health and safety services of employees of the department and the implementation of the human resource strategy and policy.

- **Professional Development and Management of Bursary Fund:**
  Provide Bursaries to external full time students in medical, allied and other related professions.
  Provide internal Bursaries to qualifying staff members to improve performance in functional areas.
- Placement, management and support of medical doctors, Allied Health Professionals and medical interns in compliance with statutory mandate.
- Improve the competence of health care professionals through continuous professional development **Special Programmes:** Implement the South African Cuban Programme in line with the Bilateral Corporation Agreement between South Africa and Cuba.
- **Regional Training Centres:** Provide proactive in-service training and short courses for all health care workers in response to, current and emerging burden of diseases.
- **Health Training and Development**: Expand the teaching and learning platform through the Health professions Training and Development Grant in line with the MOA with institutions of higher learning.
- **Wellness Management/ EAP:** Provide Employee Wellness Management Programme that will enhance the psycho-social functioning of employees to improve productivity in the organisation through provision of psycho-social services and capacity building programmes.
- **HIV, TB, STIs in the workplace:** Provide services that will manage the prevention, support, treatment, and promotion of human rights and social justice.
- **Occupational Health and Safety** ensuring health and safety of all employees by identifying the occupational Risk Hazards, and implementation of preventative Programmes including the management of all work related injuries and diseases.
- **Leadership, Management and Skills Development**: Responsible for management and leadership development, generic skills development for all staff, functional development for non-clinical staff, orientation, induction and on-boarding as well as adult education and training.
- **Skills Development Facilitator** - focuses on compliance to legislation like Skills Development Act including accessing funding and liaison with HWSETA. Management of youth development programme like Learnerships, Internships and Artisanships.

- **Knowledge Management** is responsible for human capital information sharing including, policies, marketing of health sciences and management of non-classroom strategic interventions like youth career expos, e-learning, knowledge hub and Take the Girl Child to Work.
- **Emergency medical services**: (EMS) training college provides training through the Lebone College of Emergency Medical Training
- **Nursing Colleges** provide nurses training platform through six Nursing Colleges.

The changes to the 5 year strategic plan are described under Human Resource Development strategic objective statements as per attached Annexure A.

6.2 PRIORITIES

Training Programme	Target Group	Estimated Number of Beneficiaries	Quarter (Q1, Q2, Q3 or Q4)
Nurse-initiated and managed Drug Resistance programme	Professional nurses	100	25 per quarter
Facility Trainers on Primary Care 101	Professional nurses	80	20 per quarter
WBOT Team Leaders (professional nurses) Orientation Programme for Ward Based Outreach Teams	Professional nurses	25	Quarter 2
Basic HIV and AIDS Course: nurse-initiated and managed antiretroviral treatment (NIMART)	Professional nurses	250	63 in quarter 1 & 2 and 62 in quarter 3 & 4
Health Counselling and Testing: Provider Initiated Counselling and Testing	Professional nurses	150	38 in quarter 1 & 2 and 37 in quarter 3 & 4
Prevention of Mother to Child Transmissions (PMTCT) programme	Professional nurses	150	38 in quarter 1 & 2 and 37 in quarter 3 & 4
Integrated Management of Childhood Illnesses	Professional nurses	250	63 in quarter 1 & 2 and 62 in quarter 3 & 4
Community Health Worker on – Phase 1	Community Health Workers (CHWs)	100	25 per quarter

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

TABLE HST 1: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR HST

Strategic Objective Statement	Indicators	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Increase the number of new nursing students to fulfill replacement annually to 1000 by 2019/20	1. Number of Bursaries awarded for first year nursing students	No (QPR)	1148	1137	940	1000	1000[39]	1000	1000	1000
Increase access to training opportunities for all staff Including heads of all institutions by 2019/20	2. Number of Bursaries awarded for first year medicine students	No (QPR)	#	#	0	650	20	50	100	
	3. Number of new medical students enrolled annually on the RSA-Cuban medical	No (QPR)	#	114	140	80	80	80	80	10

[39] Not yet on bursary but salary level 3. To commence in 2017/18

Strategic Objective Statement	Indicators	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
	4. Percentage of hospital CEOs trained	No	#	#	#	#	25% (9/36)	50% (18/36)	75% (27/36)	100%
	5. Percentage of PHC facility managers trained	No	#	#	5% (18/372)	10% (37/372)	15% (55/372)	25% (93/372)	45% (167/372)	60%
Increase awareness of ethical conduct for all staff by offering a code-of-conduct training to 30% of our employees in 2019/20	6. Percentage of employees trained on 'code-of-conduct'	%	#	5%	10%	13%	15%	20%	25%	30%
Increase employee satisfaction rate to 75 % by 2019/20	7. Employee satisfaction rate	%	#	#	#	70%	72%	75%	75%	75%

Refers to new indicator where baseline data was not collected in that financial year

6.4 QUARTERLY TARGETS FOR HST

TABLE HST 2: QUARTERLY TARGETS FOR HST

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
Number of Bursaries awarded for first year medicine students[40]	Annually	No (QPR)	20	-	-	-	20
Number of Bursaries awarded for first year nursing students	Annually	No (QPR)	1000	-	-	-	1000
Number of new medical students enrolled annually on the RSA-Cuban medical	Annually	No	80	-	-	-	80
Percentage of hospital CEOs trained	Quarterly	No	25% (9/36)	5%	10%	15%	25%
Percentage of PHC facility managers trained	Quarterly	No	15% (55/372)	10%	11%	13%	15%
Percentage of employees trained on 'code-of-conduct'	Quarterly	%	15%	13%	14%	14%	15%
Employee satisfaction rate	Annually	%	72%	-	-	-	72%

Refers to new indicator where baseline data was not collected in that financial year

[40] Shaded areas are nationally customised health sector indicators

6.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HST 3: EXPENDITURE ESTIMATES: HEALTH SCIENCES AND TRAINING

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Nurse Training Colleges	689 135	674 696	645 135	771 615	761 615	698 893	817 298	858 320	909 819
2. Ems Training Colleges	24 371	27 829	27 811	40 384	39 584	36 786	38 944	39 961	42 359
3. Bursaries	43 573	52 606	132 717	52 053	52 053	93 909	54 458	57 546	60 999
4. Other Training	49 991	74 354	56 268	52 498	59 678	59 678	65 752	69 336	73 496
Total payments and estimates	**807 070**	**829 485**	**861 931**	**916 549**	**912 929**	**889 266**	**976 452**	**1 025 163**	**1 086 673**

SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**732 861**	**717 639**	**702 125**	**849 443**	**833 388**	**767 022**	**898 475**	**943 468**	**1 000 076**
Compensation of employees	686 494	680 787	654 032	791 784	777 834	706 437	840 081	882 087	935 012
Goods and services	46 367	36 852	48 093	57 659	55 554	60 585	58 394	61 381	65 064
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies to:	**65 296**	**101 209**	**150 215**	**55 833**	**67 588**	**109 683**	**68 034**	**72 102**	**76 428**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	28 239	16 085	17 131	17 919	17 919	17 919	18 869	19 812	21 001
Higher education institutions	500	958	–	1 864	1 864	1 864	1 963	2 061	2 185
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	34	33 393	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	36 523	50 773	133 084	36 050	47 805	89 900	47 202	50 229	53 242
Payments for capital assets	**8 549**	**10 588**	**8 801**	**11 274**	**11 954**	**11 954**	**9 943**	**9 593**	**10 168**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	8 549	10 588	8 801	11 274	11 954	11 954	9 943	9 593	10 168
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**364**	**49**	**790**	**–**	**–**	**607**	**–**	**–**	**–**
Total economic classification	**807 070**	**829 485**	**861 931**	**916 549**	**912 929**	**889 266**	**976 452**	**1 025 163**	**1 086 672**

6.6 PERFORMANCE AND EXPENDITURE TRENDS

The budget for compensation of employees increases from R791.8 million 2015/16 to R840 million in the 2016/17 financial year. The sub-programme: Bursaries reflects an increase from R52 million in 2015/16 to R54 million in 2016/17 to provide bursaries to address scarce skills such as medical professionals, assistant pharmacists and pharmacists. This initiative includes the South African Cuban Doctor Programme.

EMS colleges are mainly utilised to provide the department with Emergency Care technicians (mid-level workers), thus ensuring that EMS norms and standards are met. The sub-Programme: Other Training grows from R52.4 million in 2015/16 to R65.7 million in 2016/17, thus ensuring that capacity for the health sector is available.

6.7 RISK MANAGEMENT

RISK	MITIGATING FACTORS
The NQF Act, the Amended Higher Education Act and Nursing Act of 2005 that requires Nursing Education to be within the realm of Higher Education will result in provinces no longer being able to manage Nursing Education	• A phased and collaborative approach will be introduced between province and Higher Education to address this risk
Limited capacity and resources to increase production of health professionals as required by services (e.g. HEI capacity, funding limitations, provincial capacity etc.)	• Inter-sectorial collaboration with National Departments of Health and Education and National Treasury • Training of mid-level workers • Expansion of experiential teaching platforms (shift from central hospitals to regional hospitals and district health services)
Inability of institutions to release staff for training results in no-shows and unauthorized expenditure	• Implement learner and supervisor contracts on accountability for both the employee and supervisors, training policy, e-learning
High staff turnovers within the Department resulting in training backlogs	• HRD training policy has been development to mitigate this risk
Poor interpretation and implementation of the Occupational Health and Safety Act in the institutions results in legislative non-compliance	• Training of all managers • Building capacity in Occupational Health and Safety

BUDGET PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

7.1 PROGRAMME PURPOSE

The purpose of this programme is to render support services required by the Department to realise its aims through sub-programmes:

- **Laundry services:** Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities;
- **Forensic services:** Rendering specialised forensic services in order to establish the circumstances and causes surrounding unnatural death;
- **Orthotic and prosthetic services:** Rendering specialised orthotic and prosthetic services; and
- **Medical supplies depot:** Managing the supply of pharmaceuticals and medical sundries to healthcare institutions.

The changes to the 5 year strategic plan are described under Pharmaceutical services and Supply Chain Management strategic objectives statements as per attached Annexure A.

7.2 PRIORITIES

- Create a platform for women cooperatives to supply linen to the department;
- Strengthen the management of laundries;
- Ensure sustainability of direct delivery of medicines to healthcare facilities; and
- Roll out of central and remote automated dispensing units to all districts.

