LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF

HEALTH

VOTE 7

ANNUAL PERFORMANCE PLAN 2017/18

The heartland of Southern Africa - *development is about people*

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FOREWORD BY THE MEC FOR HEALTH

MEC for Health
Dr P.C. Ramathuba

This year marks 21 years since the first Cuban doctors touched the South African soil as part of the South Africa-Cuba Health Cooperative Agreement. This year also the country celebrates 23 years of democracy and the African National Congress (ANC) will go for its 54th National Conference in December. This year marks the 23rd commemoration of the passing of former South African Communist Party General Secretary Martin Thembisile "Chris" Hani.

The year 2017 is the fourth year after the adoption of the National Development Plan in which Outcome 2 highlights a "Long and healthy life for all South Africans".

The Departmental Annual Performance Plan (APP) is informed by the Departmental five-year Strategic Plan which is derived from the Medium Term Strategic Framework. The objective of the APP is to link the plans, budgets and performance of the department.

Our mandate is to provide health care and emergency medical services as enshrined in Section 27 of the Bill of Rights, Public Finance Management Act (PFMA), Constitution of the Republic of South Africa, 1996. The National Health Act, No. 61, 2003 is an enabling legislation to carry out the Department's Constitutional mandate. It is upon this activity of national importance that, as a Department, we are also under obligation to review our plans annually, within the Medium Term Expenditure Framework.

From the above all-embracing planning frameworks, the subsequent key interventions that will be prioritized in this financial year are as follows:

- To re-engineer Primary Health Care (PHC) to improve access.
- To implement Ideal Clinic model across Primary Health Care (PHC) facilities in all the districts.
- To reduce maternal and child mortality.
- To improve tuberculosis prevention and cure.
- Reduce the prevalence of non -communicable diseases.
- To improve HIV, AIDS and STI care and management.
- To strengthen National Health Insurance (NHI) implementation at the pilot district.
- To improve access to Emergency Medical Services.
- To improve health Infrastructure.
- To improve health management and leadership.
- To improve human resources training and development.
- To have an upgraded ICT infrastructure and an enterprise architecture and ICT architecture designed and aligned to one another.

Regardless of the challenges faced by the Health Sector in Limpopo, the Department achieved the following amongst others:

- Life expectancy in Limpopo has improved.
- Improved and strengthened management of the department including at facility level
- The Maternal mortality ratio has reduced.
- The Medicine availability has improved in all facilities.

In addressing the health sector priorities, the Department of Health 2017/18 Annual Performance Plans has managed to prioritise the National Development Plan (NDP) outcomes, which will ultimately provide a long and healthy lifestyle to the people of Limpopo. I therefore endorse this 2017/18 Annual Performance Plan as a detailed framework for achieving the Departmental targets within the available budget.

Dr P C Ramathuba
Member of Executive Council (MEC)

STATEMENT BY THE HEAD OF DEPARTMENT (HOD)

HOD
Dr N.P. Kgaphole

The Departmental Annual Performance Plan for the 2017/18 financial year is prepared in line with the 2015/16 -2019/20 Departmental Strategic Plan and the National Development Plan is a Road Map for realizing the mission of the Department. The Annual Performance Plan is thus based on the targets we have set for ourselves in the Strategic Plan, and it is a means to provide a clear and detailed plan on what the department aspires to achieve in the 2017/18 financial year.

The Department enters the 2017/18 financial year with a clear mandate to carry out the commitments made in the Strategic Plan. In the 2017/18 Financial Year the department will see an improvement to advance service delivery guided by the NDP, MTSF, LDP, Social Cluster Programme of Action and the

The above plans are guiding documents to ensure that the Departmental outputs are achieved, and the following interventions are prioritized:

- To implement the Primary Health Care re-engineering strategy.
- To increase the percentage of PHC facilities scoring above 80% on the ideal clinic dashboard.
- To implement strategies to reduce maternal and child mortality rates.
- To implement tuberculosis prevention and cure programmes.
- To prevent and control non -communicable diseases.
- To implement HIV & AIDS and Sexually Transmitted Infections (STI) strategy.
- To implement NHI in the pilot district.
- To continue with replacement of old ambulance fleet and implement a computer aided dispatch and vehicle monitoring system.
- To improve and maintain health Infrastructure.
- To fill posts with committed competent and skilled individuals.
- To train more health professionals to meet the requirements of the reinvigorated primary health care system.
- To continue monitoring the implementation of the Medico-legal Policy and intensify integrated management of medico-legal claims.
- To sustain the rehabilitation service at hospitals and number of hospitals offering the service will be increased.
- To continue with pooling of financial resources to ensure a more equitable distribution of health technology resources through prioritization and establish five district health

technology units.

The Department will continue with the improvement and implementation of the National Health Insurance pilot project in Vhembe District. The Department is striving towards completing the process, and will improve based on the lessons learnt.

The Department has appointed District Clinical Specialist teams (DCST), established Ward Based PHC Outreach Teams (WBPHCOT), implemented integrated school health programme, drafted a Referral System Policy, drafted a plan to connect broadband in all facilities and is implementing the Ideal clinic project among others. The Department continues to implement the National Core Standards compliance assessments in preparation for accreditation towards the National Health Insurance. Through conducting these assessments, the following six ministerial priorities are expected to improve drastically:

- Cleanliness,
- Safety and security of staff and patients,
- Reducing long waiting times,
- Staff attitudes,
- Infection prevention and control and
- Addressing drug stock-outs.

Regardless of the challenges, the Department significantly achieved on various targets reported in the annual report of 2015/16. The Department envisions “A long and healthy life for people in Limpopo” through the implementation of the 2017/18 Annual Performance Plan.

The Department is confident that the limited available resources will be utilized efficiently, effectively and economically to achieve the health outputs as outlined in the 2017/18 Annual Performance Plan.

Dr NP Kgaphole
Head of Department

OFFICIAL SIGN OFF

It is hereby certified that this Annual Performance Plan:

- Was developed by the Provincial Department of Health in Limpopo;
- Was prepared in line with the current Strategic Plan of the Department of Health of Limpopo under the guidance of Dr Phophi Constance Ramathuba; and
- Accurately reflects the performance targets which the Provincial Department of Health in Limpopo will endeavour to achieve given the resources made available in the budget for 2017/18.

....	06/03/2017 ....
Mr MJ Molokwane **Strategic Planning & Policy Coordination**	**Date**
....	06/03/2017 ....
Mr MJ Mudau **Chief Financial Officer**	**Date**
....	06/03/2017 ....
Dr NP Kgaphole **Head of Department**	**Date**

APPROVED BY:

....	06/03/2017 ....
Dr PC Ramathuba **Executive Authority**	**Date**

PART A

PART A

1. STRATEGIC OVERVIEW

1.1 VISION

A long and healthy life for people in Limpopo.

1.2 MISSION

The Department is committed to provide quality health care service that is accessible, comprehensive, integrated, sustainable and affordable.

1.3 VALUES

The department adheres to the following values and ethics that uphold the Constitution of the Republic of South Africa through:

- Honesty
- Integrity
- Fairness
- Equity
- Respect
- Dignity
- Caring

1.4 STRATEGIC GOALS

National Development Plan 2030

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

By 2030, South Africa should have:

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

9. Fill posts with skilled, committed and competent individuals

Sustainable Development Goals 2030

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

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

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

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

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

Sustainable Development Goals 2030

TABLE A1. STRATEGIC GOALS

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVE STATEMENT	LINKAGE WITH MTSF 2014 – 2019
1. Universal health coverage achieved	Progressively improve the readiness of health facilities for the implementation of NHI in 2025	1.1 To re-engineer Primary health care 1.2 To improve access to quality hospital services	Expanded and re-engineered Primary Health Care, including Municipal Ward-based outreach teams and school health services Expanded District-based piloting of NHI services
2. Improved quality of Health Care	Accelerate the improvement of quality of care in the health sector through the enhancement of accountability and implementation framework by 2020	2.1 To improve access to quality hospital services 2.2 To improve access to Emergency Medical services 2.3 To prevent and control communicable and Non-Communicable Diseases (NCDs) 2.4 To provide all essential medicines 2.5 To provide rehabilitation services in facilities and communities	Improved quality of health care and reduced waiting times in the public sector, supported through the newly established Office of Health Standards Compliance and adherence to Patients Charter Promotion of healthy lifestyles and encouragement of regular screening for Non-communicable diseases
3. Primary Health Care services re-engineered	Improve the school health and community health services by 2020	3.1 To re-engineer Primary health care	Expanded and re-engineered Primary Health Care, including Municipal Ward-based outreach teams and school health services
4. Improved human resources for health	To develop a responsive health workforce by ensuring adequate training and accountability measures are in place by 2020	4.1 To improve human resources for health 4.2 To increase production for and develop human resources for health	Improved human resource for health, revitalisation of nursing colleges and expanded professional health training
5. Improved health Management and leadership	Strengthen management and leadership by improving capacity and	5.1 To provide efficient and effective financial management system	Invest in health management improvement and

STRATEGIC GOAL	GOAL STATEMENT	STRATEGIC OBJECTIVE STATEMENT	LINKAGE WITH MTSF 2014 – 2019
	mechanisms for management by 2020		leadership, including reform of the governance, funding and management of central hospitals as national referral facilities • Reduced health care costs
6. Improved health facility planning and infrastructure delivery	Improve health facility planning by implementing existing norms and standards in all districts by 2020	6.1 To improve quality of health infrastructure	Improved health facility planning and accelerated infrastructure delivery
7. HIV & AIDS and Tuberculosis prevented and successfully managed	Prevent and reduce the disease burden and TB mortality rate by 50% in 2020	7.1 To increase access to comprehensive HIV and AIDS, STIs and TB treatment, management and support	Strengthened implementation of HIV/AIDS and Tuberculosis prevention and management programmes
8. Maternal, infant and child mortality reduced	Prevent and reduce maternal and child mortality by 50% in 2020	8.1 To reduce maternal and child morbidity and mortality	• Expanded access to sexual and reproductive health by improving the availability of diverse contraception methods • Reduced unwanted pregnancies with a special focus on teenage pregnancies • Implementation of the African Union-inspired Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)
9. Efficient Health Management Information System for improved decision making	Overhaul the health information system by 2020	9.1 To improve health management information system	

Table A2. Impact indicators and targets

The Strategic Goals and Objectives must deliver against the key actions, indicators and targets reflected in the Medium Term Strategic Framework 2014-2019 (attached as annexure A) in order to reach below outcome targets committed by the health system.

Impact Indicator	South Africa Baseline (2009[1])	South Africa Baseline (2012[2])	2019 Targets (South Africa)	2012 Baseline (Province)	2019 Target (Province) (Consistent with targets with your SP 2020)
Life expectancy at birth: Total	56.5 years	60.0 years (increase of 3,5years)	63 years by March 2019 (increase of 3 years)	56 years	63 years
Life expectancy at birth: Male	54.0 years	57.2 years (increase of 3,2 years)	60.2 years by March 2019 (increase of 3 years)	55 years	60.2 years
Life expectancy at birth: Female	59.0 years	62.8 years (increase of 3,8years)	65.8 years by March 2019 (increase of 3years)	58 years	65.8 years
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)	42/1 000	20/1 000 per 1,000 live-births
Neonatal Mortality Rate	-	14 per 1000 live births	6 per 1000 live births	12.8 per 1 000 live births	6 per 1 000 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	37.9 per 1000 live births	18 per 1000 live births

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

Impact Indicator	South Africa Baseline (2009[1])	South Africa Baseline (2012[2])	2019 Targets (South Africa)	2012 Baseline (Province)	2019 Target (Province) (Consistent with targets with your SP 2020)
Child under 5 years diarrhoea case Fatality rate	-	4.2%	<2%	7.8%	2%
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	7.8%	2%
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	177.9 per 100 000 live births	95 per 100 000 live births

1.5 SITUATIONAL ANALYSIS

1.5.1 Demographic Profile

The Province of Limpopo is situated in the north of the Republic of South Africa. It shares borders with the provinces of Gauteng, Mpumalanga and North West. It also shares borders with the Republics of Mozambique in the east, Zimbabwe in the north and Botswana in the west. The province covers a land area of 125 754 km^2 with a population of 5.8 million people (Stats SA, 2016 mid-year population estimates). The population of Limpopo Province increased from 5.7 million in 2015 to 5.8 million in 2016. Limpopo Province is the fifth most populated province in the country after Gauteng, KwaZulu-Natal, Eastern Cape, and Western Cape respectively (Stats SA, 2016).

Migration is an important demographic process which shapes the age structure and distribution of the provincial population. According to Stats SA 2016 Mid-year population estimates, Limpopo Province is projected to experience an out-migration of nearly 305 030 between 2011 and 2016.

Life expectancy in South Africa (SA) has increased over time, but can only increase at a better rate provided the necessary social, health and economic policies and interventions are revitalised to take into account the changing needs of the population. The life expectancy at birth for Limpopo Province is estimated at 56.6 years for males and 64.0 years for females in 2016. SA has also witnessed a declining total fertility rate (TFR), though teenage pregnancy remains a challenge. The average total fertility rate is estimated at 2.86 in 2016, having declined from 3.16 between 2006 and 2011.

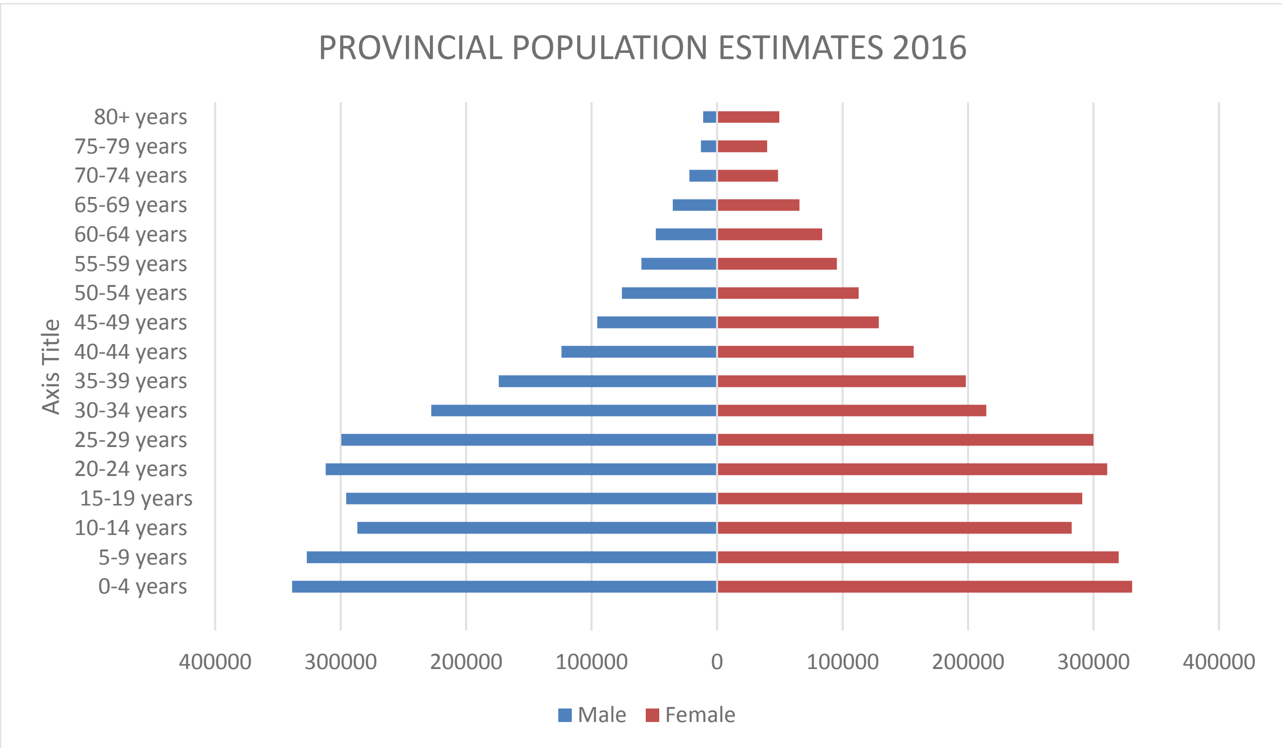
Table A3 provides the age and sex distribution of the population while Figure 1 depicts the age and sex structure (Stats SA Mid-year Population Estimates, 2015).

Table A3. Population of Limpopo Province by age and sex, 2016

Age	Male	Female	Total
0-4 years	338 759	330 784	669 542
5-9 years	327 047	320 199	647 246
10-14 years	286 627	282 543	569 169
15-19 years	295 665	290 949	586 614
20-24 years	311 825	310 968	622 794
25-29 years	299 482	300 108	599 590
30-34 years	227 774	214 535	469 309
35-39 years	174 035	198 350	372 384
40-44 years	124 120	156 811	280 931
45-49 years	95 357	128 840	224 197
50-54 years	75 763	112 738	188 501
55-59 years	60 379	95 507	155 886
60-64 years	48 797	83 887	132 684
65-69 years	35 404	65 654	101 058
70-74 years	22 097	48 580	70 678
75-79 years	12 806	39 818	52 624
80+ years	11 113	49 622	60 735
Total	2 747 049	3 056 893	5 803 941

Source: Stats SA Mid-year Population Estimates, 2016

Figure 1. Age – sex structure for Limpopo Province, 2016



Source: Stats SA Mid-year Population Estimates, 2016

Figure 1 is wider at the bottom, indicating that the population of Limpopo Province is youthful with 33,2% (1.9 million) being children under the age of 15 years. Economically active population (persons aged 15-64 years) constitute 61.6% or (3.5 million). The population of persons aged 60 years or older is increasing over time, contributing to 7.3% of the province's population. The Pyramid shows that there are significantly less males than women aged 80+ years in Limpopo Province. Females constitute more than half of the population in Limpopo Province, estimated at 52.8 % (3. 02 million).

1.5.2 Socio–Economic Profile

Approximately 80% of the population in Limpopo Province is rural based. This situation impacts on the population's capacity to acquire education, in particular, tertiary education - which influences the potential for gainful employment in the formal economic sector. The census 2011 results show that Limpopo Province has the highest proportion of people aged 20 years and older with no schooling (17.3%) compared to other provinces. The results also show that persons aged 20 years and older, who passed Grade 12 (Matric) in Limpopo Province constituted 22.7 % - a figure that is lower than 28.9% recorded for SA.

The rate of unemployment plays a key role in depicting the employment status of the labour force in SA and, to a fair extent, the functioning of the economy at large. Stats SA conducts the Quarterly Labour Force Survey (QLFS) to track employment and unemployment patterns (labour market activities) of individuals aged 15 -64 years who live in SA quarterly. Results of the 2015 third Quarter (QLFS) put the national unemployment rate at 25.5%. From a provincial perspective, the official unemployment rate increased by 2.9 percentage points from the first quarter to third quarter of 2015 (15.9% to 18.8%).

Furthermore, the Poverty Headcount using Community Survey 2016 data has shown that Limpopo Province is having the second largest poverty headcount of all provinces after Eastern Cape.

Table A4. Household indicators

Census Year	Headcount (H)	Intensity (I)
2011	10.1%	41.6%
2016	11.5%	42.3%

Source: Stats SA-Community Survey 2016

Limpopo Province poverty headcount increased from 10.1% in 2011 to 11.5% in 2016. The intensity of poverty has increased from 41.6% in 2011 to 42.3 in 2016. Sekhukhune (13.6%), Mopani (13.1%) and Vhembe district (12.8%) are the mainly affected in terms of poverty headcount as compared to Waterberg (9.0%) and Capricorn districts (8.5%). These demonstrates the acuteness of poverty the province is experiencing in particular at the three districts (Sekhukhune, Mopani and Vhembe). The hardly hit municipalities are the Greater Tubatse (27.7%), Fetakgomo (24.5%) and Makhuduthamaga (24.2%) all in Sekhukhune District. These increased poverty levels attributes to performance of indicators such as incidences of severe acute malnutrition (SAM), diarrhoea, prevalence of HIV and AIDS etc. Furthermore, these multi-dimensional factors of poverty further constrain the resources of the department in delivering services. Most importantly, these demographic changes impacts the financial resources allocated to the Limpopo Department of Health.

1.5.3 Epidemiological profile/ Burden of disease

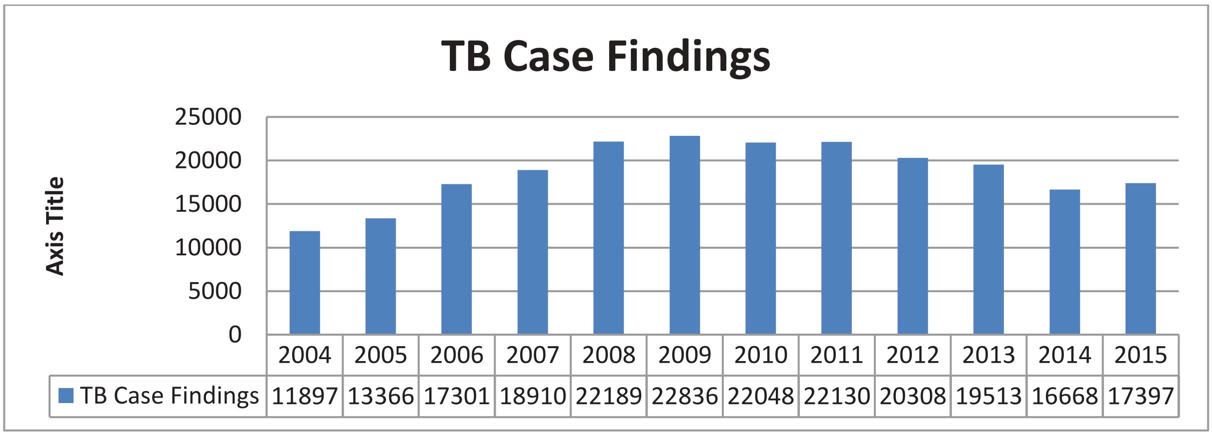
Tuberculosis and HIV

Tuberculosis is the most prevalent Notifiable Medical Condition in South Africa.

TB Case finding

In Limpopo Province, the case detection shows a steady decline of the case load from 22 189 in 2008 to 17397in 2015 (figure 2 below) which could either be a reversal of the epidemic or inadequate screening. One of the reasons for this decline is the increasing number of people with HIV who are on antiretroviral drugs (ARVs). The department is however, embarking on Intensified Case finding (ICF) through TB screening, testing and linking them to care.

Figure 2. TB Case finding in Limpopo Province, 2004 – 2015

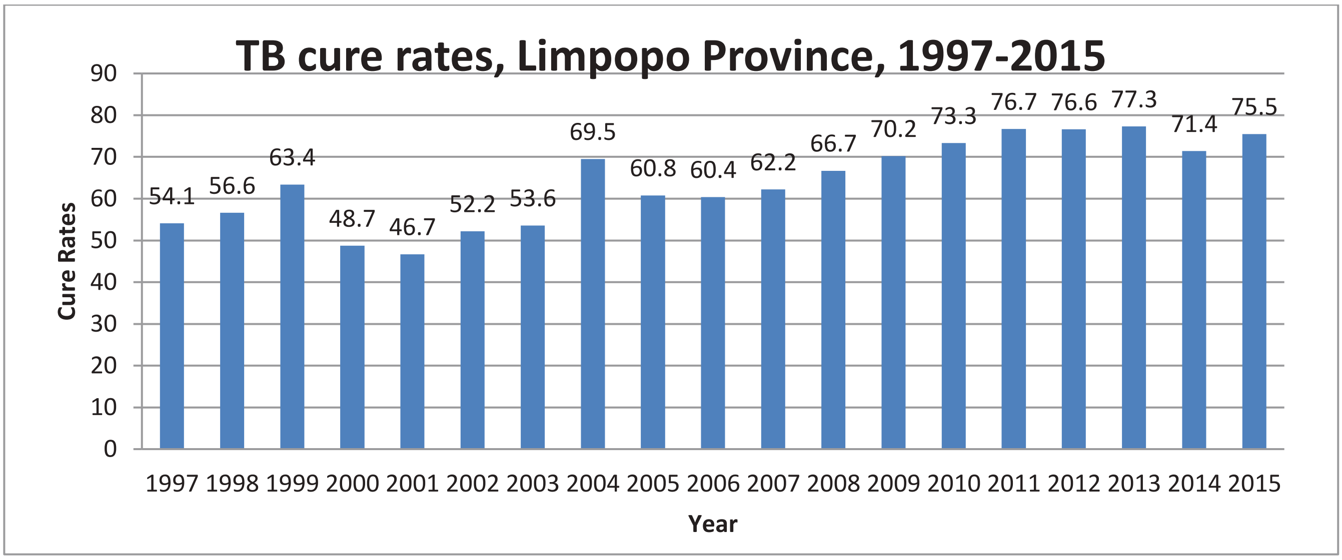


Source: Limpopo Department of Health, TB Control Programme

TB cure rate

The TB cure rate has drastically improved from 62.2% in 2007 to 75.5% in 2015 which is approximately 10% improvement attributable to the following factors: utilisation of TB tracer teams, intensive case finding campaigns, improvement of DOT support, intensified counselling and support, proper record keeping, compliance to treatment, This is best illustrated in Figure 3 below.

Figure 3.TB Cure rates for Limpopo Province, 1997 – 2015

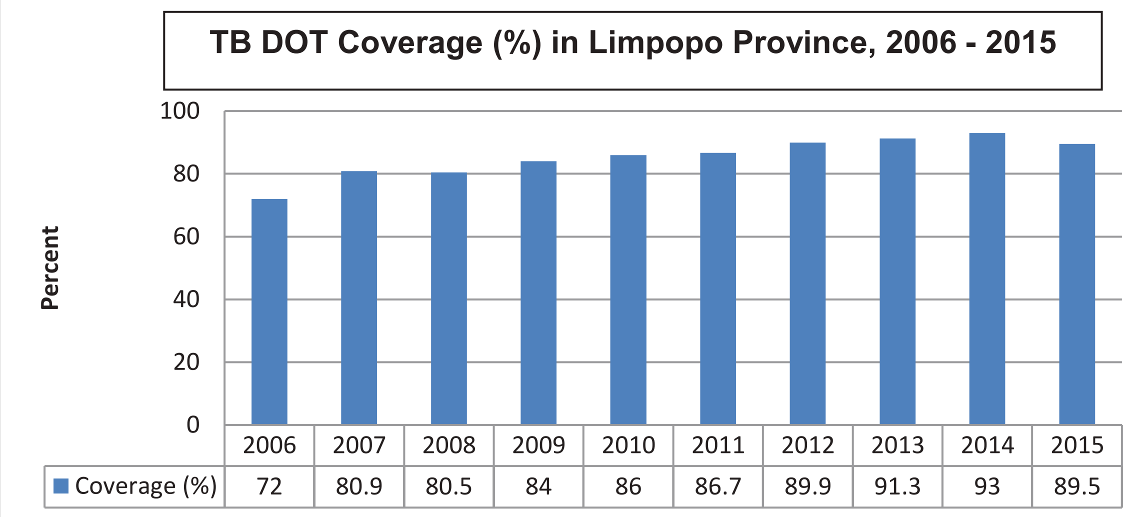


Source: Limpopo Department of Health, TB Control Programme

TB DOT coverage

There is a consistent increase in the number of patients with a DOT supporter leading to an increase in TB DOT Coverage from 72.0% in 2006 to 89.5% in 2015 as illustrated in figure 4 below. This shows positive contribution to the cure rate in the province as better adherence to treatment and intensified care in the community is achieved.

Figure 4. TB DOT Coverage in Limpopo Province, 2006 – 2015



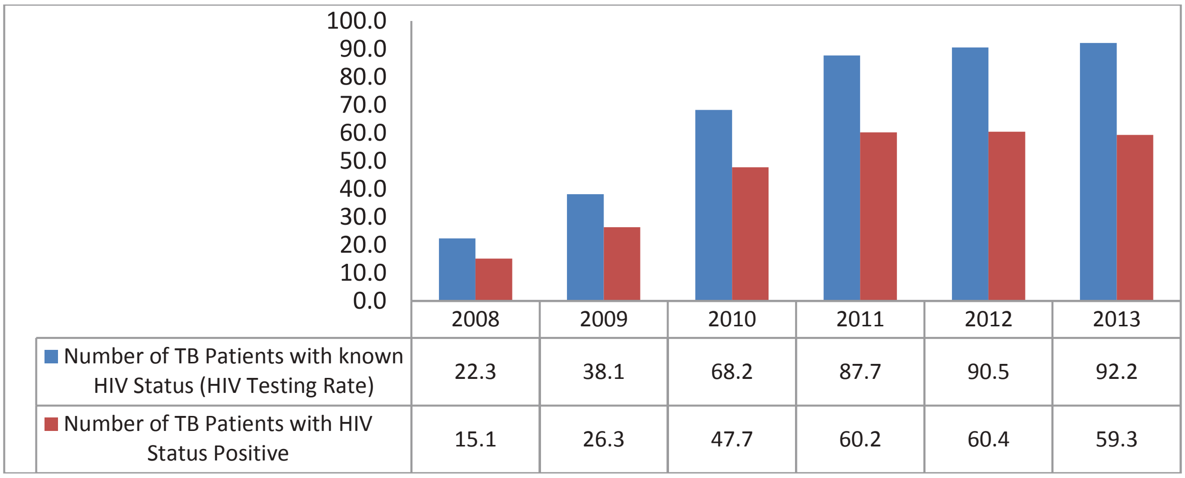
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Coverage (%)	72	80.9	80.5	84	86	86.7	89.9	91.3	93	89.5

Source: Limpopo Department of Health, TB Control Programme

TB/HIV co-infection

HIV/TB Co-infection has been a challenge in the Province but great achievements has been made with regard to case findings and management. The number of TB patients with “Known” HIV status has improved from 22.3% in 2008 to 92.2% in 2013, attributable to improvements in awareness campaigns, case detection as presented in figure 5 below.

Figure 5. Case Finding Indicators for TB/HIV, 2008 – 2013



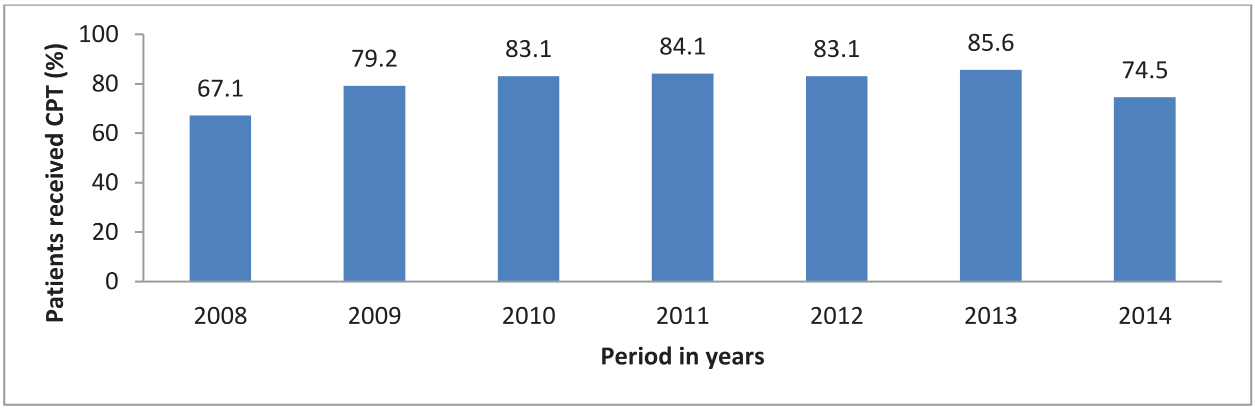
	2008	2009	2010	2011	2012	2013
Number of TB Patients with known HIV Status (HIV Testing Rate)	22.3	38.1	68.2	87.7	90.5	92.2
Number of TB Patients with HIV Status Positive	15.1	26.3	47.7	60.2	60.4	59.3

Source: Limpopo Department of Health, TB Control Programme

HIV and AIDS

The number of HIV positive TB patients who started/received co-trimoxazole preventive therapy (CPT), which is an intervention made to prevent TB infection amongst the vulnerable groups (especially those already infected with HIV) has been improved from 67.1% in 2008 to 74.5% in 2014, as presented in figure 6 below. The value of co-trimoxazole in reducing the morbidity and mortality associated with HIV infection is well established through clinical trials conducted in industrialized and developing countries.

Figure 6. HIV Positive TB Patients who started/received CPT, 2008 - 2014

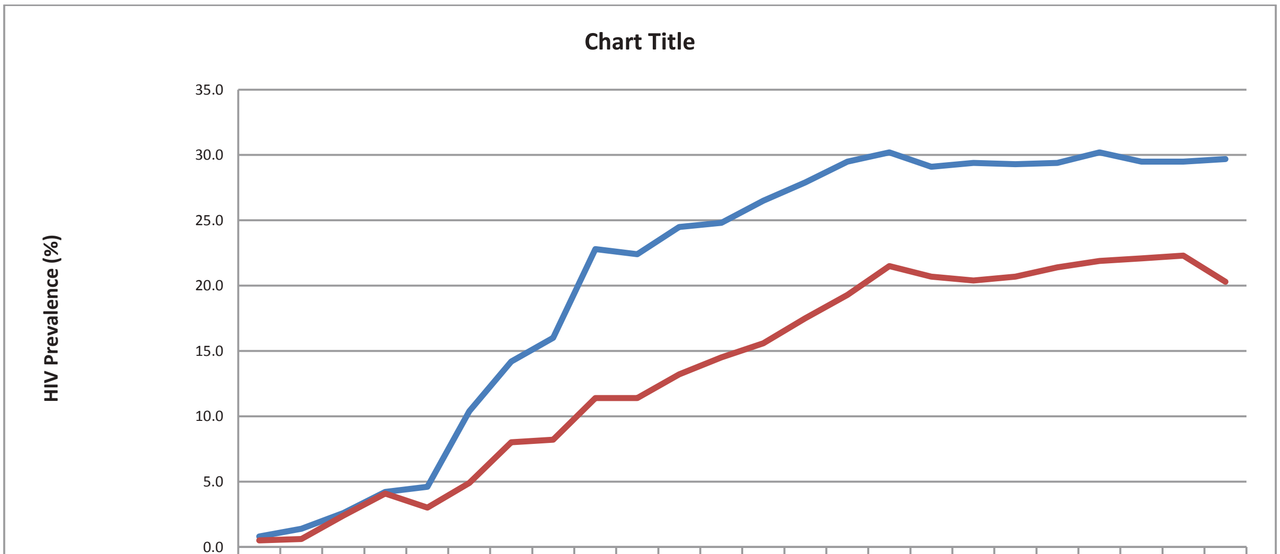


Source: Limpopo Department of Health, TB Control Programme

HIV Prevalence

The prevalence of HIV in South Africa has been consistently monitored through the use of the sentinel surveillance data. This data relates to pregnant women aged 15-49 who seek antenatal care services in public health facilities. The 2013 ANC sentinel surveillance data puts the national prevalence rate at 29.7%. Figure 7 below compares the national HIV prevalence trend with the situation in Limpopo. The HIV Prevalence increased from 0.8% in 1990 to 20.3% in 2013 as compared to National prevalence of 0.5% in 1990 to 29.7% in 2013.