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

TABLE HCSS1: PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH CARE SUPPORT SERVICES

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets			Strategic Plan target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Maintain % of linen contracts awarded to women cooperatives at 100% by 2019/20	1. Percentage of linen contracts awarded to women cooperatives	%	#	#	100%	100%	100%	100%	100%	100%
Increase % of hospitals procuring vegetables from local farmers to 90% by 2019/20	2. Percentage of hospital procuring/buying vegetables from local farmers	%	#	#	100% (36/36)	40% (14/36)	80% (29/36)	90% (3236)	95% (34/36)	>90%
Increase % of hospitals procuring dairy products from local farmers to 80% by 2019/20	3. Percentage of hospital procuring/buying dairy products from local farmers	%	#	#	0%	20% (7/36)	50% (18/36)	60% (21/36)	70% (24/25)	>80%
Increase % of hospitals procuring bread from small/medium scale bakeries to 70% by 2019/20	4. Percentage of hospital procuring/buying bread from small medium scale Bakeries	%	#	#	0%	0%	40% (14/36)	60% (21/36)	65% (23/36)	>70%
Increase conversion to electronic SCM system to 100% of hospitals by 2019/20	5. Percentage hospitals with electronic SCM system	%	#	#	80% (28/36)	80% (28/36)	100% (36/36)	100% (36/36)	100% (36/36)	100%
Increase % of vital medicine available and accessible from 82% in 2013/14 to 98% by 2019/20	6. Percentage of vital medicine availability at health facilities	%	64%	82%	90%	90%	99% (426/430)	99%	99%	98%
Increase % of essential medicine available and accessible from 82% in 2013/14 to 95% by	7. Percentage of essential medicine availability at health facilities	%	#	82%	79%	90%	99% (481/486)	99%	99%	95%

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term targets			Strategic Plan target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
2019/20										
Increase access to chronic medication for stable patients through use of central chronic dispensing and distribution centres and pick-up points from 0 in 2013/14 to 600 000 by 2019/20	8. Number of patients enrolled on centralized chronic medicine dispensing and distribution programme	Number	#	#	30000	60000	170 000	270 000	350 000	600 000
	9. Number of patients registered with remote automated dispensing unit	Number	#	#	#	50000	30 000	60 000	180 000	210000
Improve quality of NHLS services delivered to GDoH by increasing turn-around times for laboratory test results by 33% by 2019/20	10. Percentage of genexpert results available within 48 hours	%	#	64%	70%	90%	90% 361540/401 712	90%	90%	90%

7.4 QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

TABLE HCSS 2: QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

INDICATOR	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
			Q1	Q2	Q3	Q4
1. Percentage of linen contracts awarded to women cooperatives	%	100%	100%	100%	100%	100%
2. Percentage of hospital procuring/buying vegetables from local farmers	%	80% (29)	80%	80%	80%	80%
3. Percentage of hospital procuring/buying dairy products from local farmers	%	50% (18)	50%	50%	50%	50%
4. Percentage of hospital procuring/buying bread from small medium scale Bakeries	%	40% (14)	40%	40%	40%	40%
5. Percentage health institutions with electronic SCM system	%	100%	100%	100%	100%	100%
6. Percentage of vital medicine availability at health facilities	%	99% (426/430)	99%	99%	99%	99%
7. Percentage of essential medicine availability at health facilities	%	99% (481/486)	99%	99%	99%	99%
8. Number of patients enrolled on centralized chronic medicine dispensing and distribution programme (cumulative)	No	170 000	87500	115000	142500	170000
Number of patients registered with remote automated dispensing unit (cumulative)	N0	30 000	7500	15000	22500	30000
% of genexpert results available within 48 hours	%	90% 361540/401712	90%	90%	90%	90%

7.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HCSS 3: EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Laundries	152 113	151 214	158 418	191 005	190 473	178 274	195 706	204 845	217 136
2. Food Supply Services	44 281	43 420	53 124	69 322	69 322	57 637	73 040	76 692	81 293
3. Medicine Trading Account	150	236	–	1	1	1	1	1	1
Total payments and estimates	**196 544**	**194 870**	**211 542**	**260 328**	**259 796**	**235 912**	**268 747**	**281 538**	**298 430**

SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**194 173**	**190 355**	**205 901**	**240 818**	**249 174**	**225 163**	**255 441**	**268 216**	**284 309**
Compensation of employees	120 031	121 428	124 875	153 770	153 770	138 548	163 125	171 282	181 558
Goods and services	74 142	68 927	81 026	87 048	95 404	86 615	92 316	96 934	102 750
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies to:	**276**	**729**	**658**	**317**	**317**	**419**	**536**	**565**	**599**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	1	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	276	728	658	317	317	419	536	565	599
Payments for capital assets	**2 052**	**3 747**	**4 964**	**19 193**	**10 305**	**10 305**	**12 770**	**12 758**	**13 523**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	2 052	3 747	4 964	19 193	10 305	10 305	12 770	12 758	13 523
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**43**	**39**	**19**	**–**	**–**	**25**	**–**	**–**	**–**
Total economic classification	**196 544**	**194 870**	**211 542**	**260 328**	**259 796**	**235 912**	**268 747**	**281 538**	**298 430**

7.6 PERFORMANCE AND EXPENDITURE TRENDS

The budget of this programme is allocated to five laundries throughout the province that provide cleaning services and purchase linen for health facilities as well to one cook-freeze facility that provide pre-packed food service supply to health facilities. The 2016/17 budget has increased when compared with the 2015/16 financial year by R8 million.

Compensation of employees budget increased from R153.7 million in 2015/16 to R163.1 million in 2016/17. In 2018/19 year, the personnel budget grows to R181.5 million to make provision for the cost of living adjustment and filling of vacancies.

The goods and services budget increases from R87 million in 2015/16 to an estimated R92.3 million for the 2016/17 financial year as part of the improvement on hygiene and for the replacement of linen.

7.7 RISKS MANAGEMENT

RISK	MITIGATING FACTORS
Maintenance of machinery	Strengthen partnership and support from DID
Inadequate linen and Cook Freeze meals	Maintenance of machinery, steam and air supply from DID
Non-availability / Shortages on pharmaceutical items, etc.).	• Finalize and implement re-engineering process • Decentralise procurement of non-pharmaceutical items • Implementation of National Inventory system • Develop an Integrated Patient Management System • Develop and Implement Communication Strategy • Roll-out of (Central Chronic Medicine Distribution and Dispensing (CCMDD)

BUDGET PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

8.1 PROGRAMME PURPOSE

The purpose of this programme is to plan, provide and equip new facilities/assets, upgrade and rehabilitate community health centres, clinics, district, provincial, specialized and academic hospitals, and other health-related facilities, and also to undertake life cycle management of immovable assets through maintenance of all health facilities.

Health Facilities Management Programme does not reflect changes to the 5 year strategic plan under Annexure A.

8.2 PRIORITIES

- Improved health infrastructure design, delivery and maintenance;
- Medical supplies depots standards complied with in line with SAHPRA licensing;
- Maintenance improved through adequate budget allocation and average completion for minor maintenance within 48 hours;
- Reduce under-spending on infrastructure budget; and
- Ensure compliance with all statutory requirements.

8.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH FACILITIES MANAGEMENT

TABLE HFM1: PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HEALTH FACILITIES MANAGEMENT

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term goals			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Build 10 new clinics/community health centres and 2 additional new hospitals, and refurbish 21 health care facilities by 2019/20, out of which 100% will comply to the gazetted norms and standards for facilities	1. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District[41]	No (QPR)	#	#	#	#	0	4	0	21
	2. Number of health facilities that have undergone major and minor refurbishments outside NHI pilot district (excluding facilities in NHI Pilot District)	No (QPR)	#	#	#	#	8	7	2	
Improve contract management by establishing Service Level Agreement (SLA) with Department of Infrastructure Development (DID) by 2019/20	3. Service Level Agreements (SLAs) with Departments of Infrastructure Development Established	Yes-No (QPR)	#	#	0	1	1	1	1	1

[41] Shaded areas are nationally customised health sector indicators

Strategic Objective Statement	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium-term goals			Strategic Plan Target
			2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
Build 10 new clinics/community health centres by 2019/20; out of which 100% will comply to the gazetted norms and standards	4. Proportion of P8 budget spent on maintenance (preventative and scheduled)	%	51%	47%	84%	55%	31%	46%	53%	
	5. Number of additional clinics and community health centres constructed	No	#	#	0	1	10 (under construction)	10 (under construction)	10 completed	10
Build 2 additional new hospitals and refurbish 21 health facilities by 2019/20; out of which 100% will comply to the gazetted norms and standards	6. Number of additional hospitals constructed or revitalized	No		1	**1**	2	5 (under construction)	5	7	6
Increase the number of projects finished on time and within budget to 80% and 100% respectively by 2019/20	7. Percentage of capital work projects finished on time	%	#	#	#	60%	80%	100%	100%	80%

4.4 QUARTERLY TARGETS FOR HEALTH FACILITIES MANAGEMENT

INDICATOR	Frequency of Reporting	Indicator Type	ANNUAL TARGET 2016/17	TARGETS			
				Q1	Q2	Q3	Q4
1. Number of health facilities that have undergone major and minor refurbishment) in NHI Pilot District	Annually	No	0	-	-	-	0
2. Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	Annually	No	8	-	-	-	8
3. Service Level Agreements (SLAs) with Departments of Infrastructure Development Established	Annually	Yes-No	1	-	-	-	1
4. Proportion of P8 budget spent on maintenance (preventative and scheduled)	Annually	No	31%	-	-	-	31%
5. Number of additional clinics and community health centres constructed	Annually	No	10 (under construction)	-	-	-	10 (under construction)
6. Number of additional hospitals constructed or revitalized	Annually	No	5 (under construction)	-	-	-	5 (under construction)
7. Percentage of capital work projects finished on time	Annually	No	80%	-	-	-	80%

8.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HFM 4: EXPENDITURE ESTIMATES: HEALTH FACILITIES MANAGEMENT

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
1. Community Health Facilities	101 168	133 050	145 238	286 122	319 515	319 515	447 225	699 619	606 272
2. Emergency Medical Rescue Services	18 507	1 501	1 108	1 390	3 390	3 390	5 400	18 871	21 302
3. District Hospital Services	271 851	201 983	209 253	208 967	298 291	298 291	346 226	783 221	1 005 593
4. Provincial Hospital Services	505 784	384 383	464 429	397 880	573 518	573 518	491 415	197 932	262 824
5. Central Hospital Services	212 039	242 822	398 392	306 909	509 193	509 193	443 681	415 500	324 206
6. Other Facilities	134 482	157 727	165 675	246 705	253 745	253 745	283 983	310 191	324 673
Total payments and estimates	**1 243 831**	**1 121 466**	**1 384 095**	**1 447 973**	**1 957 652**	**1 957 652**	**2 017 930**	**2 425 334**	**2 544 870**

SUMMARY OF PROVINCIAL EXPENDITURE ESTIMATES BY ECONOMIC CLASSIFICATION

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	**2012/13**	**2013/14**	**2014/15**	**2015/16**			**2016/17**	**2017/18**	**2018/19**
Current payments	**638 152**	**666 714**	**858 884**	**570 667**	**1 080 146**	**1 080 146**	**668 421**	**781 160**	**934 855**
Compensation of employees	10 234	10 408	10 167	15 573	16 673	16 673	38 680	35 678	37 869
Goods and services	627 918	656 306	848 717	555 094	1 063 473	1 063 473	629 741	745 482	896 986
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies to:	**212**	**39**	**22**	**–**	**–**	**–**	**–**	**–**	**–**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	8	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	113	–	–	–	–	–	–	–	–
Households	91	39	22	–	–	–	–	–	–
Payments for capital assets	**605 467**	**454 713**	**525 189**	**877 306**	**877 506**	**877 506**	**1 349 509**	**1 644 174**	**1 610 015**
Buildings and other fixed structures	526 772	413 088	364 769	869 741	869 741	869 741	1 235 355	1 630 974	1 595 444
Machinery and equipment	78 695	41 625	160 420	7 565	7 765	7 765	114 154	13 200	14 571
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**1 243 831**	**1 121 466**	**1 384 095**	**1 447 973**	**1 957 652**	**1 957 652**	**2 017 930**	**2 425 334**	**2 544 870**

8.6 PERFORMANCE AND EXPENDITURE TRENDS

The bulk of the budget for this programme is transferred to the DID for major capital works programmes performed on behalf of the department. This includes new facilities, and the rehabilitation, upgrading and maintenance of facilities.