Figure 7. National vs Limpopo HIV prevalence trends 1990-2013

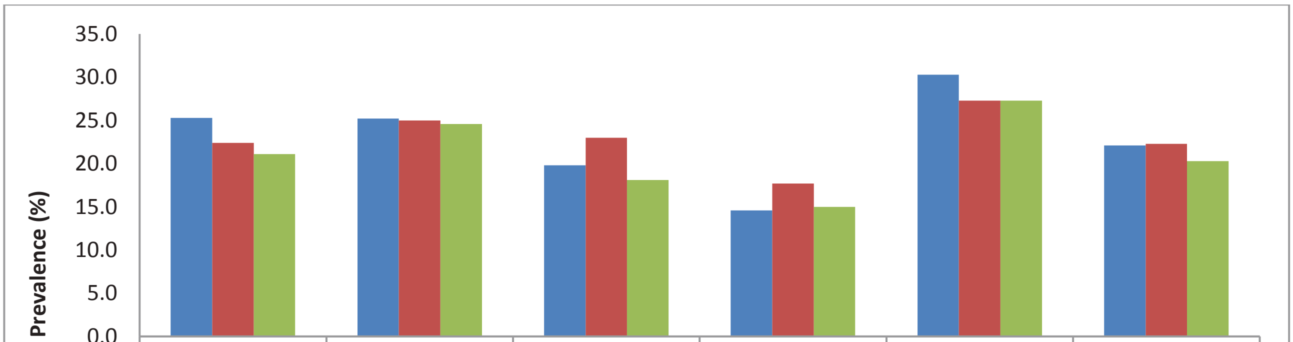


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
National	0.8	1.4	2.6	4.2	4.6	10.4	14.2	16.0	22.8	22.4	24.5	24.8	26.5	27.9	29.5	30.2	29.1	29.4	29.3	29.4	30.2	29.5	29.5	29.7
Limpopo Province	0.5	0.6	2.4	4.1	3.0	4.9	8.0	8.2	11.4	11.4	13.2	14.5	15.6	17.5	19.3	21.5	20.7	20.4	20.7	21.4	21.9	22.1	22.3	20.3

Source: National Department of Health, HIV and Syphilis Survey (2013)

Figure 8 below presents the district HIV prevalence, which shows that the HIV prevalence varies considerably with Waterberg district recording the highest prevalence of 27.3%. Capricorn district and Waterberg District have recorded a significant decline of 4.2% (from 25.3% in 2011 to 21.1% in 2013) and 3% (from 30.3% in 2011 to 27.3% in 2013) respectively. Vhembe district recorded the lowest prevalence of 15% in 2013.

Figure 8. HIV prevalence among antenatal women by district, Limpopo, 2010 to 2013

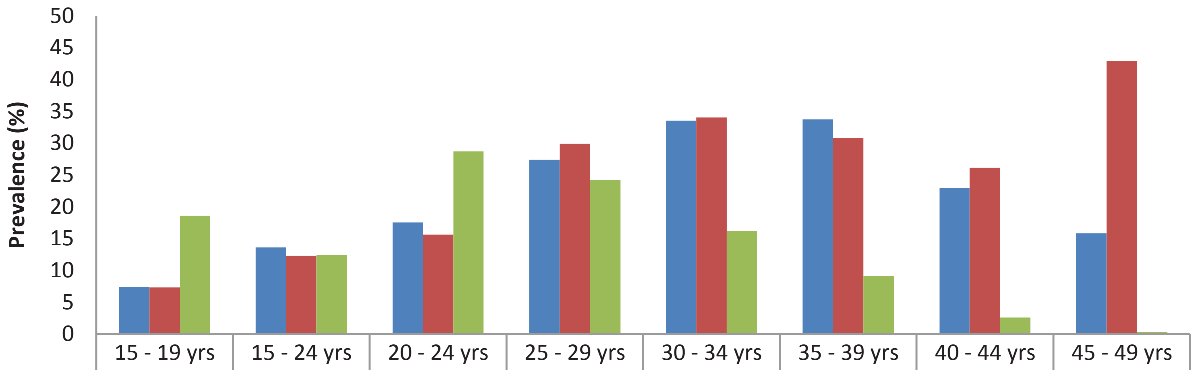


	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Province
2011	25.3	25.2	19.8	14.6	30.3	22.1
2012	22.4	25.0	23.0	17.7	27.3	22.3
2013	21.1	24.6	18.1	15.0	27.3	20.3

Source: Limpopo Department of Health, Epidemiology Services

Figure 9 below shows HIV prevalence trends by age group in Limpopo Province. The HIV prevalence among women in the age group 30 - 34 years, which was the highest in the previous years, has shown a significant decline of 17.3% (from 33.5% in 2011 to 16.2 in 2013). The age groups 15-19 and 25-29 have both shown a significant increase of 11.2% which is from 7.4% in 2011 to 18.6% in 2013 and from 17.5% in 2011 to 28.7% in 2013 respectively.

Figure 9. HIV prevalence among antenatal women by age group, Limpopo, 2011 - 2013.



	15 - 19 yrs	15 - 24 yrs	20 - 24 yrs	25 - 29 yrs	30 - 34 yrs	35 - 39 yrs	40 - 44 yrs	45 - 49 yrs
2011	7.4	13.6	17.5	27.4	33.5	33.7	22.9	15.8
2012	7.3	12.3	15.6	29.9	34	30.8	26.1	42.9
2013	18.6	12.4	28.7	24.2	16.2	9.1	2.6	0.3

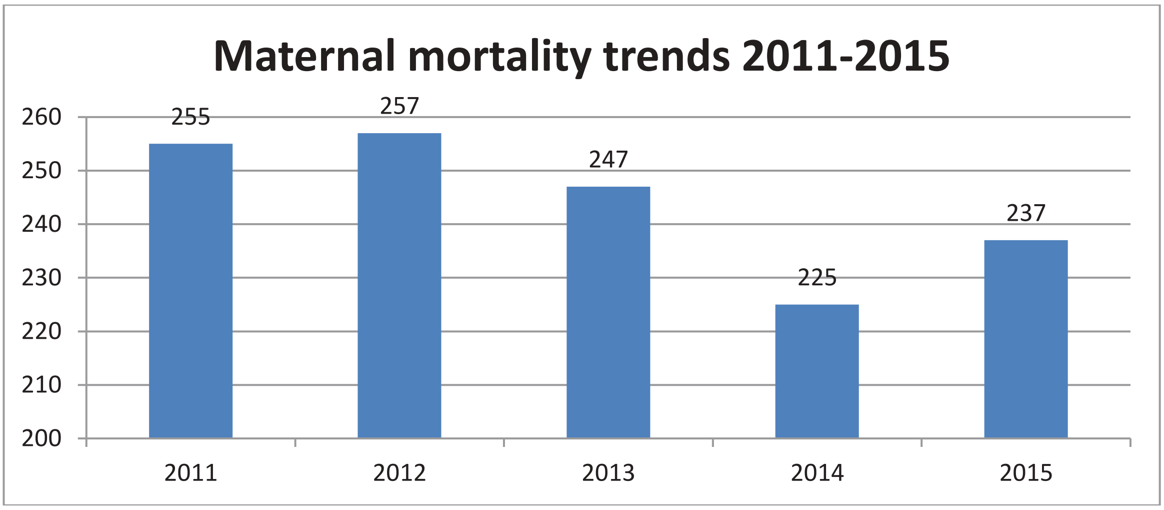
Source*:* Limpopo Department of Health, Epidemiology Services

MATERNAL, CHILD and WOMEN'S HEALTH

Maternal Health

The province has implemented programmes to reduce maternal morbidity and mortality in all facilities through training of health professionals on Essential Steps in the Management of Obstetric Emergencies (ESMOE) to improve the quality of care in managing pregnant women. Provincial/District Clinical Specialists in Obstetrics and Gynaecology at the District and Provincial levels, support doctors and midwives to achieve an improved output. All maternal deaths are reported through the Confidential Enquiry into Maternal Deaths.

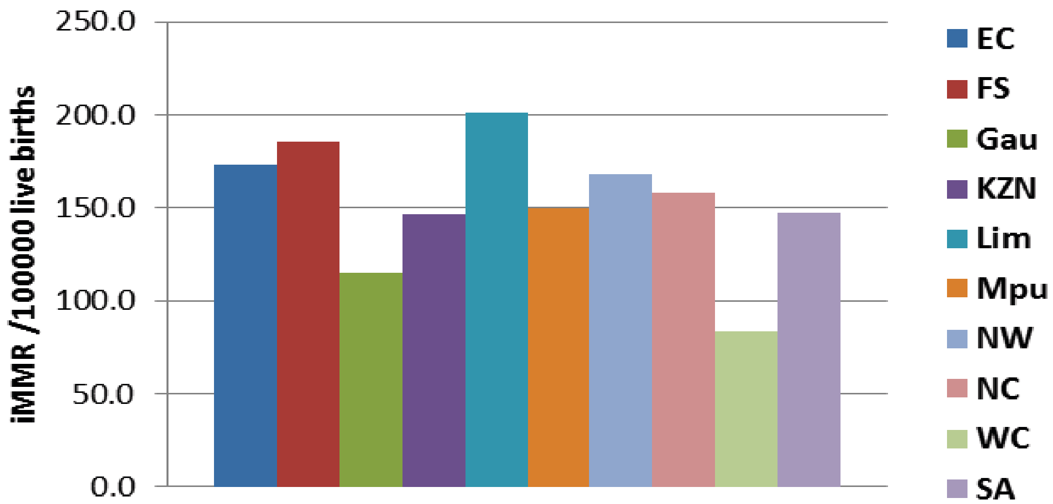
Figure 10. Limpopo Maternal Mortality Trends 2011 – 2015



Source: Provincial DHIS

According to Figure 10 above, Limpopo reported 1221 maternal deaths from 2011 to 2015, Departmental DHIS. The picture does not look good from 2014 – 2015. There is a need to involve Traditional Birth Attendants, traditional healers, community leaders and the community at large.

Figure 11. Provincial Distribution iMMR 2011 – 2013



Source: Saving Mothers Report, Triennium 2011-2013

While other provinces are showing a decline in IMMR Limpopo continue to remain high probably due to high Non Pregnancy related infection which contributed 30.6% of all maternal deaths in the triennia.

Table A5. Institutional Maternal Mortality Ratio

iMMR for Limpopo per District 2011-13

	2011	2012	2013	201-2013
CAPRICON	353.98	269.14	418.55	347.08
Gr SEKHUHKUNE	153.8	188.69	153.98	164.97
MOPANI	160.48	186.62	134.46	160.78
VHEMBE	130.35	134.63	131.19	132.06
WATERBERG	184.36	196.40	149.32	176.69
LIMPOPO	196.40	192.89	201.21	196.83

Source: Savings Mothers Report, Triennium 2011-2013

1Table A6. Institutional Maternal Mortality

YEAR	CAPRICORN DISTRICT	MOPANI DISTRICT	SEKHUKHUNE DISTRICT	WATERBERG DISTRICT	VHEMBE DISTRICT	TOTAL
2014	99	34	47	14	31	225
2015	103	28	34	15	24	204
2016	38	23	15	13	8	97
TOTAL	240	85	96	42	63	526

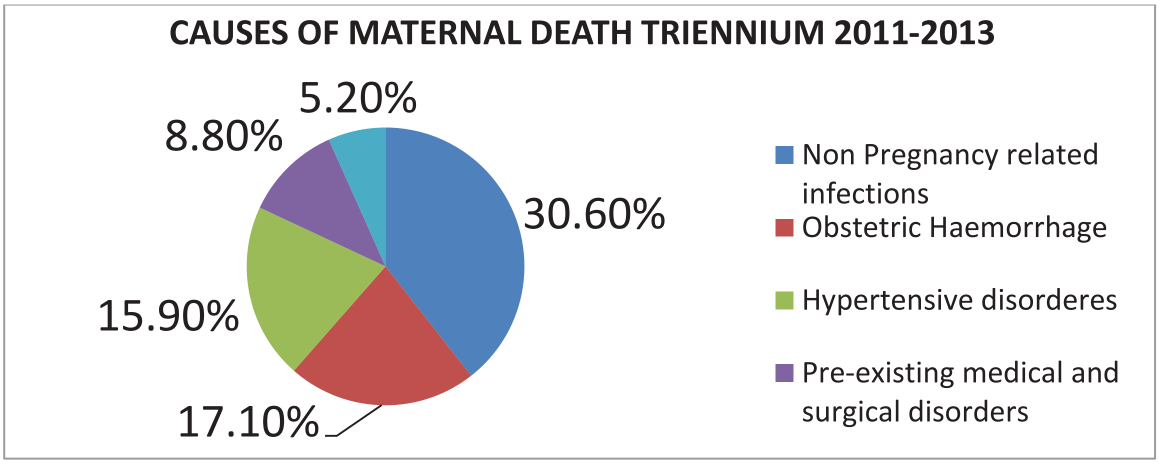
MCWH&N Directorate

Tables A6 in relation to table A5 indicates that Capricorn district is still reporting the highest maternal mortality in the province followed by Sekhukhune district in 2014 and 2015. Capricorn district cases might be as a result of referrals from other districts. Otherwise there is a decline in all the districts which might be because of specialist appointed who are able to capacitate health professionals. Clinical specialists should continue providing capacity building to health professionals. Nursing Education should review Midwifery curriculum to enable nurses to manage pregnant women and delivery.

There is also a need to strengthen and improve the quality of care among pregnant women.

The five major causes of maternal deaths in Limpopo in the triennium 2011-2013 were as illustrated in Figure 12 below.

Figure 12. Five major causes of maternal death triennium 2011-2013



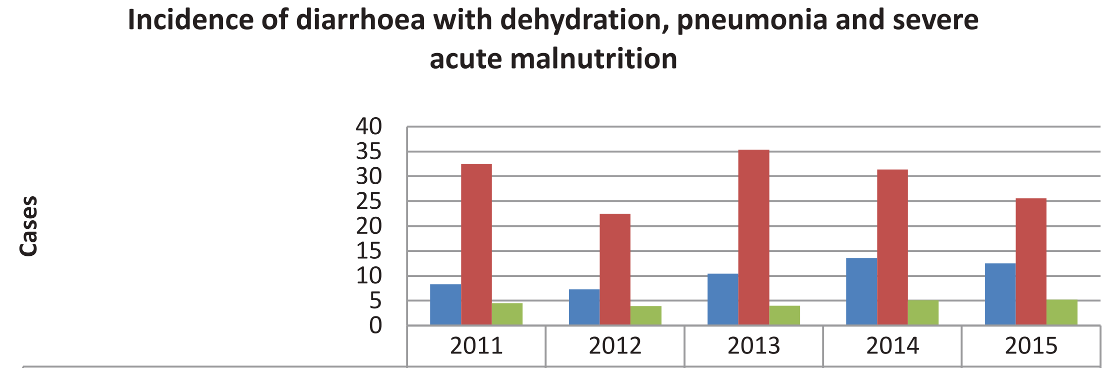
Source: Saving Mothers Report, 2011-2013

Infant and Child Health

Reducing child deaths is an important global and national goal as indicated by the Sustainable Development Goals (SDG's) and Medium Term Strategic Framework, which identifies a reduction in maternal and child mortality as one of the four key strategic outputs for the health sector

Malnutrition and HIV infection are frequent comorbidities in children dying of sepsis and according to the Saving Children Report, 49% of children who died of sepsis had severe malnutrition; 26% were underweight for age; and 55% were either HIV exposed (24%) or HIV infected (31%). This confirms the malign influence of poverty and nutritional deficiencies on child morbidity and mortality, and quantifies the complexities of service delivery. Figure 13 below shows the trend of Pneumonia, Diarrhoea and Severe Acute Malnutrition incidences from 2011 to 2015. Decline in diarrheal disease under 5 years is attributable to Rotavirus and pneumonia with Pneumococcal Conjugated Vaccines (PCV). Children will be saved through a continues vaccinaton programme. Severe Malnutrition will be reduced through implementation of an outreach programme for children.

Figure 13. Incidence of diarrhoea with dehydration, pneumonia and severe acute malnutrition in children under 5 years, 2011 – 2015



	2011	2012	2013	2014	2015
Child under 5 years diarrhoea with dehydration incidence (annualisd)	8.3	7.3	10.4	13.6	12.5
Child under 5 years peumonia incidence (annualised	32.5	22.5	35.4	31.4	25.6
child under 5 years severe acute malnutrition incidence (annualised)	4.5	3.9	4	5.1	5.2

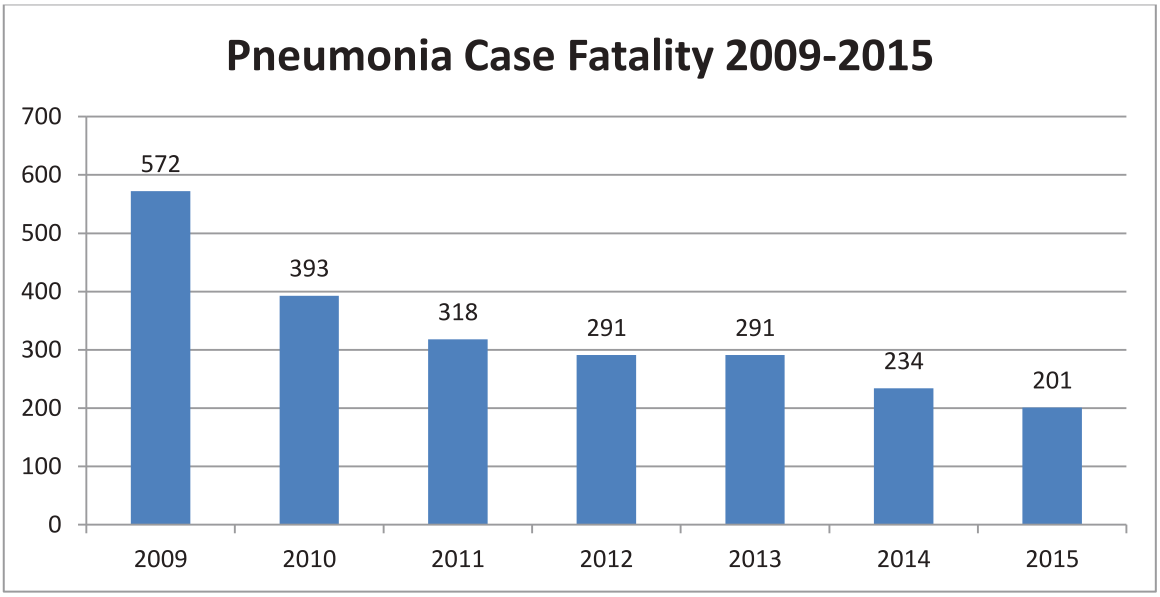
Source: Limpopo Department of Health, DHIS

Pneumonia

Pneumonia remains an important cause of mortality in young children. The incidence of pneumonia is reported as the number of new cases in children under 5 years per 1 000 children under 5 years in the catchment population.