The goods and services budget has increased by 13 percent from 2015/16 to 2016/17 to cater for the day to day maintenance of health facilities.

8.7 RISK MANAGEMENT

RISK	MITIGATING FACTORS
Inadequate infrastructure delivery.	• Finalisation and implementation of Service Level Agreement (SLA) • Revival of the monthly monitoring meetings with DID • Consequence management and Performance Management Development System for non-delivery • Appointment of adequately skilled personnel. • Full implementation of E- Maintenance
Reduced infrastructure delivery for facilities which may not be fit for purpose in terms of new buildings, upgraded facility and well maintained building	• Maintain a fine balance between time, cost and scope management
Delayed payment, scope management and additional time due inadequate fine balance between time, cost and scope management	

PART C: LINKS TO OTHER PLANS

LINKS TO THE LONG TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

TABLE PC1: SUMMARY PROVINCIAL INFRASTRUCTURE PAYMENTS AND ESTIMATES PER CATEGORY									
	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2012/13	2013/14	2014/15	2015/16			2016/17	2017/18	2018/19
1. New and replacement assets (R '000	**508 359**	**389 005**	**353 467**	**354 528**	**301 053**	**301 053**	**744 504**	**666 658**	**782 052**
Existing infrastructure assets	**672 981**	**692 599**	**977 588**	**1 041 192**	**1 604 346**	**1 604 346**	**1 223 064**	**1 701 817**	**1 702661**
Total new and replacement assets									
2. Maintenance and repairs (R'000	606 576	566 804	745 235	778 147	1 286 242	1 286 242	624 384	705 701	854 898
Total maintenance and repairs	606 576	566 804	745 235	778 147	1 286 242	1 286 242	624 384	705 701	854 898
3. Upgrades and additions	32 357	55 387	174 783	185 763	231 876	231 876	319 230	693 116	664 963
Total Upgrades and additions	32 357	55 387	174 783	185 763	231 876	231 876	319 230	693 116	664 963
4. Rehabilitation, renovations and refurbishments	34 048	70 408	57 570	77 282	86 228	86 228	279 450	303 000	182 800
Total Rehabilitation, renovations and refurbishments	34 048	70 408	57 570	77 282	86 228	86 228	279 450	303 000	182 800

1. CONDITIONAL GRANTS

DORA indicators to be populated from the final Conditional Grant framework and submitted as part of the final APP

Name of Conditional Grant	Purpose of the Grant	2016/17 Performance Indicators	2016/17 Targets
COMPREHENSIVE HIV AIDS CONDITIONAL GRANT	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing • To support the implementation of the National operational plan for comprehensive HIV and AIDS treatment and care • To subsidise in-part funding for the antiretroviral treatment plan	Number of Male condoms distributed	219,180,253
		Number of Female condoms distributed	4,600,000
		Number of HTA intervention sites	117
		Number of active Lay counsellors on stipend	2,353
		Number of clients tested (including antenatal)	3,592,943
		Number of health facilities offering MMC	96
		Number of MMC performed	209,189
		Number of sexual assault cases offered ARV prophylaxis	6,500
		Number of antenatal clients initiated on ART	42,500
		Number of babies PCR tested at 10 weeks	49,000
		Number of facilities offering ART	400
		Number of new patients started on treatment	193,658
		Number of patients on ART remaining in care	1,028,811
		Number of active home based carers receiving stipends	6,300
		Number of beneficiaries served by home based carers	340,000
		Number of HIV positive clients screened for TB	363,000
		Number of HIV positive clients started on IPT	100,000
		Number of Doctors trained on HIV/AIDS, TB, STIs and other chronic diseases	65
		Number of Nurses trained on HIV/AIDS, TB, STIs and other chronic diseases	4,455
		Number of Non-professional trained on HIV/AIDS, TB, STIs and other chronic diseases	3,170

Name of Conditional Grant	Purpose of the Grant	2016/17 Performance Indicators	2016/17 Targets
NATIONAL TERTIARY SERVICES GRANT	• To ensure provision of tertiary health services for all south African citizens • To compensate tertiary facilities for the costs associated with provision of these services including cross border patients	Posts funded as per Financial National tertiary services grant Business plan 1. Number of medical specialist posts funded 2. Number of nursing posts funded 3. Number of Allied and support staff posts funded 4. Number of other post funded **DORA 2016/17 indicators and targets (non-financial information) have not been developed**	2887 posts funded as per Financial National tertiary services grant Business plan 1. 826 2. 1669 3. 365 **4.** 37
HEALTH PROFESSIONAL TRAINING AND DEVELOPMENT GRANT	Support provinces to fund service costs associated with training of health science trainees on the public service platform Co-funding of the National Human Resources Plan for Health in expanding undergraduate medical education for 2012 and beyond (2025)	Professional categories funded as per Financial Health professional training and development grant Business plan 1. Number of post graduates funded 2. Number of registrars funded 3. Number of specialists funded 4. Number of clinical Supervisors funded 5. Number of grant Management funded 6. Number of resource Centre funded	532 of professional categories funded as per Financial National tertiary services grant Business plan 1. 81 2. 399 3. 21 4. 24 5. 7 6. 0

Name of Conditional Grant	Purpose of the Grant	2016/17 Performance Indicators	2016/17 Targets
HEALTH FACILITIES REVITALISATION GRANT	• Help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including, inter alia, health technology, organisational systems (OD) and quality assurance (QA). • Supplement expenditure on health infrastructure delivered through public-private partnerships	DORA 2016/17 Health Facilities Revitalisation Grant indicators and targets have been developed Department User Asset Management Plan (UAMP) with list of all infrastructure projects to be conducted in 2016/17	As per Department User Asset Management Plan with list of all infrastructure projects
Name of Conditional Grant	**Purpose of the Grant**	**2016/17 Performance Indicators**	**2016/17 Targets**
NATIONAL HEALTH INSURANCE GRANT	• Test innovations in health service delivery and provision for implementing NHI, allowing for each district to interpret and design innovations relevant to its specific context; in line with the vision for realising universal health coverage for all. • To undertake health system strengthening activities in identified focus and priority areas. • To assess the effectiveness of interventions/activities undertaken in the district; funded through this grant.	DORA 2016/17 indicators have not been developed, for the National Health Insurance Grant. **However, the National Grant outcome statements are as follows:** • Strengthened district capacity for service delivery, planning, monitoring and evaluation in selected districts; • Support the ideal clinics realisation with focus on National Core Standards; • Strengthened coordination and integration of Primary Health Care teams within pilot districts; and • Strengthened supply chain management systems and processes improved through innovative interventions at the district level	DORA 2016/17 targets have not been developed, for the National Health Insurance Grant

Name of Conditional Grant	Purpose of the Grant	2016/17 Performance Indicators	2016/17 Targets
NATIONAL HEALTH INSURANCE GRANT	• Test innovations in health service delivery and provision for implementing NHI, allowing for each district to interpret and design innovations relevant to its specific context; in line with the vision for realising universal health coverage for all. • To undertake health system strengthening activities in identified focus and priority areas. • To assess the effectiveness of interventions/activities undertaken in the district; funded through this grant.	DORA 2016/17 indicators have not been developed, for the National Health Insurance Grant. However, the National Grant Outputs are as follows:	DORA 2016/17 indicators have not been developed
		• Strengthened district capacity for service delivery, planning, monitoring and evaluation in selected districts;	
		• Support the ideal clinics realisation with focus on National Core Standards; • Strengthened coordination and integration of Primary Health Care teams within pilot districts; and • Strengthened supply chain management systems and processes improved through innovative interventions at the district level.	

2. PUBLIC ENTITIES

The Gauteng Department of Health has no public entities.

NAME OF PUBLIC ENTITY	MANDATE	OUTPUTS	CURRENT ANNUAL BUDGET (R' 000	DATE OF NEXT EVALUATION
N/A	N/A	N/A	N/A	N/A

3. PUBLIC - PRIVATE PARTNERSHIPS (PPPs)

NAME OF PPP	PURPOSE	OUTPUTS	CURRENT ANNUAL BUDGET (R' THOUSANDS)	DATE OF TERMINATION	MEASURES TO ENSURE SMOOTH TRANSFER OF RESPONSIBILITIES
1. Dr George Mukhari Hospital Revitalisation Project			National Department of Health Budget	Managed by National Department of Health	
2. Chris Hani Baragwanath Hospital Revitalisation Project			National Department of Health Budget	Managed by National Department of Health	

4. CONCLUSIONS

The development of the Annual Performance Plan for the next MTEF (2016/17-2018/19) as the second year for the implementation of the five year (2015/16-2019/20) was an inclusive and consultative process. It is therefore reasonable to conclude that all the Department's employees and external stakeholders will proudly take ownership of this annual performance plan to achieve the Gauteng Health outcomes.

The Department has ensured that the annual performance plan align with the departmental strategic plan which is aligned to the government's priorities at national and provincial level; using the format customised for the health sector and approved by National Treasury for the development of the annual performance plan and considered the priorities from the NDP 2030, Medium Term Strategic Framework (MTSF), the National Health Strategic Plan, Gauteng Provincial Government vision 2055, State of the Nation Address (SONA) and the State of the Province Address (SOPA). In addition, a great effort has been made in determination of the indicators and targets. The Department hereby commits itself to the implementation of the annual performance plan for the next MTEF.