Figure 14 below shows the trend over 7 years from 2009 – 2015 in case fatality from Pneumonia. Evidence suggests that the incidence of pneumonia has decreased significantly in Limpopo Africa in the past six years, with the decline being attributed to a reduction in the prevalence of HIV infection in young children (as a result of the success of the PMTCT programme) as well as the introduction of pneumococcal vaccine to the routine immunisation schedule in 2009. District Clinical Specialist Teams played an important role in ensuring improvements in case management of children with pneumonia.

Figure 14. Under 5 deaths due to pneumonia



Source: Limpopo Department of Health, DHIS

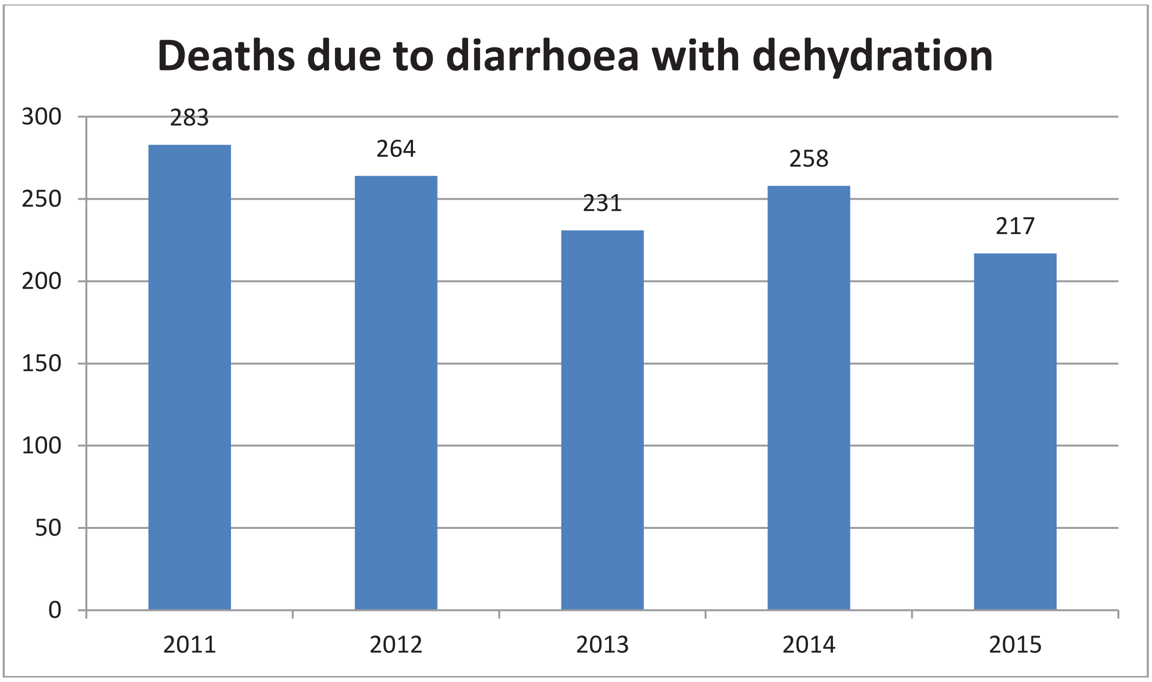
Efforts to continue this downward trend should focus on on-going efforts to reach all children with PMTCT and immunisation as well as other child survival interventions such as promotion of exclusive breastfeeding, better complementary feeding and vitamin A supplementation.

Diarrhoea

Diarrhoea remains an important cause of mortality in young children. The case fatality rate, which measures the proportion of all diarrhoea-related admissions of children under 5 years who died, provides an indication of the extent to which children who develop severe diarrhoea are correctly identified and treated

As shown in Figure 15, child under 5 year diarrhoea case fatality rate has declined in 2015. The decline is attributable to door-to-door campaigns headed by ward based outreach teams (WBOT's), Integrated Management of Childhood Illnesses trainings conducted throughout the province in collaboration with other stakeholders. These also reflect better outcomes for children who are admitted to hospital with diarrhoea.

Figure 15. Deaths due to diarrhoea with dehydration



Source: Limpopo Department of Health, DHIS

Province should ensure on-going improvement in case management of children presenting diarrhoea with at household, primary health care and hospital levels is of importance. Districts and facilities with a high number of deaths from diarrhoea should be targeted and interventions put in place to ensure that healthcare workers are trained and mentored to correctly assess and treat children with diarrhoea. Where appointed, District Clinical Specialist Teams (DCST) should play an important role of ensuring improvements in case management of children with diarrhoea.

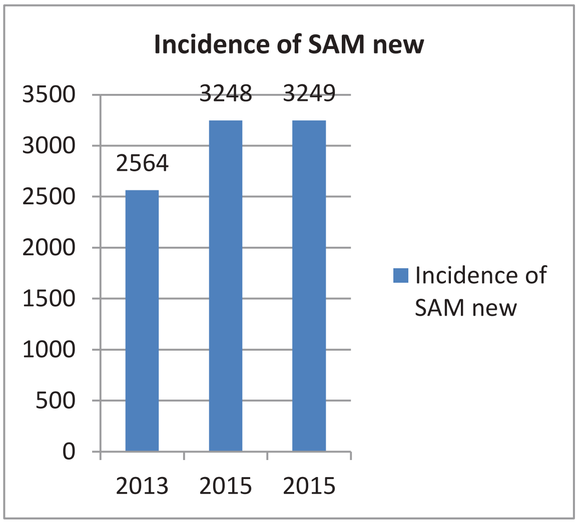
Malnutrition

Malnutrition is known to contribute substantially to child mortality and morbidity. The recent South African National Health and Nutrition Examination Survey (SANHANES) suggest that under-nutrition among children younger than 10 years of age has decreased in South Africa; this is more apparent with regard to underweight (low weight-for-age) and wasting (low weight-for-height) than with regard to stunting (height-for-age).

Correct identification of children with Severe Acute Malnutrition (SAM) is particularly challenging. Children with SAM will usually present at health facilities with other conditions, and will only be identified through correct measurement and plotting of weight and height.

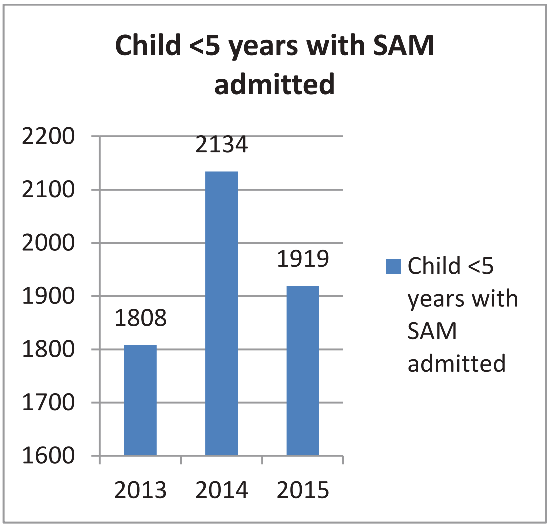
An increase in incidence may therefore reflect more active case-seeking and recognition, rather than a true increase in the SAM incidence.

Fig 16: Child <5 years with SAM new



Source: Limpopo Department of Health, DHIS

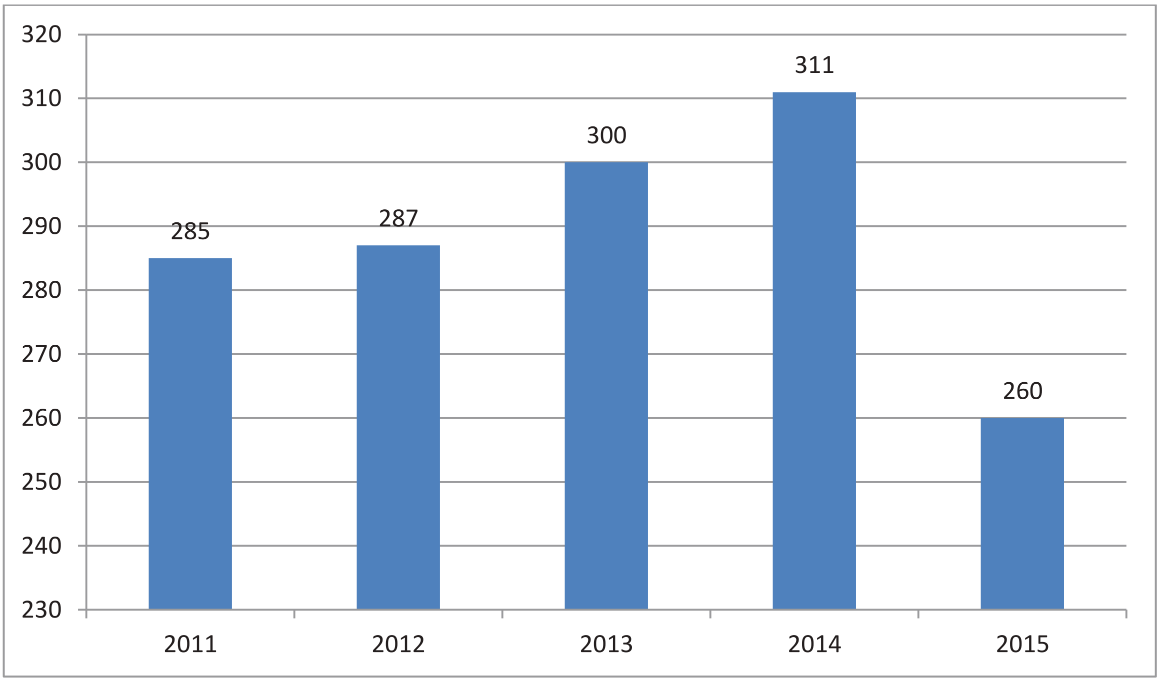
Fig 17: Child <5 years with SAM admitted



Source: Limpopo Department of Health, DHIS

The child under 5 years severe acute malnutrition case fatality rate measures the proportion of all admissions of children under 5 years with SAM who died as a result of the condition.

Figure 18: Child <5 years with severe acute malnutrition case fatality rate



Source: Limpopo Department of Health, DHIS

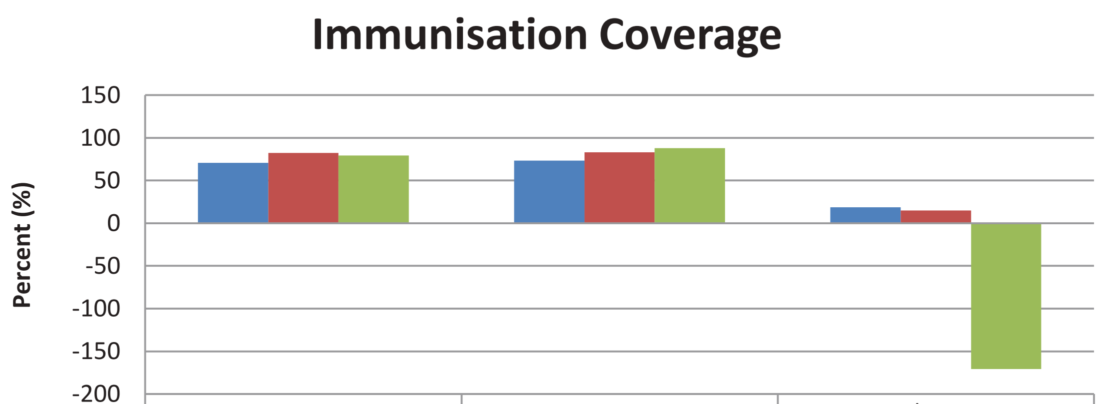
Children who are identified as having SAM are admitted to hospital, and should be managed or rehabilitated based on the WHO guidelines known as the WHO Ten Steps for Managing Children with Severe Malnutrition. Implementation of the WHO Ten Steps for Managing Children with Severe Malnutrition have been demonstrated to result in significant reductions in the SAM case fatality rate and its being implemented in all hospitals in Limpopo

The decrease in the number of death due to SAM is mainly attributed to optimal infant and young child feeding practices (exclusive breastfeeding for six months followed by introduction of appropriate high quality complementary feeds), as well as strategies for identifying and addressing growth faltering in young children in the province. This all is done through training of health professionals on the use of Road to Health Booklet, Integrated Management of Childhood Illnesses an update on WHO guidelines on the management of SAM.

Immunisation

Immunisation is one of the most important and cost-effective health interventions available. Key challenges include the need to procure WHO-prescribed refrigerators, EPI personnel and the consistent supply of vaccines. Non-achievement is attributable to vaccine stock-outs and poor recording in facilities.

Figure 19. Immunisation Coverage



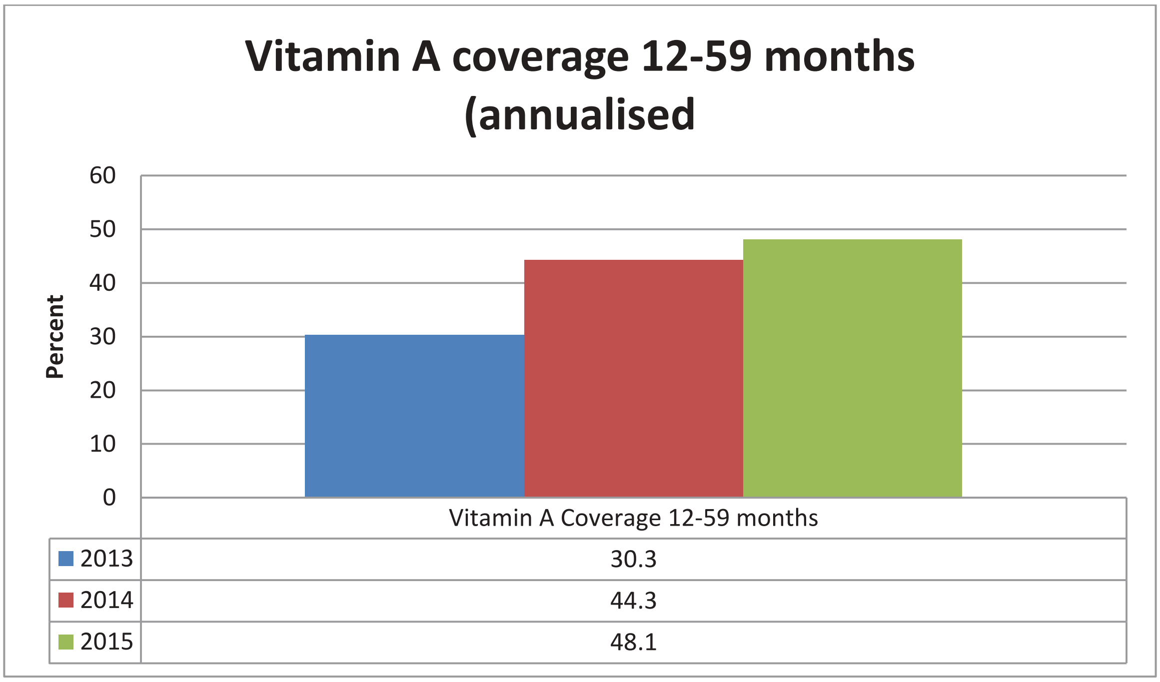
	Immunisation Coverage <1 year	Measles 2nd dose coverage	DTAP-IPV/Hib3-Measles 1 drop out rate
2013/14	70.8	73.5	18.6
2014/15	82.2	83.2	15
2015/16	79.2	88	-170.7

Source: Limpopo Department of Health, DHIS

Vitamin A Coverage

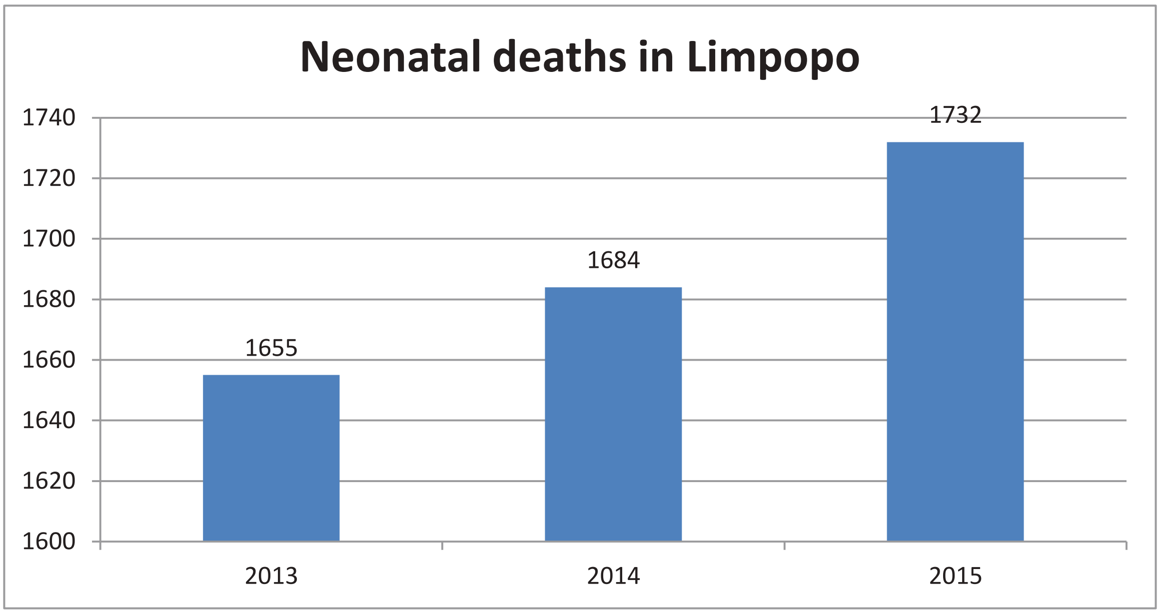
Vitamin A is a micronutrient that is essential for healthy eyes, growth, immune function and survival. Deficiency of vitamin A is associated with blindness as well as a fourfold increase in child mortality secondary to prematurity, neonatal infections, diarrhoeal disease and measles. The vitamin A coverage acts as a proxy indicator for access to preventive health services among children aged 12 to 59 months. Since 2012, community health workers have been permitted to administer vitamin A (under supervision of a professional nurse). This has the potential to substantially increase coverage, although the extent to which this has been implemented remains unclear in the province.