ANNEXURE A: CHANGES TO 5 YEAR (2015/16- 1920) STRATEGIC PLAN

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
1. Improved health and well-being of all citizens, with an emphasis on children and women	We will improve basic and preventive care for children and women to reduce the infant mortality rate from 34 per 1,000 live-births in 2013/14 to 20 per 1,000 live-births in 2019/20, the neonatal mortality rate from 15/1,000 (2013/14) to <10/1,000 (2019/20), the child (under 5 mortality rate) from 43 per 1,000 in 2013/14) to 23 per 1,000 in 2019/20 and the in facility maternal mortality ratio from 143 per100,000 in 2013/14 to <100 per 100,000 live births in 2019/20	We will improve basic and preventive care for children and women to reduce the infant mortality rate from [42]34 per 1,000 live-births in 2013/14 to 20 per 1,000 live-births in 2019/20, the neonatal mortality rate from 15/1,000 live births in 2013/14) to 6/1,000 live births in 2019/20, the child (under 5) mortality rate from 43 per 1,000 live births in 2013/14 to 23 per 1,000 live births in 2019/20 and the in-facility maternal mortality ratio from 143 per 100,000 live births in 2013/14 to 80 per 100,000 live births in 2019/20.	1. Reduce in facility maternal mortality ratio from 143 in 2013/14 to <100 per 100,000 live birth 2. Reduce neonatal mortality from 15/1,000 to <10/1,000 live births by 2019/20 3. Decrease child (under-5 years) diarrhoea case fatality rate from 3.5% to <2% by 2019/20 4. Decrease child (under 5 years) severe acute malnutrition case fatality rate from 6.1% to 5% by 2019/20 5. Sustain immunisation coverage at 95%, currently at 109%, for children under 1 year	1. Reduce in-facility maternal mortality ratio from 143 in 2013/14 to 80 per 100,000 live births in 2019/2020 2. Reduce neonatal mortality from 15 per 1,000 live births in 2013/14 to 6 per 1,000 live births by 2019/20 3. Decrease child (under-5 years) diarrhoea case fatality rate from 3.5% in 2013/14 to 1.5% by 2019/20 4. Decrease child (under 5 years) severe acute malnutrition case fatality rate from 6.1% in 2013/2014 to 3% by 2019/20 5. Sustain immunisation coverage at 100% for children under 1 year by 2019/20	Programme 2; District Health Services *Sub-Programme: Maternal. Neonatal, Child, Youth and Women's Health and Nutrition*

[42] One of the comments that were received from the stakeholders following an earlier analysis of the 2nd draft of the 2016/17 APP, was that the goal and objective statements were the same; it was recommended that the goal statements be shortened and the objective statements be smarter; this couldn't be done as the Strategic Plan couldn't be reviewed before the submission of the final APP 2016/17.

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
			6. Decrease DTaP-IPV/HIB 3-Measles 1st dose drop-out rate from 3.5% to <2% and increase measles 2nd dose coverage from 85% to 95% by 2019/20 7. Increase breast cancer screening for all woman 8. Increase couple year protection rate from 24.9% in 2013/14 to 80% by 2019/20 9. Increase HPV coverage rate from 87.1% for 1st dose to 90% by 2019/20 11. Increase cervical cancer screening coverage from 41.7% to 70% of women by 2019/20	6. Decrease DTaP-IPV/HIB 3-Measles 1st dose drop-out rate from 3.5% in 2013/14 to 2% in 2019/20 and increase measles 2nd dose coverage from 85%in 2013/14 to 95% by 2019/20 7. Increase breast cancer screening from 20 000 in 2013/14 to 60 000 women by 2019/120 8. Increase couple year protection rate from 24.9% in 2013/ to 99% by 2019/20 9. Increase HPV vaccine coverage rate for 1st dose from 87.1% to 90% by 2019/20 10. Increase HPV vaccine coverage rate for 2nd dose to 90% by 2019/20 11. Increase cervical cancer screening coverage from 41.7% of women in 2013/14 to 99% of women by 2019/20	
	We will reduce the incidence and prevalence of non-communicable diseases (NCDs) and the number of non-natural deaths by promoting healthy, safe lifestyles to reduce the	We will reduce the incidence and prevalence of non-communicable diseases (NCDs) and the number of non-natural deaths by promoting healthy, safe lifestyles to reduce the	12. Assist in reducing deaths from violence and injury by 50% by increasing number of people reached through campaigns or programmers to educate against misuse of	12. Reduce case fatality rate due to violence and injury by 50% 2019/120	Programme 2; District Health Services *Sub-programme: Disease prevention*

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
	prevalence of diabetes from 2.6% (2013/2014) to 0.2% (2019/20) and the prevalence of hypertension from 17.2% (2013/14) to 3.2% (2019/20) and support the decrease of number of people that die annually from non-natural deaths due to e.g., injury, accident or violence, currently at 10,000	prevalence of diabetes from 2.6% (2013/2014) to 0.2% (2019/20) and the prevalence of hypertension from 17.2% (2013/14) to 3.2% (2019/20) and support the decrease in number of people that die annually from non-natural deaths due to e.g., injury, accident or violence	drugs and alcohol. 13. Increase proportion of population reached through NCD educational campaigns/ programmes increased from 20 to 240 by 2019/20	13. Increase clients screened for mental health to 100%, cataract surgery rate from 1408 per million in 2013/14 to 1500 per million ; malaria case fatality rate reduced to 1.7% in 2019/20	*and control*
2. Reduced rate of new infections and burden of HIV & AIDS and TB	We will reduce the rate of new HIV and TB infections by increasing awareness and testing opportunities and ensuring the availability of the right products, services and medication (condoms, circumcision, ARV for pregnant women). 90% of the population should know their status. We aim to reduce the HIV incidence rate from 1.72% in 2013/14 to 0.86% in 2019/20, the percentage of babies born to HIV positive mothers who test positive from 2% in 2013/14 to 0.8% in 2019/20, and the number of new TB infections per total population from 310/100,000 in 2013/14 to155/100,000 (2019/20). 90% of all people receiving ART will	We will reduce the rate of new HIV and TB infections by increasing awareness, testing opportunities and access to the right products and services (medication, condoms, circumcision, ARV for pregnant women).	1. Increase number of male and female condoms distributed annually as rate of total respective male and female population 15 years and above from male 69 480 000 and females1 451 696 in 13/14 to 309 100 000 male condoms and 5 million by 2019/20 3. Increase number of men medically circumcised percentage of total male population age 15-40 from 132 095 in 13/14 to 335 408 by 2019/20 4. Aligned from Part B of the strategic plan	1. Increase number of male condoms distributed annually from: 69 480 000 to 309 100 000 by 2019/20 2. Increase number of female condoms distributed annually from 1 451 696 to 5 000 000 by 2019/20 3. Increase number of men medically circumcised from 132 095 in 13/14 to 335 408 by 2019/20 4. Increase number of men/women aged 15-49 tested for HIV from 1.8 million to 4 million	Programme 2; District Health Services *Sub-programme: HIV & AIDS, STIs and TB Control*

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
	have viral suppression				
	We will prolong and improve the lives of people living with HIV, STIs and TB by ensuring that the right medication and services are available and increase awareness on how to use them. In 2019/20, 90% of people living with HIV should use ARV compared to 80% in 2013/14. We aim to reduce the number of people who die from HIV-related illnesses annually as a percentage of people living with HIV from 31.9% (2013/14) to 20% in 2019/20 and the TB death rate from 5.2% in 2013/14 to <5% in 2019/20 while increasing the current cure rate of 83% to > 88% in 2019/20	We will prolong and improve the lives of people living with HIV, STIs and TB by ensuring that the right medication and services are available and increase awareness on how to use them.	5. Increase proportion of HIV positive population on ARV from 80% to 90% in order to decrease HIV mortality rate from 31.9% to 15 % by 2019/20 6. Increase the percentage of people cured of TB from 83% to 88% by 2019/20 by reducing defaulter rate from 5.1% to <4% and death rate from 5.2% to <5% by 2019/20 8. Increase proportion of HIV positive population on ARV from 80% to 90% in order to decrease HIV mortality rate from 31.9% to 15 % by 2019/20	5. Increase proportion of HIV positive population on ARV from 80% to 90% by 2019/20 6. Increase the percentage of people cured of TB from 83% to 85% by 2019/20 by reducing treatment defaulter rate from 5.1% to 1% 7. TB treatment success rate from 84.5% to 95% by 2019/20 8. Decrease HIV mortality rate from 31.9% to 15% by 2019/20 9. Decrease TB death rate from 5.2% in 2013/14 to 3.5% by 2019/20	
2. Increased equal and timely access to efficient and quality health care services, thereby preparing for roll-out of NHI	We will transform primary health care through broader access and better quality and getting closer to communities to increase the number of fully fledged, functional Ward-Based Outreach Teams to 508 by 2019/20	We will transform primary health care through broader access and better quality and getting closer to communities by 2019/20	1. Increase number of fully-fledged, functional Ward Based Outreach Teams from 130 to 508 by 2019/20 2. Increase percentage of health facilities with annual quality improvement plan based on a PHC facilities self-assessment	1. Increase number of fully-fledged, functional Ward Based Outreach Teams from 130 to 508 targeted wards by 2019/20 2. Fixed PHC clinics scoring above 70% on the ideal clinics dashboard; 90% of PHC facilities and district hospitals compliant	Programme 2; District Health Services

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
			to 100%, fixed PHC clinics scoring above 80% on the ideal clinic dashboard, 90% of PHC facilities and district hospitals compliance with extreme and vital measures of national core standards and PHC facilities and district hospitals conducting national core standards self-assessment increase to 100% by 2019/20 3. Realigned from Part B of the 5 year strategic Plan 4. Realignment with Part B of the 5 year of the Strategic Plan	with extreme and vital measures of national core standards and PHC facilities and district hospitals conducting national core standards self-assessment increase to 100% by 2019/20 3. Increase patient satisfaction rate to 85% by 2019/20 4. Increase quality and access in PHC facilities through 24 hours service provision in all CHCs, integration of mental health and rehabilitation services in 100% of PHC facilities by 2019/20	
	We will support the launch of the NHI by following the national guidelines and supporting the increasing number of pilot districts	Removed due to discontinuation of National Health Insurance Grant	5. Expand number of districts implementing NHI interventions to from 1 to 5 by 2019/20 6. Establish provincial NHI forum and annual provincial dialogue with patient groups by 2019/20	5. Removed due to discontinuation of National Health Insurance Grant	

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
	We will improve access to secondary, tertiary and central specialised care by improving efficiency, adding capacity, and improving the referral system to increase: patient satisfaction to 80%; compliance with essential and vital medicines to >90% of all hospitals; clinical outcomes to lower the inpatient crude death rate from 5.6% to 5.2%	We will improve access to secondary, tertiary and central specialised care by improving efficiency, adding capacity, and improving the referral system to increase patient satisfaction	7. Improve efficiency of hospitals such that waste, expense and unnecessary effort is reduced, and bed utilisation in each hospital will not be too high nor too low	7. Improve efficiency of hospitals by reducing average length of stay to less than 5 days increasing bed utilisation to 80% and decreasing expenditure per PDE in hospitals by 2019/20	Prograqmme 4: Provincial Hospitals
			8. Improve the allocation of care across the different hospitals to ensure that regional and specialised hospitals focus on regional care provision	8. Reduce the number of primary care patient cases that are seen at regional, tertiary and central hospitals by 20% in 2019/20	
			9. Quality of care will be improved by increasing compliance to extreme and vital measures of core standards to 100% in 2019/20, and a completion of self- assessments in all hospitals	9. Increase compliance to extreme and vital measures of core standards to 100% in 2019/20, and complete self- assessments in all hospitals by 2019/20	
			10. Improve availability of pharmaceuticals by increasing percentage of essential medicines that are directly delivered to facilities from 52% to 70% in accordance with CALS agreement	10. Improve availability of pharmaceuticals by increasing percentage of essential medicines that are directly delivered to facilities from 52% in 2013/14 to 70%	Programme 7: Health Care Support Services