Figure 20. Vitamin A coverage 12-59 months (annualised)



Source: Limpopo Department of Health, DHIS

Figure 21. Neonatal deaths in Limpopo



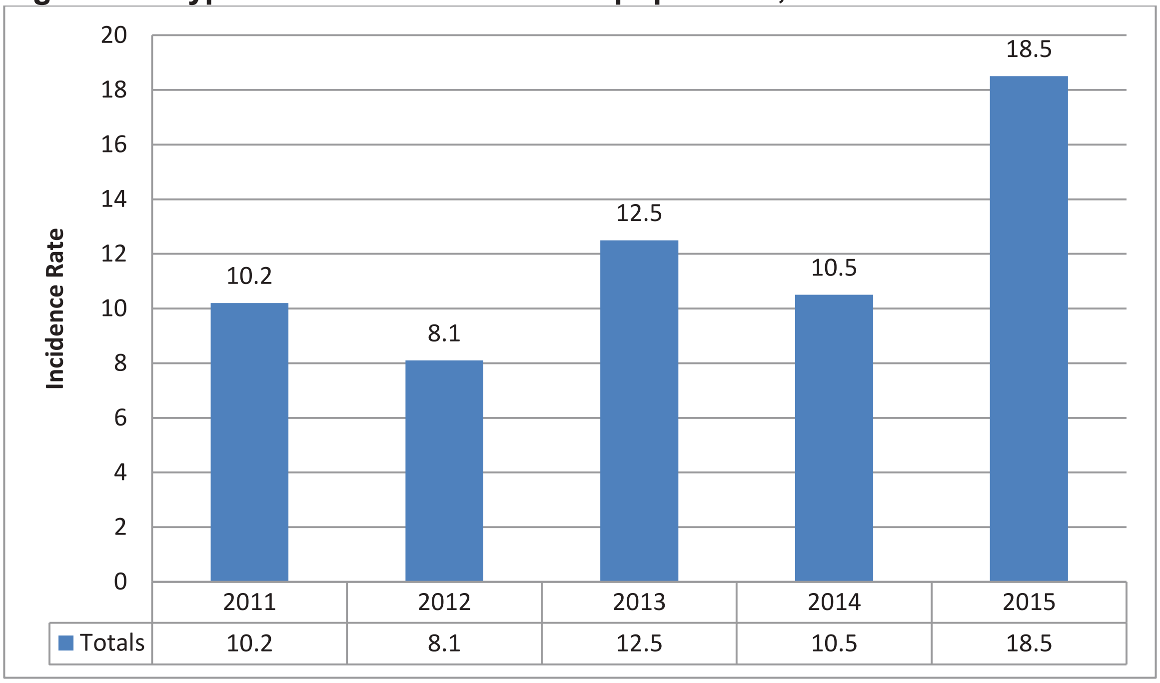
Source: Limpopo Department of Health, DHIS

Neonatal Mortality currently makes up the largest portion of facility deaths in children under 5 years of age, with Intrapartum care and birth asphyxia being the main contributing causes to the rise in neonatal mortality. Neonatal Mortality rates vary widely between districts and facilities, with some hospitals achieving a Neonatal Mortality rate of 6/1000 and others having rates four fold of 24/1000 live births. The department will continue to train health professionals in Essential Steps in the Management of Obstetric Emergencies (ESMOE), Helping Babies Breath (HBB) and Management of Small Sick Neonates (MSSN).

Non-Communicable diseases

Mortality due to non-communicable diseases continues to rise impacting negatively on life expectancy. Figure 22 below shows the trend in hypertension prevalence over the period 2011 to 2015. The increase in incidences in 2015 compared to 2014 is attributable to intensive hypertension screening.

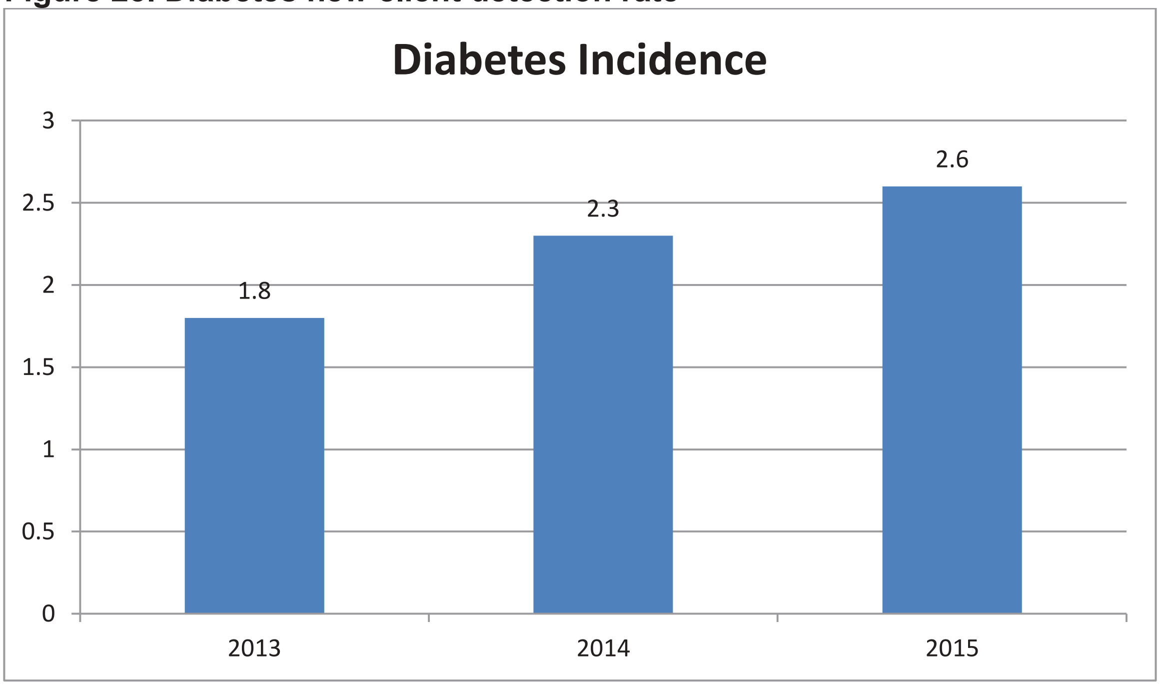
Figure 22. Hypertension incidence/1000 population, 2011 – 2015



Source: Limpopo Department of Health, DHIS

Figure 23 below demonstrates diabetes data for 2013 and 2015. There is an indication that diabetes incidence is on an upward trend from 2.3 in 2014 to 2.6 in 2015. The increase is attributable to intensive diabetic screening.

Figure 23. Diabetes new client detection rate

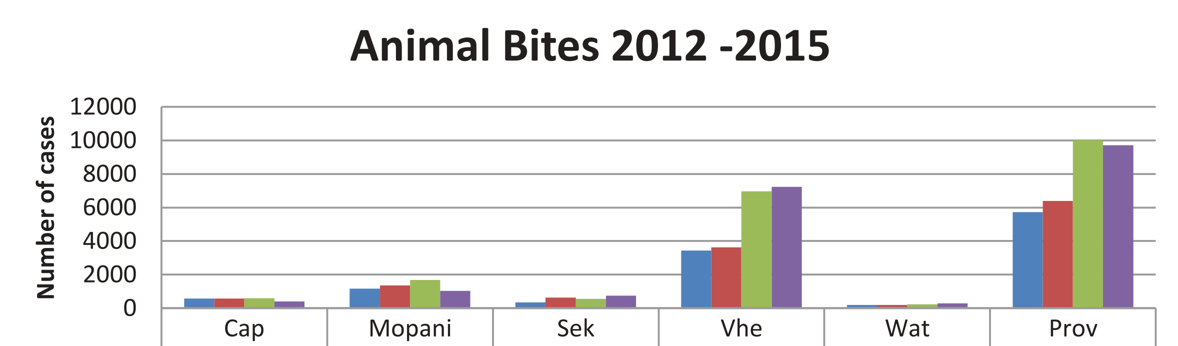


Source: Limpopo Department of Health, DHIS

Animal bite

Animal bite patients are seen daily in health facilities. Below in the number of patients consulted and given Rabies vaccine or with Rabies Immunoglobulin depending on the wound category. Those who consulted early were saved from developing human rabies. Vhembe district sees a lot of animal bites followed by Mopani district. Having trained personnel and the availability of Rabies vaccine saves lives.

Figure 24. Animal bites 2013-2015 in Limpopo province districts



	Cap	Mopani	Sek	Vhe	Wat	Prov
2012	584	1160	343	3445	198	5730
2013	577	1357	634	3620	199	6387
2014	588	1677	550	6971	228	10014
2015	404	1033	756	7238	287	9718

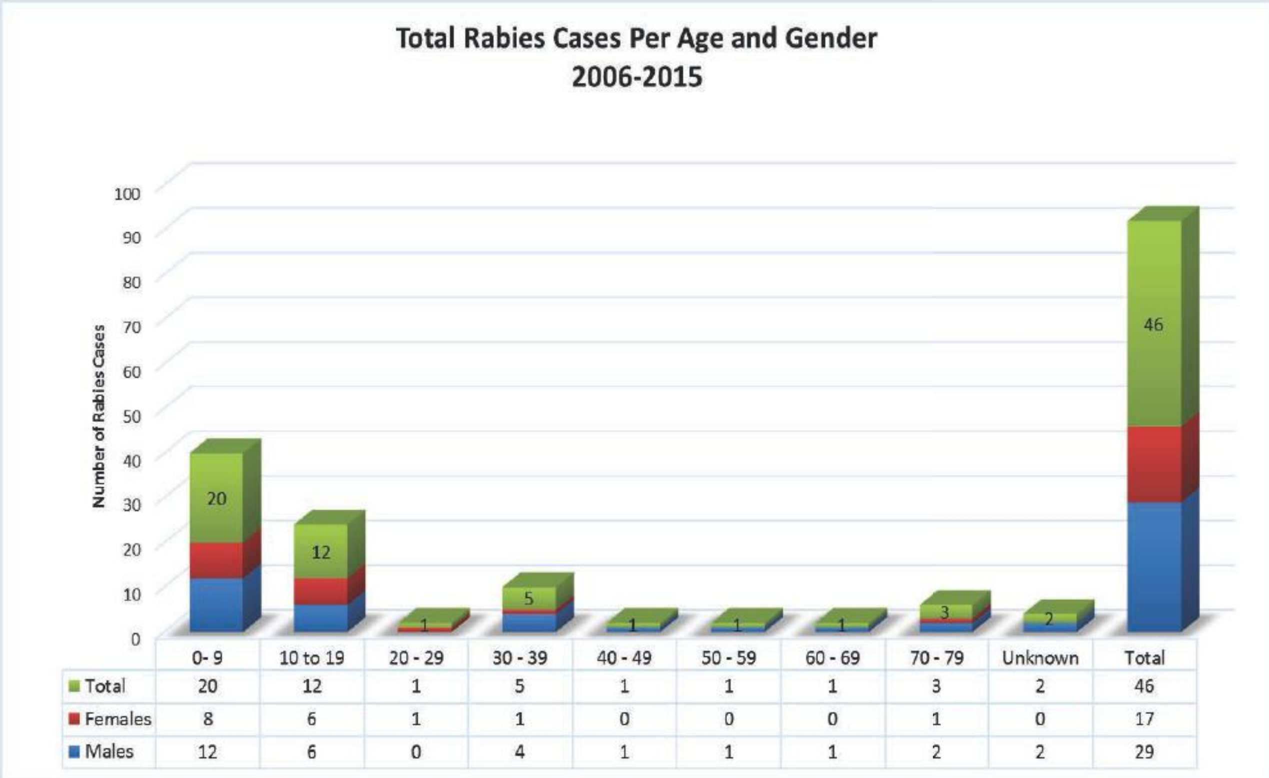
Source: Limpopo Department of Health, Public Health Programs

Human Rabies

Human rabies is one of the most fatal diseases in Limpopo with a case fatality of 100%. Human rabies deaths are mostly reported from Vhembe district; cases for Capricorn district are mostly referrals from other districts. The main source of human rabies in the province is dog bites.

Dogs mostly bite children less than twelve years, especially males as illustrated in Figure 25 below. Most of the dogs are not vaccinated against rabies although vaccination is free. There is collaboration between the Department of Health and the Department of Agriculture to minimise the number of dog bites and the control of rabies in the province. Department of Health, Agriculture, Environment, SAPS and SPCA need to embark on a massive campaign to address the problem. The department need to start implementing One Health approach. Currently, department of health and agriculture conduct annual rabies awareness campaigns in the high risk areas.

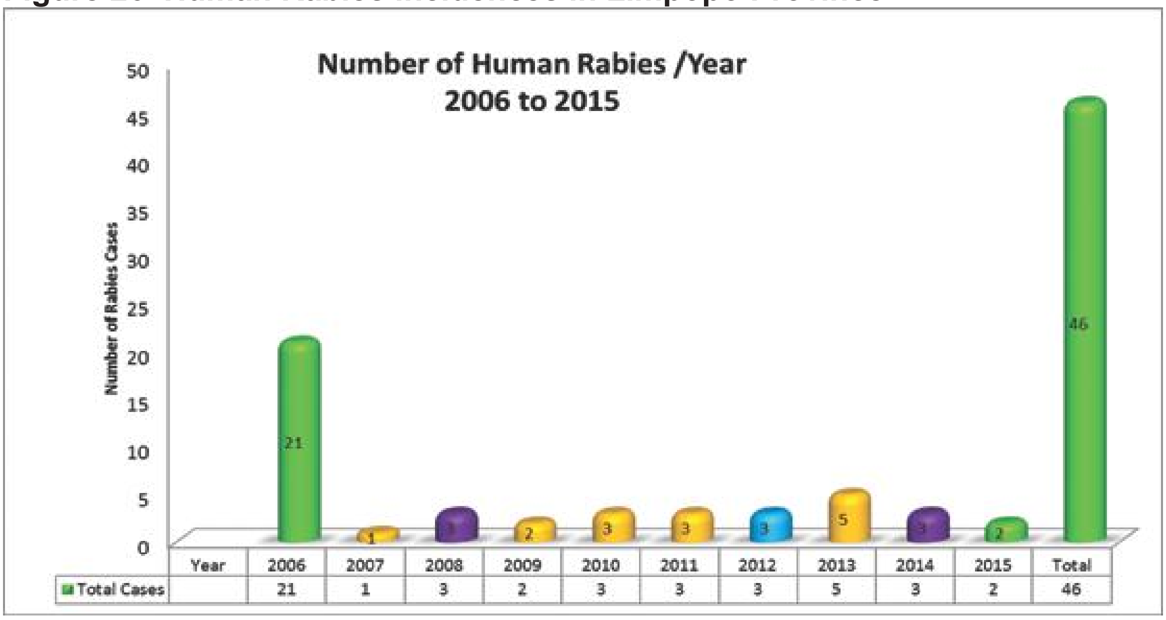
Figure 25. Total Rabies cases per age and gender, 2006 - 2015



Source: Limpopo Department of Health, Public Health Programs

Figure 26 below illustrates that the incidence of confirmed human rabies in Limpopo has decreased from 22 in 2006/07 to 02 cases in 2015. This is attributed to awareness campaigns and availability of rabies vaccines and immunoglobulin

Figure 26. Human Rabies incidences in Limpopo Province

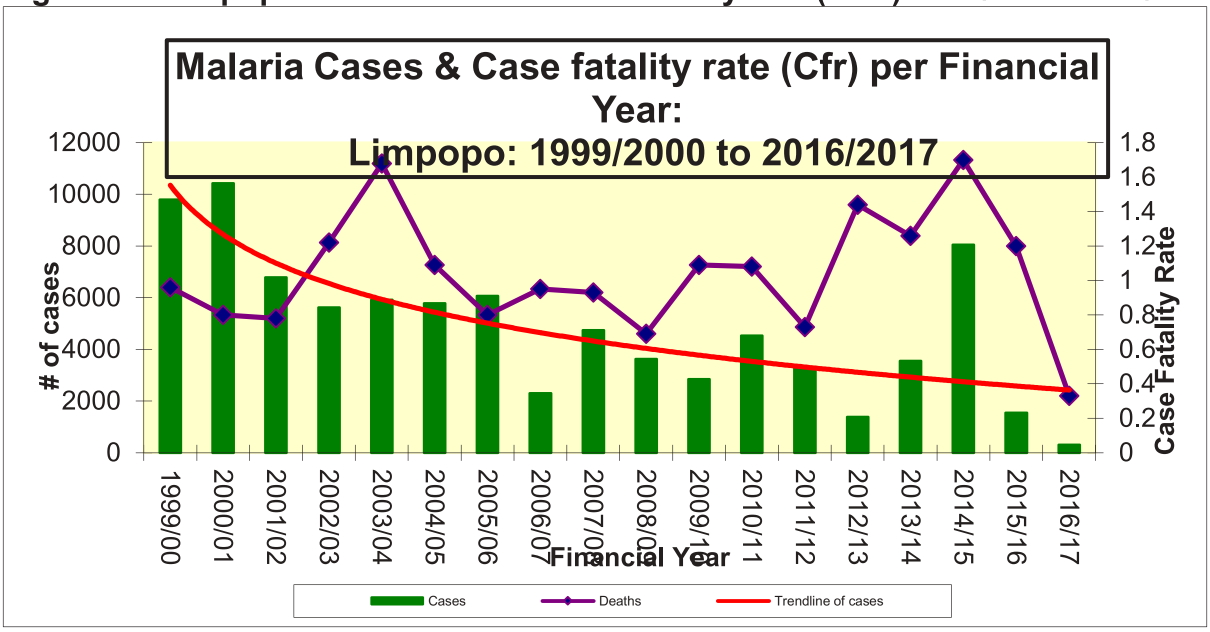


Source: Limpopo Department of Health, Public Health Programs

Malaria

Figure 27 below indicates a gradual decline in the incidence of malaria over a period of 16 financial years, with the malaria case fatality rate (CFR) remaining at above 1 %.Although case numbers in Limpopo declined from 9 487 in 2000 to 4 215 in 2010, this province has become the largest contributor to malaria incidence of the three endemic provinces[1]. This is attributable to weather conditions experienced in the province: Rainy conditions and dry weather conditions experienced in 2014/15 and 2015/16 respectively.

Figure 27. Limpopo Malaria cases & case fatality rate (CFR) 1999/2000-2014/15



Source: Limpopo Department of Health, Malaria Control Programme

The levels of malaria transmission in Limpopo is influenced by a number of factors namely; climatic conditions, lack of malaria control on a regional level and the influx of parasite carriers into the province, as well as the reduced availability and use of the chemical DDT. Over the past year, malaria transmission increased in the SADC region contributing to sustained higher levels of transmission in Limpopo, through introduced and induced malaria.

The main malaria control intervention, being the Indoor Residual Spraying Programme, has continued to perform above set targets, with 1,280,254 structures sprayed in the 2014/15 financial year, against a target of 1,100,000. The success of this programme has been dependent on the commitment of seasonal spray workers employed from communities.

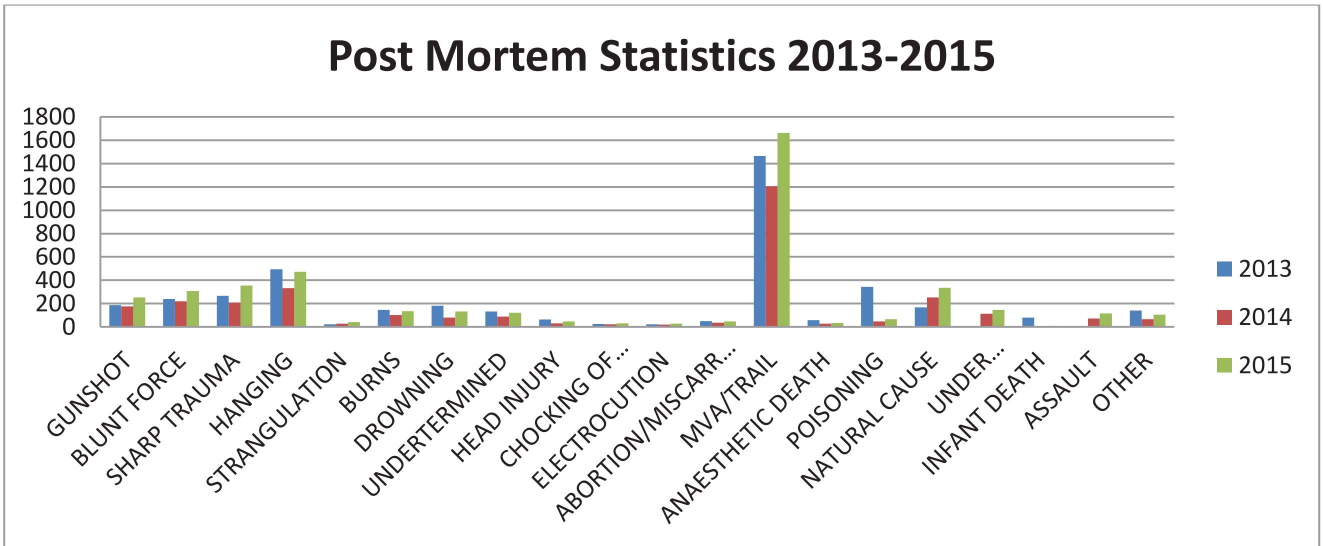
Malaria fatalities is still a concern, aggravated by delays in seeking treatment, co-morbidity and the unavailability of the treatment IV Artesunate (WHO recommended treatment for severe and complicated malaria). This treatment has been introduced in 2015/16 financial year.

Various research initiatives are underway to find innovative ways to counter the higher levels of transmission. While there are ongoing activities in creating community awareness and training of health care workers, there will also be a focus on refining parasite surveillance tools, using a Geographical Information System (GIS) platform, in communities with higher levels of transmission. The aim is to use the available resources for malaria control more efficiently, by improving targeting of communities susceptible to malaria transmission.

Injuries and violence mortalities

Motor vehicle accidents are the main cause of deaths in Limpopo, constituting 38.3% of the reported non-natural deaths, followed by hanging with an average of 13% per annum (Figure 28). Victims of these incidents finally land at the departments's facilities impacting on service delivery logistics. However, this is a challenge that needs a multi-disciplinary approach including other sector departments to be addressed.

Figure 28. External causes of death, Limpopo Province: January 2013 – December 2015



Source: Limpopo Department of Health, Forensic Pathology Services

1.6 FACTORS IN THE ORGANISATION THAT WOULD IMPACT ON SERVICE DELIVERY

Human Resource

The department is experiencing competency limitations in adequately delivering on sets strategic objectives. The mostly affected areas are the following:

- Family physicians specialty specifically at district hospitals;
- Radiographers in specialty areas e.g. ultra sonographers;
- Health technicians at district level;
- Nursing in specific specialties e.g. advanced midwifery, pediatricians, advanced psychiatry, emergency care and theatre & intensive care; and
- Emergency personnel e.g. intermediate life support & paramedics.

Expansion in competency among health professional categories such as the ones mentioned above is deemed necessary in delivering health care services that meet with expectations of the clients and contribute towards attainment of provincial and national objectives.

Finance

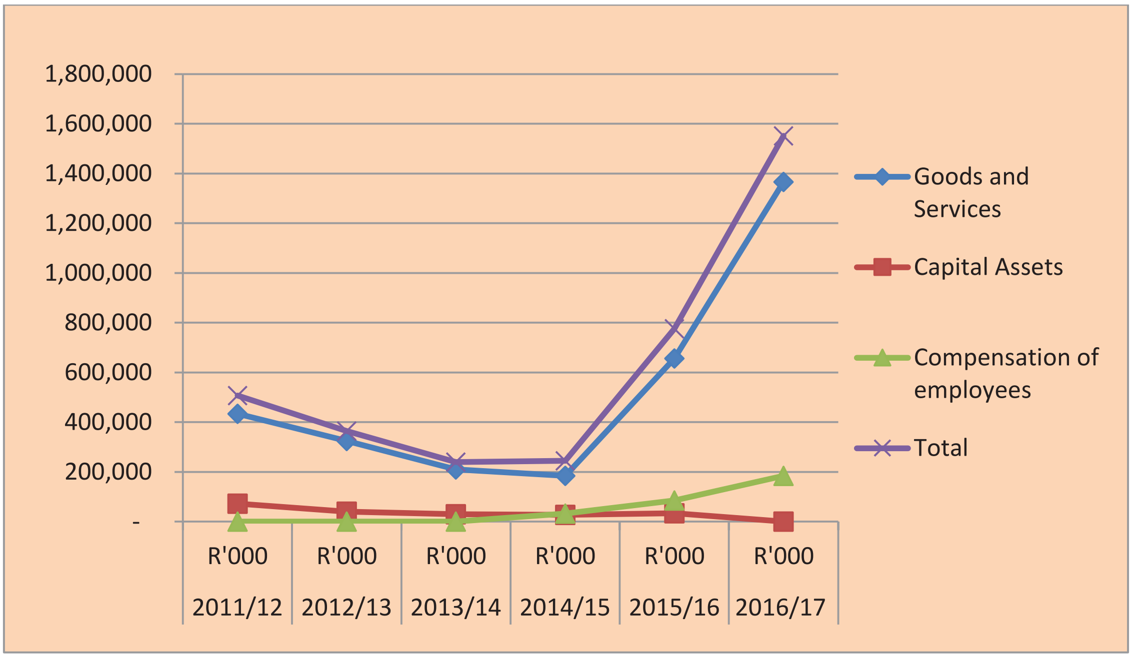
-Budgets

The Department has over the past 3 recent years experienced a budget deficit that impacted negatively on the implementation of key priorities for health in the province. This includes, amongst others, renovations/upgrading of health facilities, health professionals' accommodation and emergency medical services stations including their maintenance. Access to health services is negatively affected as running costs of mobile clinics and emergency vehicles have been curtailed. The safety of patients and workers including provision of 24 hours clinic services and emergency response time is being compromised as the budget is not sufficient to sustain the current services. Lack of key medical equipment, poor maintenance of medical equipment and facilities pose a major risk to the treatment of patients.

Based on the 2016/17 financial year total allocation of R16.3 billion and 2nd quarter spending, the baseline budget of R17 billion as per the 2017/18 MTEF allocation, indicates a baseline growth of only 4% against the revised Consumer Price Index

(CPIX) of 6.2%.This indicates an overall budget deficit of 2.2%.The overall projected spending for 2016/17 financial year is R17.7 billion. Taking into consideration this expected expenditure and other funding priorities; the 2017/18 baseline allocation shows a further deficit of R2.3 billion. The continuous budget deficit over the years has resulted in the high yearly growth of accruals that impact negatively on yearly allocated budgets. The chart below indicates the growth on accruals from 2011/12 financial year to date.

Accruals Growth from 2011/12-2016/17 Financial Year



Engagements are continuing with Provincial Treasury and other relevant stakeholders to address the funding gap.

-Performance and Regulatory compliance

During the previous financial years, the Department made significant strides to achieve a number of outputs and outcomes, including moving the department from the disclaimer to unqualified audit opinion in 2014/15 financial year. The Department has however regressed to qualified audit opinion in 2015/16 financial year. An audit action plan has been developed and being implemented to address the shortcomings identified and hoping for positive outcome in 2016/17 financial year.

Health Facilities Management

The department is experiencing a backlog in infrastructure development resulting in number of facilities been dilapidated or old to handle the modern services delivery model. Some of the infrastructure challenges are associated with limited funding, slow decision making turn-around time by implementing agencies, limited maintenance capacity at district and facilities level and shortage of qualified built environment officials programme and project management.

Despite all this challenges, more projects than anticipated have been completed. The department established an effective Project Progress Review process to ensure that programme management is strengthened. Furthermore, good expenditure on maintenance projects was achieved with all five districts spending 90% or more of their maintenance budget.

The department will continuously work closely with implementing agencies to scope projects and to prepare briefing documents. Furthermore, training of artisans and general maintenance workers will continue in phases.

Information and Communication Technology (ICT)

The department is experiencing a high dependence on ICT contractors and consultants. This is attributed to the high vacancy rate in the unit. On the other hand, the state of ICT infrastructure and systems in the Department is outdated. This makes it difficult to conduct maintenance as some of the equipment are not software-manageable and therefore cannot be traced. These devices cause broadcast bottlenecks on the network. This is as a result of funding deficit in the department.

Information and Communication Technology unit has successfully in 2015/16 financial year developed an ICT Strategic Plan in line with the Departmental Strategic Plan, National eHealth Strategy 2012-2016, National Health Normative Standards Framework 2014 and National m-Health Strategy 2015-2019.

In 2017/18 financial year the department intends to have an upgraded ICT infrastructure and an enterprise architecture and ICT architecture designed and aligned to one another. Furthermore, the department envisage to have centrally hosted PHIS in place and providing a single patient view and medical record which is accessible by both clinics and hospitals. The department intends to have a new organizational structure for the unit approved and implemented for scarce ICT specialist skills insourcing and retention.

Information Management

Standardised Operating Procedures (SOPs) have been developed to guide the implementation of the District Health Management Information System Policy. However, the department still experiences challenges with the quality of data. This is attributed to lack of recourses i.e. data capturers, ICT infrastructure and lack of standardised data collection tools. In addition, the introduction of new data collection tools mid-year compromises consistency in reporting.

Despite the above challenges, the department has been able to implement regionalised registers, develop standard verification tools, conduct intensive data clean up at districts and piloted health patient registration system (HPRS) and web District Health Information System in Vhembe district. In overcoming the challenges, the department intends to develop health information system strategy and continue standardisation of data collection tools for hospitals and primary health care facilities.

Records management

The department is experiencing shortage of records filling space in all categories of records. There is congestion of records in the semi-archive repository because of lack of disposal and transfer to archive repository. In addition, there is inadequate staff at districts and primary health care as well as absence of structure at clinics to maintain files that have been opened as per National Department of Health new strategy. The department is faced with a challenge of limited ICT equipment in outpatient departments (OPD).

Significant strides were achieved resulting in development of the Disaster Recovery Plan and reviewing and implementation of Records Management Policy. Furthermore, the Registry Procedure Manual and file plan have been reviewed and are in a process of implementation. Development of new standard reporting tool and establishment of district forums was achieved. Contract workers were appointed to assist in addressing backlog on disposal project.

In addressing the challenges stipulated, the department intends to provide recording space for all institutions through: 1. In short term - mobile containers; and 2. In long term – warehouses. Furthermore, disposal process will be intensified for the records that have reached the retention period. Lastly, the department will appraise and transfer records that have an archival value to the Provincial Archive.

Medico-Legal

The department faced the following challenges: lack of dedicated unit to handle medico-legal cases; lack of provincial, district and institutional structures; high incidence of medico-legal claims; lack of awareness of impact of medico-legal claims; and loss of records at facilities.

A Medico-legal Policy has been developed and implemented. A unit to handle medico-legal cases has been established. The department further established three tier structures in the form of Adverse Event and Clinical Governance Committees at level of the Province, District, and Institutions with clear terms of reference. An alternate dispute resolution was done on twenty-five cases, five cases were defended, six cases have been settled and ten workshops have been conducted.

The department will continue monitoring the implementation of the Medico-legal Policy and intensify integrated management of medico-legal claims. There will be enhancement of alternate dispute resolution, defence of cases, settlement of claims and alignment of process to handle medico-legal cases.

Emergency medical services

The department commissioned eighty new ambulances and twenty Obstetric ambulances. Furthermore, Planned Patient Transport (PPT) was integrated into EMS. Three purpose built stations were completed. Staff was trained in Essential Steps to Manage Obstetric Emergencies (ESMOE). On the other hand, there have been challenges on aging fleet affecting response time lack of effective call-taking, dispatch and vehicle monitoring system.

The department will continue with replacement of old ambulance fleet and implement a computer aided dispatch and vehicle monitoring system. Furthermore, three new purpose build stations will be completed. The coverage of advanced life support to all districts improved.

Oral health

Dental outreach services are in place in all districts. Oral Health services are partially established at Thabomoopo Hospital. However, there is still limited services at specialised hospitals. The department has established full dental laboratories at Mankweng and Polokwane Hospitals.

The department intends to establish oral health services at specialized hospitals. Preventative oral health services for children will be intensified. Restorations will be increase as compared to extractions.

Clinical Support Services

There is limited rendering of rehabilitation services at Primary Health Care (PHC) level with services not fully established at all hospitals. Backlog in the provisioning of assistive devices is still experienced. Nonetheless, centralized procurement assisted in addressing the assistive devises backlog.

The department has managed to have thirty-six of forty hospitals providing full rehabilitation services. Furthermore, all districts are providing community based rehabilitation services.

In future, rehabilitation service at hospitals will be sustained and number of hospitals offering the service will be increased. Rehabilitation services at forty-three PHC facilities will be established.

Health Technology

The current situation demonstrates that there is inadequate health technology management systems (procurement, replacement, commissioning, maintenance and de-commissioning). This is associated with lack of clinical engineers at district level. In addition, limited funding hinders the ability to procure new equipment. Fluctuations in the functionality of the current old units occasionally destabilise delivery of quality health care at various facilities. However, revitalization of hospitals provided for health technology equipment in affected facilities.

The department will continue with pooling of financial resources to ensure a more equitable distribution of health technology resources through prioritisation and establishment of five district health technology units.

Pharmaceutical

The department is experiencing inadequate management of pharmaceutical services at Primary Health Care level occasionally leading to limited inventory management which result in high expiry of medicines. However, training of Pharmacist Assistants for placement at PHC level on completion is on-going. Medicine availability at PHC level exceeded the target. RxSolution pharmaceutical management system has been installed at all hospitals.

In addressing the above challenges, the department will continually appoint all Post Basic Pharmacist's Assistants who are in training at PHC level preferentially. There will be a continues implementation of the Stock Visibility System (SVS) at all PHC facilities towards an informed push stock replenishment model. The dispensing model of RxSolutions will be implemented. There will be a rollout of Intenda platform for depot warehousing, procurement and supplier management.

1.7 ORGANISATIONAL ENVIRONMENT

1.7.1 Summary of the organisational structure

- As part of the Section 100 1 (b) intervention, DPSA embarked on the development of Service Delivery Model to realign the structure with the departmental strategic plan. From 2012 up to 2014, the Department together with the DPSA, embarked on the process to relook into the functional arrangements of the structure with the view to reorganise the department in line with Service Delivery Model and in alignment with the Departmental Strategic Plan. The mandate of this process was aimed at developing a generic structure for all departments of Health in terms of the Outcome 12 of the service delivery agreements.
- The structure was finally reviewed and eventually approved by the MEC during May 2015. The department is in the process of implementing the structure, i.e. capturing on PERSAL and expediting the evaluation of all newly created posts/jobs.
- Consequently, institutional (hospitals) structures that were approved and implemented during 2009/10 were reviewed to align with the gazette on the re-classification of hospitals during 2015/16. The structures were duly captured on PERSAL and currently, in the process of implementation.
- The approved structures for the different service levels assist the department in the provision of service delivery in that the structures are aligned to the objectives of the department, i.e. strategic plan, service delivery model, outcome 12, etc. Adequate posts have been provided to assist programmes in making sure that both back office and front office services are provided by relevant personnel with appropriate competencies.