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
		No Changes to the Emergency Medical Services (EMS) goal statement	11. Increase percentage of qualified EMS personnel per rostered ambulance to 45% thus increasing compliance of EMS personnel with the norm of 10 personnel per operational ambulance, thus increasing	11. Increase percentage of qualified EMS personnel per rostered ambulance to 90% by 2019/20	Programme 3: Emergency Medical Services and Patient Transport
4. Excellence in clinical and non-clinical functions (Strategic Goal changed)	**Original goal** Excellence in non-clinical functions	No Changes to the Human Resource goal statement	1. Improve the matching of supply and demand of health care professionals by developing a 5 year "Human Resources for Health Plan" on a province level in 2016/17 2. Improve the competence of health care professionals through continuous professional development 3. Increase training opportunities for all staff including heads of all institutions to ensure competence 4. Increase the diversity and equity of our workforce thus increasing SMS women in management positions from adequate (41%) to good (50%) by 2020 and increasing people with disability employed to 2% by 2020	1. Develop a 5 year "Human Resources for Health Plan" on a province level in 2016/17 2. Increase training of health care professionals on continuous professional development from 5000 to 7500 3. Increase access to training opportunities for all staff Including heads of all institutions to ensure competence by 2019/20 4. Increase the diversity, verification of qualifications and equity of our workforce thus increasing women in senior management positions from adequate (41%) to good (50%) by 2020 and increasing people with disability employed to 2% by 2019/20	Programme 1: Administration

STRATEGIC GOAL	ORIGINAL GOAL STATEMENT	CHANGES TO GOAL STATEMENT	ORIGINAL STRATEGIC OBJECTIVE STATEMENT	CHANGES TO STRATEGIC OBJECTIVES STATEMENT	ALIGNMENT WITH BUDGET PROGRAMME
			5. Improve awareness of GDOH as an employer of choice by 2020	5. Strategic Objective Statement removed	
		No changes to the Financial Management goal statement	6. Receive unqualified audit opinion from Auditor-General by 2016 7. Increase revenue collection from qualifying paying patients from R522 048 000 in 2013/14 to R650 602 000 in 2018/19	6. Receive unqualified audit opinion from Auditor-General by 2016/17 and obtain a clean audit by 2019/2020 7. Increase revenue collection from qualifying paying patients from R522 048 000 in 2013/14 to R 1.7 000 000 by 2019/20	Programme 1: Administration
			8. Increase percentage of linen contract awarded to women cooperatives to 100%	8. Maintain percentage of linen contract awarded to women cooperatives to 100%	Programme 7: Health Care Support Services
		No Changes to the Information Management goal statement		9. No Changes to the Information Management strategic objective statements	Programme 1: Administration
		No Changes to the Health Facilities Management goal statement		10. No Changes to the Health Facilities Management strategic objective statements	Programme 8: Health Facilities Management

ANNEXURE B: MEDIUM TERM STRATEGIC FRAMEWORK 2014-2019
(Double click to open the document)

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

1. National Development Plan 2030 vision and trajectory

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

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

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

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

2. Constraints and Strategic Approach

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

(a) a complex, quadruple burden of diseases;

ANNEXURE E: NATIONAL PERFORMANCE INDICATORS DEFINITIONS

PROGRAMME 1: HEALTH ADMINISTRATION& MANAGEMENT

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Percentage of fixed PHC facilities with broadband access	Percentage of fixed PHC facilities with broadband access	To ensure broadband access to PHC facilities	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	**Num:** Total Number of fixed PHC facilities with minimum 1Mbps connectivity **Den:** Total Number of fixed PHC Facilities	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity	ICT Directorate / Chief Directorate

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Percentage of fixed PHC Facilities scoring above 70% on the ideal clinic dashboard.	Facilities that have implemented the ideal clinic and adhering to more than 70% of the elements as defined in the Ideal Clinic Dashboard (to be published during March 2016)	To track implementation of the ideal clinic principles	Reports from the Ideal Clinic Dashboard information system	**Num**: Number of fixed PHC Facilities scoring above 70% on the ideal clinic dashboard	The indicator measures self or peer assessment, and performance is reliant on accuracy of interpretation of ideal clinic data elements	Cumulative	Percentage	Quarterly	Yes	Higher percentage indicates greater level of ideal clinic principles	District Health Services and Quality Assurance Directorates

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Den: Number of Fixed PHC facilities that conducted an assessment to date in the current financial year							
Client Satisfaction Survey Rate (PHC)	The percentage of fixed Primary Health Care facilities that conducted a Patient Satisfaction survey that were satisfied with the services.	Tracks the service satisfaction of the Primary Health Care users	Patient Satisfaction Survey forms from Clinics	**Num:** Total number of Fixed PHC Health facilities that conducted a Patient Satisfaction Survey to date in the current financial year **Den:** Total number of Fixed PHC facilities	Availability of the report	Quality	Percentage	Quarterly	Yes	Higher percentage indicates commitment of facilities to conduct the survey	District Health Services and Quality Assurance Directorates

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Client Satisfaction Rate (PHC)	The percentage of patients whom participated in the client satisfaction survey that were satisfied with the service.	To monitor satisfaction of patients using PHC facilities	DHIS - Patient Satisfaction Module	**Num** Total number of patients satisfied with the service at PHC facilities **Den** Total number of patients that took part in a Patient Satisfaction survey at PHC facilities	Generalisability depends on the number of users participating in the survey.	Quality	Percentage	Annually	Yes	Higher percentage indicates better compliance to Batho pele principles	District Health Services and Quality Assurance
OHH registration visit coverage (Annualised)	Proportion of households in the target wards covered by Ward Based Outreach Teams	Monitors implementation of the PHC re-engineering strategy	DHIS, household registration visits registers, patient records	**Num:** OHH registration visit **Den** OHH in population	Dependent on accuracy of OHH in population	Output	Percentage	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	CBS programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Number of Districts with fully fledged District Clinical Specialist Teams (DCSTs)	Number of Districts who have DCSTs functioning with all required members, as per the Ministerial Task Team (MTT) report	Track the availability of clinical specialists in the Districts	Appointment letters per district (and/or Reports outlining activities of DCSTs)	Sum of Districts with fully fledged DCSTs	There are multiple combinations of team members that qualifies to be a fully functional team. These combinations can change in year o reporting	Input	No	Quarterly	No	Higher number indicated greater availability of clinical specialists	DHS Cluster
PHC utilisation rate	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	DHIS, Stats SA, facility register, patient records	**Num:** PHC headcount total **Den:** Population total	Dependent on the accuracy of estimated total population from StatsSA	Output	Percentage	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate underutilization of facility	Programme Manager
Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in PHC facilities	DHIS, complaints register, redress report	**Numerator** Number complaints resolved **Denominator**	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC facilities	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Total number of complaints received							
Complaint resolution within 25 working days rate	Percentage of complaints of users of PHC facilities resolved within 25 days	To monitor the management of the complaints in PHC Facilities	DHIS, complaints register, redress report	**Num** Total number of complaints resolved within 25 days **Den** Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC Facilities	Quality Assurance

SUB-PROGRAMME: COMMUNITY BASED SERVICES

DISEASE PREVENTION AND CONTROL (DPC)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Clients screened for hypertension	Measure the number of people counseled and screened for high blood pressure as part of	Counseling and screening increases early detection and treatment before complications	Facility Register	Sum of Clients screened for hypertension	The new data collection tools may not exist all facilities	output	Sum	Quarterly	No	Greater number of people screened for high blood pressure	CD: health Programmes

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	comprehensive health screening	set in									
Clients screened for diabetes	Measure the number of people counseled and screened for raised blood glucose levels as part of comprehensive health screening	Counseling and screening increases early detection and treatment before complications set in	Facility Register	Sum of people counseled and screened for raised blood glucose levels	The new data collection tools may not exist all facilities	output	Sum	Quarterly	No	Greater number of people screened for raised blood glucose levels	CD: health Programmes
Clients screened for Mental Health	Measures proportion of population screened for mental disorders	Monitored to increase early detection	Facility Register	PHC Client screened for mental disorders	The new data collection tools may not exist all facilities	Output	Percentage	Quarterly	No	Greater number of for mental disorders	CD: health Programmes
Cataract Surgery Rate	Clients who had cataract surgery per 1 million uninsured population	Monitors access to cataract surgery (preventing disability through blindness)	Numerator: Facility Register Denominator: DHIS based on StatsSA proportions	**Numerator:** Total number of Cataract surgeries completed **Denominator** Uninsured population	Accuracy dependent on quality of data from health facilities	Output	Rate	Quarterly	No	1 500 operations per million un-insured population	CD NCD

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	<Province to indicate the reporting system used to collect this information>	**Numerator:** Deaths from malaria **Denominator** Total number of Malaria cases reported	Accuracy dependent on quality of data from health facilities	Outcome	Rate	Quarterly	No	Lower percentage indicates a decreasing burden of malaria	Communicable Diseases