1.7.2 Imbalances in service structures and staff mix

In the absence of staffing norms the current departmental organisational structures are developed based on the need of services, as well as National and Provincial mandates that affect health service delivery. These mandates, among others include; Medium Term Strategic Framework 2014-2019, key national programs and priorities, the MEC's Budget Speech, Strategic Plan, Sustainable Development Goals, National General Council Reports and the Limpopo Growth and Development Plan. The underlying core principles guiding the restructuring in the Department are as follows:

- Cohesion and integration of management systems across all levels of functionality;

- Need for stronger leadership and management capacity to plan, coordinate, control, monitor and evaluate to allow the provision of strategic guidelines and leadership on strategy, policy and coordination;
- Strengthen departmental management systems, services and points of accountability;
- Greater accountability and responsibility through the department in ensuring that policies are implemented and strategic objectives are delivered in the improvement of services;
- Efficient, effective, affordable and less bureaucratic structure that will promote a strong partnership orientation, stakeholder relations, inter-sectorial and interdepartmental collaboration in the delivery of services;
- Proper alignment, integration and implementation of legislative frameworks, departmental strategic plan, government priorities and other priority programmes programs;
- An appropriate structure to expedite the delivery of quality services with the overriding emphasis on delivering the department's core business;
- A more dynamic structure that will attract and retain a management cadre to deliver a high quality service;
- Increased focus and strengthening of core/line programme/functions to improve decision making and accountability; and
- Strengthen the improvement of service delivery, the achievement and delivery of strategic objectives, outcome 2, and SDG's imperatives, thus improving the health status of the Limpopo community.

Core and support personnel are therefore distributed according to the level of care. Despite the efforts to accurately allocate personnel in primary health care, district hospitals, provincial hospitals and tertiary hospital services, the Department is still experiencing challenges relating to fair and equitable distribution of both core and support personnel at various levels of health care services.

1.7.3 Summary of performance against Provincial Human Resource Plan

- **Current deployment of staff**
- In terms of the current approved organisational structure, the Department has a total number of 63 460 posts including both support and core. Based on this structure, the total number of filled posts is 35 012 as at 30 June 2016. The number of vacant posts is 28 446 which gives a vacancy rate of 44.8%. However, in terms of outcome 12, all government departments are expected to implement the Persal Clean-up project and one of the outputs of the project is to abolish all unfunded vacant posts from the Persal system. The posts status after the Persal Clean-up project is reflected as follows: Total posts are at 38 228; filled posts are at 35 012; vacant posts are at 3 216; and vacancy rate is at 8.4%.

- **Accuracy of staff establishment at all level against service requirements**
- The current institutional staff establishments at various levels of health care services such as Primary Health Care (PHC), District Hospitals, Regional Hospitals and Tertiary Hospital are appropriately aligned with service needs.

- **Staff recruitment and retention systems and challenges**

  Recruitment and retention of human resources for health in the Department remains a challenge and this is manifested by the following challenges, to mention a few:

✓ Lack of opportunities for career-pathing;

✓ Inadequate infrastructure;

✓ Inadequate and non-functional equipment; and

✓ Poor working conditions.

In response to these challenges, the Department has developed a Recruitment and Retention Strategy that is only been partially implemented due to financial constraints. Additionally, a succession plan framework has been developed with the aim of retaining required skills within the Department.

- **Absenteeism and staff turnovers**

  According to the absenteeism and staff turnover report of 2015/16 the high workload in the Department which is influenced by the high vacancy rates of health workers, contributes to burn out resulting in absenteeism and negative staff turnover. Absenteeism is analysed from the following types of leaves, vacation, sick leave, responsibility leave, unauthorised leaves and any other form of absenteeism as shown in the table A8 below:

Table A7. Types of leave for 2015/16

Type of Leave	Number of Employees	Totals Days
Sick leave	24 603	170 729
Disability leave	113	2 231
Annual leave	36 554	839 394
Capped leave	527	3 269

Absenteeism due to sick and disability leave impacts negatively on health service delivery. The department is currently strengthening the application of employee health and wellness programme in order to reduce diseases of life style.

- **Human resource information from the Provincial District Health Expenditure Review (DHER)**

Currently the department does not have a Human Resource Information System. However, systems such as PERSAL and District Health Expenditure Review are being utilised.

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

Health workforce normative guides and standards for fixed PHC facilities were developed and adopted by the National Health Council and gazetted. Currently, the implementation guideline for the health workforce have been utilised in the benchmark process in order to determine staffing needs for PHC. WISN results/data for each facility has been captured on DHIS.

The process of developing activities and standards for various hospitals has commenced where Provincial Departments of Health together with the National Department of Health have embarked on the process of consensus building towards the finalisation of activity standards.

1.8 PROVINCIAL SERVICE DELIVERY ENVIRONMENT

1.8.1 Overview of 2015/16 successes

Successes/ Achievements

- **National Health Insurance (NHI)**

  - ✓ 1 130 functional WBOTs have been established, trained and provided with households Screening Kits and over 200 000 households have been profiled and registered;
  - ✓ Central Chronic Medication Delivery and Distribution (CCMDD): One Central Service Provider and 21 Pick-up Points are providing chronic medications to stable patients closer to where they live or work to de-congest clinics and reduce waiting times.
  - ✓ Over 31 000 clients are enrolled on the programme which started with stable ART clients and has now expanded to also cover Hypertension and Diabetes.
  - ✓ 41 General Practitioners (GPs) have been contracted to provide clinical service coverage at PHC facilities in Vhembe District;
  - ✓ A Referral Communication System is being piloted
  - ✓ 90% of the 123 PHC facilities have been connected with Internet infrastructure.

- **Strengthening Health Care System effectiveness**

  In strengthening health care system effectiveness, the following where achieved:

  - ✓ All hospitals have broadband Internet access.
  - ✓ 118 of 477 PHC facilities are having broad band Internet access.
  - ✓ 100 new Ambulances were purchased to improve the ratio of Ambulance per population coverage.

- **Comprehensive primary health care services**

  In accelerating access and provision of quality primary health care services, the following were achieved:

  - ✓ All 5 districts have established District Specialist Teams to improve clinical management of cases at PHC level.
  - ✓ Ward Based Outreach Teams have been appointed to conduct House Hold Visits in all 5 districts.

- **Maternal, Child and Women's Health (MCWH) And Nutrition Programme**

  In intensifying Maternal, Child and Women's Health (MCWH) and Nutrition services the following were achieved:

  - ✓ Diarrhoea case fatality rate for under 5(five) reduced from 4.7% to 3%

- ✓ Pneumonia case fatality rate has declined from 4.2% to 3.1 %
- ✓ Ante natal care visit before 20 weeks has improved from 50.7% to 60.7%
- ✓ Maternal Mortality rate has declined from 182.6/100 000 to 140.1/100 000 live births.
- ✓ Cervical cancer screening coverage improved from 47.9% to 50.2%.

- **Prevention and Disease Control Programme**
  - ✓ Achievement of clients screened for hypertension and diabetes is at 2 605 439 and 1 171 430 respectively.
  - ✓ To prevent loss of sight 612.5 /1 000 000 population were done cataract surgery.
  - ✓ Malaria case fatality rate has improved from 1, 68% to 1.04%.

- **Comprehensive HIV and AIDS, STI and TB Programme**

In combating HIV and AIDS and decreasing the burden of disease from Tuberculosis:

- ✓ Total client remaining on ART has increased from 232 506 to 261 490
- ✓ TB client treatment success rate is 81.4% against 76.5% annual target.
- ✓ TB death rate is at 6.8% in comparison to 8% annual target.

1.8.2 Challenges in service delivery

During the 2015/16 financial year, the Department has encountered the following challenges:

- High number of reported and unreported adverse events
- High litigation costs due to medico-legal claims
- Ageing and poorly maintained infrastructure
- Unfunded infrastructure backlogs
- Ageing ICT infrastructure

Mitigating factors

Mitigating factors include:

- Motivate for additional funding for the following:
  - Infrastructure,
  - Retention of staff(Including health professionals),
  - Procurement and maintenance of medical equipment
  - Procurement of vehicles (mobile clinics, ambulances etc.), and
  - ITC capacitation in the institutions.

- Restructure, capacitate and reopen the Limpopo EMS College

TABLE A8: HEALTH PERSONNEL IN 2016/17

Categories	Number employed	% of total employed	Number per 100, 000 people	Number per 100,000 uninsured people[2]	Vacancy rate[5]	% of total personnel budget	Annual Notch cost per staff member
Medical officers	1094	3.03%	21	21	18.41%	6.62%	633 397
Medical specialists	91	0.25%	2	2	16.51%	1.00%	1 148 075
Dentists	201	0.56%	4	4	5.63%	1.20%	624 375
Dental specialists	4	0.01%	0	0	0.00%	0.06%	1 606 610
Professional nurses	9349	25.85%	178	178	3.66%	36.35%	406 956
Enrolled Nurses	4309	11.92%	82	82	2.49%	8.61%	209 271
Enrolled Nursing Auxiliaries[3]	5098	14.10%	97	97	0.25%	8.38%	171 992
Student nurses	611	1.69%	12	12	0.00%	0.85%	146 002
Pharmacists	504	1.39%	10	10	20.00%	2.55%	530 028
Physiotherapists	197	0.54%	4	4	5.74%	0.71%	376 431
Occupational therapists[3]	168	0.46%	3	3	8.70%	0.49%	302 441
Radiographers	249	0.69%	5	5	8.19%	0.66%	278 499
Emergency medical staff	1922	5.31%	37	37	1.54%	4.15%	225 839
Nutritionists	43	0.12%	1	1	0.00%	0.13%	312 325
Dieticians	316	0.87%	6	6	3.36%	1.25%	412 808
Community Health Workers	597	1.65%	11	11	13.97%	2.42%	424 484
All Other Personnel	11410	31.55%	217	217	12.43%	24.58%	225 537
Total	36163	100%	687	687	7.00%	100%	289 465

Data Source: Persal (or use latest information from South African Health Review 2013/14 if Persal data is not available)

This table should be for provincial health personnel. If data are available, another table for local government personnel should also be added, as well as a third table showing public health personnel in total (provincial plus local government).

1. Populations should be those of resident people.
2. Interns and community service should be included.
3. This group comprises 'health therapists' (e.g. physiotherapists, speech therapists, occupational therapists, clinical psychologists, environmental health practitioners, dental therapists) and specialised auxiliary service staff.

1.9 LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

a) Constitutional mandates

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

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

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

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

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

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

(1) Everyone has the right to have access to –

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and

(3) No one may be refused emergency medical treatment..

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

b) Legal mandates

The following national legislation and policy documents form the legal and policy framework being implemented within the Department.

- **National Health Act, 61 of 2003**

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

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

- **National Health Amendment Act, 2013**

Provides for the amendment of the National Health Act, 2013 so as to provide for the establishment of the Office of Health Standards Compliance.

Legislation falling under the Minister of Health's portfolio

- **Medicines and Related Substances Act, 101 of 1965**

Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 (as amended)**

Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.

- **Hazardous Substances Act, 15 of 1973**

Provides for the control of hazardous substances, in particular those emitting radiation.

- **Occupational Diseases in Mines and Works Act, 78 of 1973**

Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

- **Pharmacy Act, 53 of 1974 (as amended)**

Provides for the regulation of the pharmacy profession, including community service by pharmacists 9

- **Health Professions Act, 56 of 1974 (as amended)**

Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

- **Dental Technicians Act, 19 of 1979**

Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

- **Allied Health Professions Act, 63 of 1982 (as amended)**

Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.

- **Human Tissue Act, 65 of 1983**

Provides for the administration of matters pertaining to human tissue.

- **National Policy for Health Act, 116 of 1990**

Provides for the determination of national health policy to guide the legislative and operational programmes of the health portfolio.

- **SA Medical Research Council Act, 58 of 1991**

Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

- **Academic Health Centres Act, 86 of 1993**

Provides for the establishment, management and operation of academic health centres.

- **Choice on Termination of Pregnancy Act, 92 of 1996 (as amended)**

Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

- **Sterilisation Act, 44 of 1998**

Provides a legal framework for sterilisations, including for persons with mental health challenges.

- **Medical Schemes Act, 131 of 1998**

Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

- **Tobacco Products Control Amendment Act, 12 of 1999 (as amended)**

Provides for the control of tobacco products, the prohibition of smoking in public places and of advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry.

- **National Health Laboratory Service Act, 37 of 2000**

Provides for a statutory body that offers laboratory services to the public health sector. 10

- **Council for Medical Schemes Levy Act, 58 of 2000**

Provides a legal framework for the Council to charge medical schemes certain fees

- **Mental Health Care Act, 17 of 2002**

Provides a legal framework for mental health in the Republic and, in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on human rights for mentally ill patients.

- **Nursing Act, 33 of 2005**

Provides for the regulation of the nursing profession.

Other legislation in terms of which the Department operates

- **Children's Act, 38 of 2005**

Gives effect to certain rights of children as contained in the Constitution; sets out principles relating to the care and protection of children; defines parental responsibilities and rights.

- **Occupational Health and Safety Act, 85 of 1993**

Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

- **Compensation for Occupational Injuries and Diseases Act, 130 of 1993**

Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

- **The National Roads Traffic Act, 93 of 1996**

Provides for the testing and analysis of drunk drivers.

- **Constitution of the Republic of South Africa Act, 108 of 1996**

Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.

- **Employment Equity Act, 55 of 1998**

Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

- **State Information Technology Agency Act, 88 of 1998**

Provides for the establishment of an institution responsible for the provision state's information technology services to the public administration.

- **Skills Development Act, 97of 1998**

Provides for the measures that employers are required to take to improve the levels of skills of employees in a workplace.

- **Public Finance Management Act, 1 of 1999**

Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

- **Promotion of Access to Information Act, 2 of 2000**

Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

- **Promotion of Administrative Justice Act, 3 of 2000**

Amplifies the constitutional provisions pertaining to administrative law by codifying it.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**

Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

- **The Division of Revenue Act, 7 of 2003**

Provides for the manner in which revenue generated may be disbursed.

- **Broad-based Black Economic Empowerment Act, 53 of 2003**

Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

- **Labour Relations Act, 66 of 1995**

Provides for regulation of the organisational rights of trade unions, promotes employee participation in decision making by establishment of workplace forums.

- **Basic Conditions of Employment Act, 75 of 1997**

Provides for the minimum conditions of employment that the employer must conform with in the workplace.

- **Preferential Procurement Policy Framework Act, 5 of 2000**

Provides for the implementation of policy on preferential procurement pertaining to historically disadvantaged individuals.

- **Prevention and combating of corrupt Activities Act, 12 of 2004**

Provide for the strengthening of measures to prevent and combat corruption and corrupt activities.

c) Policy Mandates

National Mandates

National Development Plan (NDP)

Vision of NDP is a health system that works for everyone, comprising an appropriate balance between preventative health promotion and curative services that are affordable and accessible to all. The department is embarking on various strides to address key issues raised in the NDP: 1. Social determinants of health; 2. Health reform systems; 3. Reduction of maternal, infants and child mortality; and 4. Communicable and non-communicable diseases.

MTSF 2014-2019

This plan intends to implement the NDP. The plan takes into cognisance the achievements health sector has realised. On the other hand, it also notes the immense challenges still facing health. Health falls short in adequately addressing of social determinants of health, high levels of maternal mortality, a rising burden of diseases and rising costs pressures in both the public and private health sectors. The department has aligned itself with the MTSF through development of the five (5) year Strategic Plan 2015/16 – 2019/20.

Furthermore, as part of committing to the vision “A long and healthy life for people in Limpopo” the department developed strategies and direct efforts towards achieving: 1. Increasing life expectancy (e.g. training of health care workers on early diagnosis and treatment of Malaria and indoor residual spraying & implementation of hypertension and diabetes care model at PHC facilities); 2. Decreasing maternal and child mortality (e.g. implementation of the recommendations of Saving Mothers and Saving Babies reports, strengthening of childhood immunisation & mainstream HCT to all programs targeting children and pregnant women); 3. Combating HIV/AIDS and decreasing the burden of diseases from tuberculosis (e.g. increasing access to ART & implement National TB management guidelines) 4. Strengthen health systems effectiveness (e.g. data quality assessments in all health facilities, infrastructure maintenance & strengthening of M&E in health facilities).

Primary Health Care (PHC) Re-Engineering

The National Health Council has mandated that in order to improve health outcomes significantly steps be taken to restructure the health system. This is one of the 10 points in the five year Health Sector 10 Point Plan, noted as 'overhauling the healthcare system'. It is also the fourth pillar of the Negotiated Service Delivery Agreement as 'strengthening the effectiveness of the health system'. The model contains three streams: (a) a ward based PHC outreach team for each electoral ward; (b) strengthening school health services; and (c) district based clinical specialist teams (DCST) with an initial focus on improving maternal and child health. The department has thus far established the DCST structure and all teams are functional. A one year training for community health care workers have been conducted. In Mopani, the community health care workers have each been provided with BP machines, scales and MOAC tapes. Integrated school health vehicles have been purchased and distributed to enable delivery of these services. The department intends to establish organisational structure for school health and WBHOTS.

Operation Phakisa (Ideal Clinic)

An Ideal Clinic is a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community. During the launch of this initiative the President of South Africa noted that South Africans will most likely define "Ideal Clinic" as one that opened on time and did not close until the last patient was helped even if this was beyond the set closing time.

In the province, thirty-five clinics have achieved the ideal clinic status. The delay is attributed to dilapidated infrastructure. However staff has been capacitated in ideal clinic realisation model.

National Health Insurance (NHI)

The Minister formally launched the National Health Insurance Pilot in Limpopo on **17th April 2012**, followed by the 3 days of stakeholder consultative workshops. Vhembe District the only district in the province piloting NHI. As with other Conditional Grants, NHI activities are funded from the **NHI Conditional Grant on the basis of an approved Business Plan.** However, the grant is not aligned with the current needs of the district and there are delays in supply chain resulting in underspending. Despite this, the department achieved the following: stakeholder awareness conducted successfully; additional consulting rooms were built for 32 clinics; all clinics were supplied with computers, printers and staff was trained on computer skills; and forty-three General Practitioners are contracted to support 109 of 124 PHC facilities.

90-90-90 Strategy

This is a concept introduced by United Nations on HIV/AIDS programme in 2013. South Africa has adopted UNAIDS 90-90-90 Strategy by 2020. These treatment targets are intended to end the AIDS epidemic by 2030. South African approach to the strategy does not only address HIV but also TB. The strategy calls for 90% of HIV and TB infected individuals to be diagnosed of whom 90% will be put on treatment, 90% of those on Anti-retroviral therapy (ART) will achieve viral load suppression and 90% on TB treatment should be successfully treated. Reaching these targets by 2020 will reduce the HIV and TB epidemics to a low level of endemics by 2030.