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Total adults remaining on ART	Adults remaining on ART	Track the number of adults on ARV Treatment	Facility Register	SUM [Total adults remaining on ART at end of the reporting period] SUM Clients remaining on ART equals [Naive (including PEP and PMTCT) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + Lost to follow-up (LTF) + Transfer out (TFO)]	None	Input	Cumulative total	Quarterly	Yes	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Total children remaining on ART	Total children (under 15 years) remaining on ART - total	Track the number of children on ARV Treatment	Facility Register	SUM [Total children under 15 years remaining on ART at end of the reporting period] SUM Clients remaining on ART equals [Naive (including PEP and PMTCT) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + Lost to follow-up (LTF) + Transfer out (TFO)]	None	Input	Cumulative total	Quarterly	Yes	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
TB/HIV co-infected client on ART rate	TB/HIV co-infected clients on ART as a proportion of HIV positive TB clients	All eligible co-infected clients must be on ART to reduce mortality. Monitors ART initiation for TB clients	Facility Register	Num: Total number of registered HIV+TB patients on ART **Den**: Total number of registered HIV+TB patients	Availability of data in ETR.net, TB register, patient records	Outcome	Percentage	Quarterly	No	Higher proportion of TB/HIV co-infected on ART treatment will reduce co-infection rates	TB/HIV manager
Client tested for HIV (incl ANC)	HIV Tests (15 Years and older)	Monitors annual testing of persons 15 years and older	Facility Register	Sum of: HIV test child 19-59 months - HIV test child 5-14 years - HIV test client 15-49 years (excl ANC)	Dependent on the accuracy of facility register	Process	Percentage	Quarterly	No	Higher percentage indicates increased population knowing their HIV status.	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				- HIV test client 50 years and older (excl ANC) - Antenatal client HIV 1st test - Antenatal client HIV re-test)							
Male Condoms Distributed	Total number of Male condoms supplied distributed	Tracks the supply of male condoms in the Province	Num Facility Register Or Den StatsSA	**Numerator:** Total number of Male condoms distributed in the province **Denominator:** Male Population 15 years and older	None	Process	Number	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in the province	HIV/AIDS Cluster
Medical Male Circumcisions conducted	Total number of Medical Male Circumcisions (MMCs) conducted	Tracks the number of the MMCs conducted	Facility Register	Total number of Medical Male Circumcisions (MMCs) conducted	None	Output	Sum	Quarterly	No	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
TB client 5 years and older screened at health facilities for TB symptoms rate	Patients 5 years and older screened in health facilities for TB symptoms rate	To determine whether all persons attending health facilities are screened for TB	Facility Register	**Numerator:** Patients over 5 screened for TB **Denominator:** Headcount of those over 5 not attending TB treatment	- Accuracy dependent on quality of data from reporting facility	Output	Rate	Annually	No	Higher	TB Programme Manager
TB client treatment success rate	Proportion TB patients (ALL types of TB) cured or those who completed treatment	Monitors success of TB treatment for ALL types of TB	Facility Register	**Numerator**: SUM [TB client cured OR **completed treatment]** **Denominator:** SUM [TB client (new pulmonary) initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	Yes	Higher percentage suggests better treatment success rate.	TB Programme Manager
TB Client loss to follow up rate	Percentage of smear positive PTB cases who interrupted (defaulted) treatment	Monitor patients defaulting on TB treatment	Facility Register	**Numerator:** SUM [TB (new pulmonary) treatment defaulter] **Denominator:** SUM [TB (new pulmonary) client initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
TB Client death rate	Proportion TB patients who died during treatment period	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB.	Facility Register	**Numerator:** SUM ([TB client death during treatment]) **Denominator:** SUM([TB (new pulmonary) client initiated on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Annually	Yes	Lower levels of death desired	TB Programme Manager
TB MDR confirmed treatment initiation rate	TB MDR confirmed clients started on treatment as a proportion of TB MDR confirmed clients	Monitors initial loss to follow up and the effectiveness of linkage to TB care strategies	Facility Register	**Num:** TB MDR confirmed client start on treatment **Den:** TB MDR confirmed client	Accuracy dependent on quality of data from reporting facility	Output	Percentage	Annually	No	Higher proportion of TB MDR clients started improve health outcomes of TB MDR client	TB Programme Manager
TB MDR treatment success rate	TB MDR client successfully treated	Monitors success of MDR TB treatment	NHLS and Facility Register	**Numerator:** SUM ([TB MDR client successfully treated]) **Denominator:** SUM ([TB MDR confirmed client initiated on treatment])	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Annually	Yes	Higher percentage indicates a better treatment rate	TB Programme Manager

SUB-PROGRAMME: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Tracks proportion of pregnant women that presented at a health facility within the first 20 weeks of pregnancy	Facility Register	**Numerator:** Antenatal 1st visit before 20 weeks **Denominator:** Antenatal 1st visit total	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Tracks proportion of mothers that received postnatal care within 6 days from giving birth	Facility Register	**Numerator:** Mother postnatal visit within 6 days after delivery **Denominator:** Delivery in facility total	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
Antenatal client initiated on **A**RT rate	Percentage of HIV positive Antenatal clients placed on ART.	Tracks the HIV Treatment policy	Facility Register	**Num:** Antenatal client start on ART **Den:** Antenatal client eligible for ART initiation	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment	MNCWH programme manager

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Infant 1st PCR test positive around 10 weeks rate	Infants PCR tested for the first time around 10 weeks after birth as proportion of live births to HIV positive women	This indicator is used to measure mother to child transmission rate	Facility Register	**Numerator:** SUM [Infant 1st PCR test positive around 10 weeks **Denominator:** SUM [Live birth to HIV positive woman]	Accuracy dependent on quality of data submitted health facilities	Output	Rate	Quarterly	No	Lower percentage indicates fewer infants received HIV from their mothers	PMTCT Programme
Immunisation coverage under 1 year (Annualised)	Percentage children under 1 year who completed their primary course of immunisation The child should only be counted ONCE as fully immunised when receiving the last vaccine in the course (usually the 1st measles and PCV3 vaccines) AND if there is documented proof of all required vaccines (BCG, OPV1, DTaP-IPV/Hib 1, 2, 3,	Monitor the implementation of Extended Programme in Immunisation (EPI)	Facility Register Denominator: StatsSA	**Numerator:** SUM([Immunised fully under 1 year new]) **Denominator:** SUM([Female under 1 year]) + SUM([Male under 1 year])	Reliant on under 1 population estimates from StatsSA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered.)	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	HepB 1, 2, 3, PCV 1,2,3, RV 1,2 and measles 1) on the Road to Health Card/Booklet AND the child is under 1 year old										
Measles 2nd dose coverage	Measles 2nd dose coverage	Monitors protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	Facility Register Den StatsSA	**Numerator:** SUM([Measles 2nd dose]) **Denominator:** SUM([Female 1 year]) + SUM([Male 1 year])	Accuracy dependent on quality of data submitted health facilities	Output	Percent	Quarterly	No	Higher coverage rate indicate greater protection against measles	EPI

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
DTaP-IPV/Hepb 3 - Measles 1st dose drop-out rate	DTaP-IPV/ Heb3 to Measles1st dose drop-out	Monitors children who drop out of the vaccination program after 14 week vaccination.	Facility Register	**Numerator:** SUM([DTaP-IPV/Hib 3rd dose]) - SUM([Measles 1st dose under 1 year]) **Denominator:** SUM([DTaP-IPV/Hib 3rd dose])	Accuracy dependent on quality of data submitted health facilities	Outcome	Percent	Quarterly	No	Lower dropout rate indicates better vaccine coverage	EPI
Infant exclusively breastfed at HepB 3rd dose rate	Percentage of Infants exclusively breastfed at HepB 3rd dose rate	Monitor Exclusive breastfeeding	Facility Register	**Numerator:** SUM([Infants exclusively breastfed at HepB 3rd dose]) **Denominator:** SUM([HepB 3rd dose])	Reliant on honest response from mother; and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	Yes	Higher percentage indicate better exclusive breastfeeding rate	Cluster: Child Health

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Child under 5 years diarrhoea case fatality rate	Proportion of children under 5 years admitted into any public health facility with diarrhoea who died	Monitors treatment outcome for children under 5 years who were admitted with diarrhoea. Include under 1 year diarrhoea deaths	Facility Register	**Numerator:** SUM [Child under 5 years with diarrhoea death] **Denominator:** SUM [Child under 5 years with Diarrhoea admitted]	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted to health facilities	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager
Child under 5 years pneumonia case fatality rate	Proportion of children under 5 years admitted into any public health facility with pneumonia who died	Monitors treatment outcome for children under 5 years who were admitted with pneumonia. Include under 1 year diarrhoea deaths	Facility Register	**Numerator:** SUM [Child under 5 years with pneumonia death] **Denominator:** SUM [Child under 5 years with pneumonia admitted]	Reliant on accuracy of diagnosis / cause of death; Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Child under 5 years severe acute malnutrition case fatality rate	Proportion of children under 5 years admitted into any public health facility with severe acute malnutrition who died	Monitors treatment outcome for children under 5 years who were admitted with severe acute malnutrition. Includes under 1 year severe acute malnutrition deaths	Facility Register	**Numerator:** SUM [Child under 5 years severe acute malnutrition deaths] **Denominator:** SUM [Children under 5 years severe acute malnutrition admitted]	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
School Grade 1 screening coverage (annualised)	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Numerator: Facility Register Denominator: Report from Department of Basic Education	**Numerator:** SUM [School Grade 1 - learners screened} **Denominator:** SUM [School Grade 1 - learners total]	None	Process	Percentage	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
School Grade 8 screening coverage (annualised)	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Num Facility Register Den Report from Department of Basic Education	**Numerator:** SUM [School Grade 8 - learners screened] **Denominator:** SUM [School Grade 8 - learners total]	None	Process	Percentage	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
Couple Year Protection Rate	Women protected against pregnancy by using modern contraceptive methods, including sterilizations, as proportion of female population 15-44 year. Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) +	Track the extent of the use of contraception (any method) amongst women of child bearing age	**Num** Facility Register **Den** StatsSA	**Numerator** (SUM([Oral pill cycle]) / 13) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4) + (SUM([Male condoms distributed]) / 200) + (SUM([Sterilisation - male]) * 20) + (SUM([Sterilisation - female]) * 10) +Sub-dermal implants X3	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	Health Information, Epidemiology and Research Programme MCWH&N Programme

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	(Norethisterone enanthate injection / 6) + (IUCD x 4) +)Male condoms distributed / 200) + (Male sterilization x 20) + (Female sterilization x 10)s			**Denominator:** SUM {[Female 15-44 years]} + SUM{[Female 45-49 years]}							
Cervical cancer screening coverage (annualised)	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older.	Monitors implementation of policy on cervical screening	**Num** Facility Register **Den** StatsSA	**Numerator:** SUM([Cervical cancer screening 30 years and older]) **Denominator:** (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10	Reliant on population estimates from StatsSA, and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
HPV 1st dose coverage	Proportion of grade 4 girl learners ≥ 9 years vaccinated per year with the 1st dose of the HPV vaccine during 2016 Calendar year	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system Denominator: Report from Department of Basic Education	**Numerator:** Girls 9 years and older that received HPV 1st dose **Denominator:** Grade 4 girl learners ≥ 9 years during 2016	None	Output	Percentage annualised	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager
HPV 2nd dose coverage	Proportion of grade 4 girl learners ≥ 9 years vaccinated per year with the 2nd dose of the HPV vaccine during 2016, and First round 2017	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system Denominator: Report from Department of Basic Education	Numerator: Girls 9 years and older that received HPV 2nd dose Denominator: Grade 4 girl learners ≥ 9 years	None	Output	Percentage annualised	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Vitamin A dose 12-59 months coverage (Annualised)	Proportion of children 12-59 months who received vitamin A 200,000 units, preferably every six months	Monitors vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year	DHIS, facility registers, patient records	**Num:** Vitamin A dose 12-59 months **Den:** Population 12-59 months*2		Output	Percentage	Quarterly	No	Higher proportion of children 12-29 months who received Vit A will increase health	MNCWH Programme Manager
Maternal mortality in facility ratio (Annualised)	Women who died in hospital as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, per 100,000 live births in facility	This is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys. Focuses on obstetric causes	DHIS, facility registers, patient records	**Num:** Maternal death in facility **Den:** Live birth in facility	Quality of reporting	Impact	Ratio per 1000 live births	Annually	No	Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care	MNCWH Programme Manager

indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Inpatient early neonatal death rate	Proportion of children 28 days admitted/separated who died during their stay in the facility as a proportion of Live birth in facility	Monitors treatment outcome for admitted children under 28 days	DHIS, facility registers, patient records	**Num:** Inpatient death early neonatal **Den:** Live birth in facility	Quality of reporting	Impact	Rate per 1000	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

PERFORMANCE INDICATORS FOR HOSPITALS (ALL LEVELS):

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	**Num:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year **Den:** Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitors whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	**Num:**Number of Hospitals that developed a Quality improvement plan to date in the current financial yea ***Den:***Number of Hospitals that conducted National Core Standards self-*assessment to date in the current financial year*	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
Percentage of health facilities compliant with all extreme and vital measures of the national core standards	Percentage of ~~s~~ health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report,	**Num:** Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				measures of national core standards **Den:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year						Standards	
Client Satisfaction Survey Rate (Hospitals)	The percentage of hospitals that conducted a Patient Satisfaction survey that were satisfied with the services	Tracks the service satisfaction of the hospitals users	Patient Satisfaction Survey forms from hospitals	***Num:*** Total number of hospitals that conducted a Patient Satisfaction Survey to date in the current financial year **Den:** Total number of hospitals	Availability of the report	Quality	Percentage	Quarterly	Yes	Higher percentage indicates commitment of hospitals to conduct the survey	District Health Services and Quality Assurance Directorates

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Client Satisfaction Rate (hospitals)	The percentage of patients whom participated in the client satisfaction survey that were satisfied with the service	To monitor satisfaction of patients using hospitals	DHIS - Patient Satisfaction Module	**Numerator:** Total number of patients satisfied with the service at hospitals **Denominator** Total number of patients that took part in a Patient Satisfaction survey at hospitals	Generalisability depends on the number of users participating in the survey	Quality	Percentage	Annually	Yes	Higher percentage indicates better compliance to Batho pele principles	District Health Services and Quality Assurance
Average Length of Stay	Average number of patient days that an admitted patient in the district hospital before separation.	To monitor the efficiency of the district hospital	DHIS, facility register & Admission	Numerator Inpatient days + 1/2 Day patients Denominator Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Inpatient Bed Utilisation Rate	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of district hospital beds	DHIS, facility register Admission	**Num:** Inpatient days + 1/2 Day patients **Den:** Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services
Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All	Track the expenditure per PDE in district hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	**Numerator** Total Expenditure in district hospitals **Denominator** Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	hospital activity expressed as a equivalent to one inpatient day										
Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	**Numerator** Number complaints resolved **Denominator** Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	**Numerator** Total number of complaints resolved within 25 days **Denominator** Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
EMS P1 urban response under 15 minutes rate	Proportion P1 calls in urban locations with response times under 15 minutes	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 15 minutes in urban areas	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	**Num:** EMS P1 urban response under 15 minutes **Den:** EMS P1 urban calls	Cumulative	Input	Rate per 10 000 population	Quarterly	No	Higher number of rostered ambulances may lead to faster response time ~~her~~	EMS Manager
EMS P1 rural response under 40 minutes rate	Proportion P1 calls in rural locations with response times under 40 minutes	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 40 minutes in rural areas	DHIS, institutional EMS registers Patient and vehicle report.	**Num:** EMS P1 rural response under 40 minutes **Den:** EMS P1 rural calls	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
3.6.3 EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses	DHIS, institutional EMS registers Patient and vehicle report	**Numerator** EMS inter-facility transfer **Denominator** EMS clients total	Accuracy dependent on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists at the appropriate level of care	EMS Manager

PROGRAMME 6: PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Number of Bursaries awarded for first year medicine students	Number of new medicine students provided with bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	Bursary contracts	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	no	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager
Number of Bursaries awarded for first year nursing students	Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	SANC Registration form	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager

PROGRAMME 8: INFRASTRUCTURE NORMS AND STANDARDS

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

Indicator Name	**Short Definition**	**Purpose /Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsibility**
	Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).		project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).								
Establish service level agreements (SLAs) with Department of Public Works (and any other Implementing Agent)	A service level agreement (SLA) / Service Delivery Agreement (SDA) was established with Public Works (and any other Implementing Agent).	To strengthen partnerships with Public Works (and any other Implementing Agent) to accelerate infrastructure delivery by means of formalising an SLA (SDA) and ensuring accountability by all relevant role players.	Service level agreement / Service Delivery Agreement	Service level agreement (SLA) / Service Delivery Agreement (SDA) established with WCG: Transport and Public Works (and any other Implementing Agent)	Availability of documentation to prove a Service Level Agreement / Service Delivery Agreement has been established.	Process	Compliance	Annual	No	A Service Level Agreement / Service Delivery Agreement was established with WCG: Transport and Public Works (and any other Implementing Agent) which should lead to accelerated infrastructure delivery.	Chief Director: Infrastructure and Technical Management

ANNEXURE E: PROVINCIAL PERFORMANCE INDICATORS DEFINITIONS

PROGRAMME 1: ADMINISTRATION

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of hospitals implementing Lean Management System	Number of hospitals with Lean Management System implemented	Monitor compliance to standards.	Lean management reporting tool	Sum total of all hospitals with Lean Management System implemented.	It is subjective	Process	Number	Quarterly	No	Improved quality and efficiency of health care service provision	QA Manager
Number of clinics implementing Lean Management System	Number of clinics with Lean Management System implemented	Monitor compliance to standards.	Lean management reporting tool	Sum total of all clinics with Lean Management System implemented.	It is subjective	Process	Number	Quarterly	Yes	Improved quality and efficiency of health care service provision	QA Manager
Number of m-health applications developed	Number of m-health applications developed in the Province	Increase electronic access to health services through mobile applications	ICT reports	Sum of m-health applications developed in the Province	It is subjective	input	Number	Annual	No	A higher number indicates the level of accessibility to health services	ICT Manager
Number of hospitals with PACS	Hospitals with Picture Archiving Communication System (PACS) implemented	Enables x-ray and scan images to be stored electronically and viewed on screens	Hospital records	Sum of total hospitals with PACS	Accuracy dependent on the quality of data from reporting facility	Efficiency	Number	Annual	No	High number will improve access and diagnosis methods	ICT Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Rand value of revenue collected	The total amount of revenue collected from patient fees as at 31 March	Monitor revenue collected from patient fees	BAS	Sum of total revenue collected from patient fees	Accuracy dependent on the quality of BAS data at end of reporting period	Input	Number (Rand)	Quarterly	No	High amount indicates quality and efficiency of health care service provision	Finance Manager
% of women in senior management posts	The number of women in senior management as a percentage of the total number of positions. Senior positions start from level13 to level16	Tracks the implementation of strategies to achieve employment equity and to manage a diverse work force	Personnel Salary System (PERSAL)	**Numerator** Total Number of funded vacant senior women management posts on 31 March/ funded vacant post for people with disabilities on 31st March **Denominator** Total number of senior management posts / total post in the province	Dependent on accuracy of and completeness of Persal data at end of the reporting period	Process	Percentage	Quarterly	No	A higher the percentage indicates the level of commitment and compliance to the goals of Employment Equity	HRM Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
% of people with disabilities employed	The number of people with disabilities employed	Tracks the implementation of strategies to achieve employment equity and to manage a diverse work force	Personnel Salary System (PERSAL)	**Numerator** Total number people with disabilities employed on 31st March **Denominator** Total post in the province	Dependent on accuracy of and completeness of Persal data at end of the reporting period	Process	Percentage	Quarterly	No	A higher the percentage indicates the level of commitment and compliance to the goals of Employment Equity	HRM Manager
Percentage of newly appointed staff members with verified qualifications	Total number of newly appointed staff members with verified qualifications as percentage of all newly appointed staff members	Track the validity of qualification for newly appointed employee	Human resource records	**Numerator** Total newly appointed staff members as with verified qualifications **Denominator** Total newly appointed staff members	Dependent on accuracy of and completeness of qualifications records from employees and training institutions	Process	Percentage	Quarterly	No	A higher the percentage indicates the level of qualifications compliance by employees	HRM Manager
Percentage of grievances cases resolved within 30 days	Total number of grievances cases resolved within 30 days as a percentage of all total grievances cases resolved	Tracks turnaround time for resolving grievances	Human resource records	**Numerator** Total grievances cases resolved within 30 days **Denominator** Total grievances cases resolved	Accuracy dependent on the quality of data from reporting facility	Process	Percentage	Quarterly	No	A higher the percentage indicates the levels of compliance	HRM Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of misconduct cases resolved within 90 days	Total number of misconduct cases resolved within 90 days as a percentage of all misconduct cases resolved	Tracks turnaround time for resolving misconduct	Human resource records	**Numerator** Total misconduct cases resolved within 90 days **Denominator** Total misconduct cases resolved	Accuracy dependent on the quality of data from reporting facility	Process	Percentage	Quarterly	No	A higher the percentage indicates the levels of compliance	HRM Manager
Percentage of precautionary suspensions uplifted within 60 days	Percentage of precautionary suspensions uplifted within 60 days as a percentage of total number of precautionary suspensions uplifted	Tracks turnaround time for lifting precautionary suspensions	Human resource records	**Numerator** Total precautionary suspensions uplifted within 60 days **Denominator** Total precautionary suspensions uplifted within 60 days	Accuracy dependent on the quality of data from reporting facility	Process	Percentage	Quarterly	No	A higher the percentage indicates the levels of compliance	HRM Manager
PROGRAMME 2: DISTRICT HEALTH SERVICES											
Number of CHCs providing 24hrs access	Total number of CHCs with 24 hour access	Measures the number of Community Health Centres that provide 24 hour service	DHS standardised reporting tool	Sum of total CHCs opened 24 hours	Accuracy dependent on the quality of data from reporting facility	Output	Number	Quarterly	No	Increased accessibility of health services to communities	DHS Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of fully fledged functional WBPOTs	Outreach households registered by Ward Based Outreach Teams as a proportion of OHH in population. The population will be divided by 12 in the formula to make provision for annualisation	Monitors implementation of the PHC re-engineering strategy	DHIS	Sum of total fully fledged functional WBPOTs	Accuracy dependent on the quality of data from reporting community health worker and households	Output	Number	Quarterly	No	Increased accessibility of health services to communities	DHS Manager
Number of PHC facilities with integrated mental health services	The total number of PHC facilities implementing mental health services as part of PHC services	Monitors integration of mental health services to PHC to improve accessibility and quality of service	DHIS	Sum of total PHC facilities implementing mental health services as part of PHC services	Accuracy dependent on the quality of data from reporting facilities	Output	Number	Quarterly	No	Increased accessibility of mental health services to communities	DHS Manager
Transmission rate from mother to child	The percentage of the babies who contracted HIV from their mothers during pregnancy, delivery or breast feeding	Monitors babies infected with HIV and start them on treatment immediately	DHIS & facility registers	**Numerator:** HIV PCR tests positive of the babies born to HIV positive women **Denominator** PCR test done to babies born of HIV positive woman	Babies coming to the clinics at times are not easily identified that they are born of HIV positive mothers	Evaluation	Number of babies tested only up to 17 months	Quarterly	No	At least 95% of the babies on PMTCT programme should not get HIV from their mothers	PMTCT manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Female condom distribution Rate (annualised)	Female condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).	Monitors distribution of female condoms for prevention of HIV and other STIs, and for contraceptive purposes. Primary distribution sites (PDS) must report to sub-districts on a monthly basis on how many female condoms were distributed to the sub-district in the reporting month	facility registers and Stats SA	**Numerator:** Female condoms distributed **Denominator** Population 15 years and older female	Accuracy dependent on the quality of data from reporting facilities and distribution sites	Process	Number	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in the province	HI/AIDS Manager
Percentage of assistive devices issued	The Proportion of assistive devices (Buggies, Prosthetics, Podiatry appliances orthotics, hearing aids, walking aids and wheelchairs etc.) issued out of all the requests for assistive devices on register	Tracks progress towards ensuring people with disabilities are issued with assistive devices to be more independent and better integrated into society	Rehabilitative Health Services record & facility registers	Numerator Sum of total new and refurbished assistive devices issued to patients (including replacements Denominator Total number of requests for assistive devices on register	Dependent on accuracy of records kept	output	Percentage	Quarterly	No	High levels increases more independency and better integration of people with disabilities into society	Rehabilitative Health Services Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
PROGRAAME 6: HEALTH SCIENCES AND TRAINING											
Number of new medical students enrolled annually on the RSA-Cuban medical	Number of new medical students enrolled annually on the RSA-Cuban medical	Tracks the numbers of medicine students enrolled annually on the RSA-Cuban medical as future health care providers	Training registers	Sum of total new medical students enrolled annually on the RSA-Cuban medical	Data quality depends on good record keeping by both the Provincial, DoH and Cuban Medical Register	input	Number	Annual	No	Higher numbers of medical students on the RSA-Cuban medical are desired, as this has the potential to increase future health care providers	HRD Manager
Percentage of hospital CEOs trained	Total number of Hospital CEOs received trained as a percentage of total CEOs	Improve management and leadership competency in hospitals	Training registers	**Numerator** Total Hospital CEOs trained **Denominator** Total hospital CEOs	Accuracy dependent on quality of data from reporting institutions	Output	Percentage	Annual	Yes	Higher percentage of CEOs trained as this has the potential to improve service delivery	HRD manager
Percentage of PHC facility managers trained	Total number of Hospital PHC Facility Managers received trained as a percentage of total PHC facility managers	Improve management and leadership competency in PHC facilities	Training registers	Numerator Total PHC facility managers trained **Denominator** Total PHC facility managers	Accuracy dependent on quality of data from reporting PHC facilities	Output	Percentage	Annual	Yes	Higher percentage of facility managers trained as this has the potential to improve service delivery	HRD manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of employees trained on 'code-of-conduct'	Percentage of all staff trained on code of conduct in all institutions	Improve accountability and decrease fraud and corruption	Training registers	**Numerator** Total staff trained **Denominator** Total number of staff in the department	Accuracy dependent on quality of data from reporting institutions (including district and central offices)	Output	Percentage	Quarterly	Yes	Higher percentage of staff trained has a potential to enhance accountability and reduce fraud and corruption	HRD manager
Employee satisfaction rate	The percentage of employees who participated in the employee satisfaction survey who were satisfied with the work environment	Determine staff morale with the view to improve staff morale in the department	Survey reports	**Numerator** Total number of employees satisfied with the service in the Department **Denominator** Total number of employees that took part in a patient satisfaction at PHC facilities	Generalisability depends on the number of employees participating in the survey	Outcome	Percentage	Annual	No	Higher percentage indicates commitment of department to conduct the survey	HR manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	PROGRAMME 7: HEALTH CARE SUPPORT SERVICES										
Percentage of linen contracts awarded to women cooperatives	Percentage of linen contracts awarded to women cooperatives against the total linen contracts awarded	Tracks how the department is contributing towards women cooperatives in the province	BAS / financial records	Numerator Total linen contracts awarded to women cooperatives Denominator Total contracts awarded	Data quality is reliant on accurate tendering processes, contracts, invoices and is subjective as it depends on the honesty of vendors (fronting issues etc.)	Process	Percentage	Quarterly	No	High score indicates increased contributing towards women empowerment in the province	Supply Chain Management Manager
Percentage of hospital procuring/buying vegetables from local farmers	Number of hospital procuring/buying vegetables from local farmers against Total hospitals	Monitors localised industrialisation and procurement strategy in the province	BAS / financial records	Numerator Total hospital procuring/buying vegetables from local farmers Denominator Total hospitals	Data quality is reliant on accurate tendering processes, contracts, invoices and is subjective as it depends on the honesty of vendors (fronting issues etc.)	output	Percentage	Quarterly	No	High number indicates Increased levels of localised procurement	Supply Chain Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of hospital procuring/buying dairy products from local farmers	Number of hospital procuring/buying dairy products from local farmers against Total hospitals	Monitors localised industrialisation and procurement strategy in the province	BAS / financial records	Numerator Total hospital procuring/buying dairy products from local farmers Denominator Total hospitals	Data quality is reliant on accurate tendering processes, contracts, invoices and is subjective as it depends on the honesty of vendors (fronting issues etc.)	output	Percentage	Quarterly	No	High number indicates Increased levels of localised procurement	Supply Chain Manager
Percentage of hospital procuring/buying bread from small medium scale Bakeries	Number of hospital procuring/buying bread from small medium scale Bakeries against total hospitals	Monitors localised industrialisation and procurement strategy in the province	BAS / financial records	**Numerator** Total hospital procuring/buying bread from small medium scale Bakeries **Denominator** Total hospitals	Data quality is reliant on accurate tendering processes, contracts, invoices and is subjective as it depends on the honesty of vendors (fronting issues etc.)	output	Percentage	Quarterly	No	High number indicates Increased levels of localised procurement	Supply Chain Management Manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage health institutions with electronic SCM system	Total health institutions with electronic SCM system as percentage of total health institutions	Monitors the implementation of electronic SCM system	BAS / financial records	Total health institutions with electronic SCM system	Total health institutions	Output	Percentage	Quarterly	No	High number indicates Increased implementation at institution level	Supply Chain Management Manager
Percentage of EML available at facilities	The percentage of available drugs in the essential medicines list	Tracks the availability of medicines in facilities	MEDSAS	**Numerator** Total number of available medicines **Denominator** Total essential medicine list x100	Reliant on accurate inventory and correct stock levels,	Process	Percentage	Quarterly		The availability of medicine in facilities measures the ability of the district health system to function effectively and efficiently in delivering the PHC mandate	MSD manager
Percentage of essential medicine availability at health facilities	The percentage of available drugs in the essential medicines list	Tracks the availability of medicines in facilities	MEDSAS	**Numerator** Total number of available medicines **Denominator** Total essential medicine list x100	Reliant on accurate inventory and correct stock levels	Process	Percentage	Quarterly	No	The availability of medicine in facilities measures the ability of the district health system to function effectively and efficiently in delivering the PHC mandate	MSD manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of vital medicine availability at health facilities	Total drugs available in the vital medicines list against total vital medicine list	Tracks the availability of medicines in facilities	MEDSAS	**Numerator** Total number of vital medicine available **Denominator** Total vital medicine list x100	Reliant on accurate inventory and correct stock levels,	Process	Percentage	Quarterly	No	The availability of medicine in facilities measures the ability of the district health system to function effectively and efficiently in delivering the PHC mandate	MSD manager
Number of patients enrolled on centralized chronic medicine dispensing and distribution programme	Number of patients enrolled on centralized chronic medicine dispensing and distribution programme	Track patients enrolled on centralized chronic medicine dispensing and distribution programme	DHS standardised reporting too MEDSAS	Sum total of patients enrolled on centralized chronic medicine dispensing and distribution programme	Accuracy dependent on the quality of data from reporting facility	Output	Number	Quarterly	No	Higher number indicates increased level of accessibility PHC level	District Manager
Number of patients registered with remote automated dispensing unit	Total number of patients registered with remote automated dispensing unit	Track patients registered with remote automated dispensing unit	Pharm records	Sum of total patients registered with remote automated dispensing unit	Accuracy dependent on the quality of data from reporting facility	Output	Number	Quarterly	No	Higher number indicates increased level of accessibility PHC level	Pharmacy manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Percentage of genexpert results available within 48 hours	Genexpert tests completed with turnaround time of less than 48 hours	Monitors time taken to complete Genexpert tests within 48 hours	Pharm records	**Numerator** Geneexpert specimens with turnaround time less than 48 hours **Denominator** All geneexpert specimens	Accuracy dependent on the quality of data from laboratory	Efficiency	Percentage	Quarterly	No	Higher number indicates increased efficiency levels at laboratories and facilities	Pharmacy manager
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT											
Proportion of Programme 8 budget spent on maintenance (preventative and scheduled)	Total Programme 8 budget spent on maintenance (preventative and scheduled) as proportion of total programme 8 budget	Track maintenance expenditure for Programme 8	BAS/ Finance records	**Numerator** Total Programme 8 budget spent on maintenance (preventative and scheduled) **Denominator** Total programme 8 budget	Accuracy dependent on the quality of data from reporting facilities	inputs	Percentage	Quarterly	No	Higher number indicates increased access to health facilities	Health facilities manager
Number of additional clinics and community health centres constructed	Total additional clinics and community health centres constructed by end of March	Monitor the construction of clinics and community health centres	DID & Facility management records	Sum of total additional clinics and community health centres constructed	Accuracy dependent on the quality of data from reporting facilities and DID	Output	Number	Annual	No	Higher number indicates increased access to health facilities	Health facilities manager

Indicator Title	Short Definition	Purpose/ Importance	Source	Method of Calculation	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Number of additional hospitals constructed or revitalised	Total additional hospitals constructed or revitalised by end of March 2015	Monitor the construction of additional hospitals	DID & Facility management records	Sum of total additional hospitals constructed by end of March	Accuracy dependent on the quality of data from reporting facilities and DID	Output	Number	Annual	No	Higher number indicates increased access to health facilities	Health facilities manager
Percentage of capital work projects finished on time	Total number of capital work projects completed on time as a percentage of total projects completed by end of March	Track completion of capital work projects turnaround time	DID & Facility management records	Sum of total capital work projects completed on time	Accuracy dependent on the quality of data from reporting facilities and DID	Process	Number	Annual	No	Higher number indicates increased access to health facilities	Health facilities manager