Universe testing and treating will enable South Africa to realise the 2030 goals and in order to achieve that the department will do the following:

(1)Intensified TB case finding and aggressive HIV testing targeting key populations like men having sex with men and hard to reach individuals like men and youth.

(2)Ensure availability of treatment and monitoring TB and HIV clinical outcomes.

What is central to 'test and treat' policy is using ART as prevention to reverse the epidemic. Furthermore, in 2017/2018 financial year, the department will be implementing phase three of Districts Implementation Plans (DIPs) of 90-90-90 strategy. The strategy was marketed well and there is a buy in at all levels of care including civil society. The lessons learned since the implementation of DIP Phase1&2, have enabled the department to address areas of concern and continue to improve processes within the system to realise 2030 goal.

Provincial Mandates

Limpopo Development Plan

Limpopo Development Plan was officially launched in the financial year 2014/15. Amongst its outcomes, the department of health is largely affected by Outcome 2: Long and healthy life. The department has embarked on a Provincial Summit to work towards delivering its Long Term Health Plan aligned to this Provincial Outcome as well as the nine pillars of the National Development impacting on Health.

Policies to inform future local policy formulation

National Department of Health has endorsed and embarked on various policy initiatives e.g.:

- National Strategies for Non-Communicable Diseases 2014 - 2019; and
- Mental healthcare strategy 2014 – 2019.

d) Relevant court rulings

Court rulings that might impact on the Department's capacity to deliver services are the following:

i. SOOBRAMONEY v MINISTER OF HEALTH (KWAZULU-NATAL) 1998 (1) SA 765 (CC)

ii. MINISTER OF HEALTH & OTHERS v TREATMENT ACTION CAMPAIGN & OTHERS (NO 2) 2002 (5) SA 721 (CC)

1.10 OVERVIEW OF THE 2015/16 BUDGET AND MTEF ESTIMATES

The Department has been allocated an amount of R16.3 billion in the 2016/17 financial year to deliver the healthcare services in Limpopo Province.

The overall health budget increased from R15.4 billion in the 2015/16 financial year to R16.3 billion in 2016/17. This indicates an accumulative growth of 5.8% over the two years.

The budget is projected to grow from R18.0 billion in 2017/18 to R20.2 billion in the year ending 2019/20. This represents a cumulative growth of 12.2%. The funding however does not adequately address the health services requirements. This therefore impacts negatively on the achievements of the department to deliver its strategic goals and objectives.

Despite the above mentioned budget growth, the Department still experiences the funding gap in the following areas:-

- Filling of critical vacant posts to reduce the vacancy rate;
- Funding of the maintenance and equipment;
- Procurement of medical and allied equipment;
- Funding of Ideal Clinic;
- Funding of Integrated School Health Programme; and

- Reduction in the funding of Non-negotiable Items due to reduction in Goods and Services budget.

1. Equitable share

The baseline for 2017/18 financial year shows a 9.3% growth as compared to the 2016/17 final Main Appropriation including additional allocation from the Provincial Revenue Fund. The baseline however shows a 4.3% growth from the Adjusted Appropriation against 6.1% revised CPIX as per Medium Term Budget Policy Statements (MTBPS). This indicates a deficit of 1.8% or R275 million.

2. Conditional grants

The total conditional grants allocation increased by 16.3% or R337 million in the 2017/2018 financial year, which is mainly on Comprehensive HIV & AIDS and Health Facilities Revitalization Grants. This will assist addressing shortfall currently experienced within the Antiretroviral Treatment Programme and to bring back some of the projects suspended in 2011.The rest of the conditional grants have grown by an average of 6.2% which is slightly above the CPIX of 6.1%.

1.10.1 EXPENDITURE ESTIMATES

Expenditure estimates

	Programme R'000	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimate		
		2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
1.	Administration	**270 891	** 251 162	263 512	279 482	283 182	286 220	304 208	306 374	323 533
2.	District Health Services	7 868 353	9 280 312	9 849 561	10 250 218	10 839 949	11 223 924	11 421 926	12 117 131	12 999 854
3.	Emergency Medical Services	522 003	548 264	645 108	686 647	684 147	684 147	728 879	755 573	797 887
4.	Provincial Hospital Services	1 688 203	1 953 932	2 010 588	2 138 442	2 218 387	2 259 531	2 364 442	2 446 172	2 583 156
5.	Central Hospital Services	1 244 436	1 356 562	1 467 011	1 593 372	1 670 957	1 726 772	1 768 187	1 870 220	1 996 656
6.	Health Sciences and Training	432 315	478 131	484 702	571 492	534 637	645 321	660 476	665 228	658 090
7.	Health Care Support Services	754 036	92 012	107 499	113 758	128 758	128 758	140 446	152 336	160 865
8.	Health Facilities Management	355 890	563 913	602 206	735 668	736 161	736 161	652 172	675 570	713 388
	Sub-total									
	Direct charges against the National	1 735	1 822	1 902	1 943	2 543	2 543	2 040	2 158	2 280

Programme R'000	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Revenue Fund									
Total	13 137 862	14 557 187	15 432 089	16 371 023	**17 098 722**	**17 693 377**	**18 042 777**	**18 990 763**	**20 235 709**
Change to 2010/11 budget estimate	13 137 862	14 526 110	15 432 089	16 371 023	**17 098 722**	**17 693 377**	**18 042 777**	**18 990 763**	**20 235 709**

****The audited 2013/14 and 2014/15 figures included the direct charges which has since be excluded and corrected.**

Table A9: Summary of Provincial Expenditure Estimates by Economic Classification

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

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	**12 316 891**	**13 459 667**	**14 364 607**	**15 194 307**	**15 990 188**	**16 463 841**	**16 684 080**	**17 839 446**	**19 159 209**
Compensation of employees	9 377 977	10 336 806	11 352 270	12 171 722	12 338 381	12 338 382	12 999 392	13 753 358	14 557 383
Goods and services	2 938 914	3 122 861	3 012 337	3 022 585	3 651 806	4 125 459	3 684 687	4 086 088	4 601 826
Communication	57 119	56 157	58 595	33 891	57 338	68 408	58 122	64 055	67 642
Computer Services	70 589	159 241	83 296	70 866	82 148	159 825	96 710	102 078	110 835
Consultants, Contractors and special services	1 011 711	747 891	761 777	649 749	1 149 599	1 203 110	776 155	1 001 964	1 120 463
Inventory	1 320 913	1 370 685	1 258 243	1 517 923	1 627 990	1 776 703	1 805 411	1 938 739	2 255 280
Operating leases	37 048	24 536	17 820	26 358	31 963	24 737	42 042	38 342	40 448

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
Travel and subsistence	81 586	89 490	89 853	12 179	40 926	81 136	59 724	62 364	64 195
Maintenance , repair and running costs	127 589	142 452	148 741	150 335	143 960	184 058	152 468	151 831	160 334
Specify Other	232 359	532 409	594 012	561 284	517 882	627 482	694 055	726 715	782 629
Payment for financial assets	3 563	3 447	1 558						
Transfers and subsidies to	509 538	569 317	566 788	534 087	**658 351**	**779 351**	**706 760**	**695 647**	**647 370**
Provinces and municipalities	41	6 277	16 490	23 108	23 312	23 312	24 768	15 619	591
Departmental agencies and accounts	25 042	35 073	9 623	15 842	60 234	72 234	15 842	13 113	13 847
Non-profit institutions	282 515	297 334	332 290	305 060	367 870	367 870	421 398	419 211	423 552
Households	201 940	230 633	208 385	190 077	206 934	315 934	244 752	247 705	209 380
Payments for capital assets	**307 870**	**493 679**	**499 136**	**642 629**	**450 183**	**450 185**	**651 936**	**455 670**	**429 130**
Buildings	204 042	379 212	301 410	467 625	211 816	211 816	184 609	208 796	218 928
other fixed structures	3 081	–							
Machinery and equipment	100 747	114 467	197 726	175 004	238 339	238 341	467 327	246 874	210 202
Software and other intangible assets					28	28			
Total economic classification	**13 137 862**	**14 526 110**	**15 432 089**	**16 371 023**	**17 098 722**	**17 693 377**	**18 042 777**	**18 990 763**	**20 235 709**

1.10.2 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

TABLE A10: TRENDS IN PROVINCIAL PUBLIC HEALTH EXPENDITURE (R'000)

Expenditure	Audited/ Actual			Estimate	Medium term projection		
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Current prices[1]							
Total[2]	13 138	14 526	15 432	17 693	18 043	18 991	20 236
Total per person	2.48	2.80	3.03	3.48	3.55	3.73	3.98
Total per uninsured person	2.34	2.59	2.75	3.15	3.21	3.38	3.60
Constant (2008/09) prices[3]							
Total	14 583	15 979	14 660	15 924	15 517	16 332	17 403
Total per person	2.7	3.0	2.7	2.9	2.9	3.0	3.2
Total per uninsured person	13 475	14 764	13 546	14 713	14 338	15 091	16 080
% of Total spent on:-							
DHS[4]	25.1%	28.9%	30.8%	28.8%	30.4%	30.4%	28.5%
PHS[5]	6.7%	6.7%	6.9%	5.8%	6.1%	6.1%	5.7%
CHS[6]	4.3%	4.8%	5.2%	5.2%	5.4%	5.4%	5.0%
All personnel	27.7%	29.6%	30.9%	28.6%	28.1%	26.7%	25.0%
Capital[2]	5.2%	7.5%	6.4%	7.3%	7.1%	6.8%	6.4%
Health as % of total public expenditure	34.2%	33.6%	32.7%	34.7%	35.1%	36.3%	37.8%

1. Current price projections for the MTEF period are not required as these figures will be the same as the Constant price projections for the same years
2. Including maintenance. Capital spending under the public works budget for health should be included. This should equal the amounts indicated in tables HFM 1 and 2 and should exclude non-HFM capital falling under the Treasury definition of Capex (i.e. more than R5, 000 and lasts more than a year).
3. The CPIX multipliers in Table A4 should be should be used to adjust expenditure in previous years to 2008/09 prices.
4. District health services; any change in content of the budget programme should be indicated.
5. Provincial hospital services or previous designation; any change in content of the budget programme should be indicated
6. Central hospital services or previous designation; any change in content of the budget programme should be indicated.

PART B

PART B - PROGRAMME AND SUB-PROGRAMME PLANS

1. BUDGET PROGRAMME 1: ADMINISTRATION

1.1 PROGRAMME PURPOSE

The purpose of the programme is to provide strategic management and overall administration of the Department including rendering of advisory, secretarial and office support services through the sub programmes of Administration and Office of the MEC.

1.2 PRIORITIES

- Unqualified audit opinion through, among other things, compliance to payment of suppliers within 30 days, maintenance of credible Asset Register, compliance to Supply Chain Management prescripts, completeness of revenue.
- Increase number fixed PHC facilities with access to broadband.

1.3 PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

TABLE ADMIN 1: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR ADMINISTRATION

Strategic objective	Indicator	Indicator type	Audited/ Actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To improve human resource for health	**Strategic Objectives/Provincial Indicators**								
	1. Number of medical specialist appointed **	No	New indicator	14	11	10	10	10	10
	2. Number of medical doctors appointed**	No	New indicator	New indicator	New indicator	250	200	200	200
	3. Number of professional nurses appointed	No	New indicator	295	639	300	250	250	250
	4. Number of cleaners appointed	No	New indicator	136	20	100	110	120	130
	5. Number of grounds men appointed	No	New indicator	27	12	40	50	60	70
Provide efficient and effective financial management system	**Programme Performance/Customized Indicators (Sector Indicators)**								
	6. Audit opinion from Auditor-General	Categorical (QPR)	New indicators	Unqualified audit opinion	Qualified audit opinion	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion
	Strategic Objectives/Provincial Indicators								
	7. % compliance to payment of suppliers within 30 days	%	New indicator	72.43%	75%	100%	100%	100%	100%

Strategic objective	Indicator	Indicator type	Audited/ Actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	8. Number of institutions with Credible Asset Register	No	New indicator	58 of 58	58 of 58	58 of 58	58 of 58	58 of 58	58 of 58
	9. Revenue Collected	R	New indicator	R165.8 million	135.6 million	174.1 million	183 million	193.6 million	204.5 million
To improve health management information system	**Programme Performance/Customized Indicators (Sector Indicators)**								
	10. Percentage of Hospitals with broadband access	% (QPR)	New indicator	New indicator	100% (40/40)	100% (40/40)	100% (40/40)	100% (40/40)	100% (40/40)
	11. Percentage of fixed PHC facilities with broadband access	% (QPR)	New indicator	New indicator	27% (118/444)	35% (167/477)	40% (191/477)	50% (238/477)	60% (286/477)

*** No new appointments but replacements due to shortage of funding. Some baselines have been corrected according to the respective annual report.*

1.4 QUARTERLY TARGETS

TABLE ADMIN 2: QUARTERLY TARGETS

Indicator	Frequency (Quarterly, Bi-annual, Annual	Annual Targets 2017/18	Targets			
			Q1	Q2	Q3	Q4
1. Number of medical specialist appointed	Bi-annual	10	-	5	-	5
2. Number of medical doctors appointed	Bi-annual	200	-	100	-	100
3. Number of professional nurses appointed	Bi-annual	250	-	125	-	125
4. Number of cleaners appointed	Bi-annual	110	-	55	-	55
5. Number of grounds men appointed	Bi-annual	50	-	25	-	25
6. Audit opinion from Auditor-General	Annual	Unqualified audit opinion	-	-	-	Unqualified audit opinion
7. % compliance to payment of suppliers within 30 days	Quarterly	100%	100%	100%	100%	100%
8. Number of institutions with Credible Asset Register	Quarterly	58 of 58	58 of 58	58 of 58	58 of 58	58 of 58
9. Revenue Collected	Quarterly	183 million	35.8 million	45.7 million	49.6 million	51.9 million
10. Percentage of Hospitals with broadband access	Quarterly	100% (40/40)	100% (40/40)	100% (40/40)	100% (40/40)	100% (40/40)
11. Percentage of fixed PHC facilities with broadband access	Quarterly	40% (191/477)	36% (171/477)	37% (177/477)	39% (186/477)	40% (191/477)

1.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE ADMIN 4: EXPENDITURE ESTIMATES: ADMINISTRATION

Sub-programme	Expenditure outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
R' thousand									
MEC's Office	1,735	1,822	1 902	1 943	2 543	2 543	2 040	2 158	2 280
Management	270,891	251,162	263 512	279 482	283 182	286 220	304 208	306 374	323 533
Corporate Services									
Property Management									
TOTAL	**272,626**	**252,984**	**265 414**	**281 425**	**285 725**	**288 763**	**306 248**	**308 533**	**325 813**

Summary of Provincial Expenditure Estimates by Economic Classification[3]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	242 606	248 044	**262 277**	**280 637**	**282 122**	**285 085**	**304 595**	**307 843**	**325 086**
Compensation of employees	188 786	204 706	218 964	246 208	245 068	245 068	262 950	268 202	283 222
Goods and services	53 820	43 338	43 313	34 429	37 054	40 017	41 645	39 641	41 864
Communication	8 631	8 215	7 811	4 433	6 433	7 208	8 431	8 688	9 175
Computer Services	–	–	–	612	612	–	612	648	684

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

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Consultants, Contractors and special services	6 922	10 980	0	11 456	11 106	606	0	0	0
Inventory	1 671	3 325	1 961	1 930	1 930	1 984	2 242	2 397	2 532
Operating leases	8 289	5 848	3 665	235	235	4 010	3 247	3 261	3 444
Travel and subsistence	11 494	10 968	13 418	442	1 042	12 531	8 349	8 369	8 837
Maintenance , repair and running costs	12 813	-12 927	34	1 240	1 241	118	1 416	1 476	1 559
Specify other	4 000	16 929	16 424	14 081	14 455	13 560	17 348	14 802	15 633
Financial transactions in assets and liabilities	**3 563**	**3 447**	**1 558**						
Transfers and subsidies to	**26 271**	**1 022**	**1 385**	**260**	**1 450**	**1 523**	**298**	**313**	**330**
Provinces and municipalities	25	-	-	-	50	124	25	25	26
Departmental agencies and accounts	25 022	-	-	-					
Universities and technikons									
Households	1 224	999	1 353	259	1 399	1 399	272	288	304
Payments for capital assets	**186**	**1 471**	**194**	**529**	**2 154**	**2 155**	**1 355**	**376**	**397**
Buildings and other fixed structures									
Machinery and Equipment	186	1,471	**194**	**529**	2 154	2 155	1 355	376	397
Total economic classification	**272 626**	**252 984**	**265 414**	**281 425**	**285 725**	**288 763**	**306 248**	**308 533**	**325 813**

1.6 PERFORMANCE AND EXPENDITURE TRENDS

The allocated budget has a direct impact on the achievements of targets in the following ways:

- Foster the improvement of financial management and control in the department as a whole, e.g. policies and procedure manuals are developed, implemented and monitored throughout the department.
- Improvement of the effectiveness and efficiency of the supply chain management
- Intensify the implementation and monitoring of the risk management strategy throughout the department.

The department has spent a total of R790.9 million from 2013/14 to 2015/16 while the 2016/17 budget amounts to R281.4 million, adjusted to R285.7million. The proposed MTEF from 2017/18 to 2019/20 projected at R940.5 million that will be used to maintain and improve the current services. The funding has therefore been aligned to the various key strategic focus of the programme.

1.7 RISK MANAGEMENT

The key risks that may affect the realisation of the objectives for the budget programme Administration and the measures to mitigate the impact of the risks are indicated below

Strategic Objective	Risks	Mitigating factors
To provide efficient and effective financial management system	Irregular and unauthorized expenditures	- Implementation of fraud prevention plan with zero tolerance for fraud and corruption - Disciplinary process for transgressors to be reported to relevant statutory

Strategic Objective	Risks	Mitigating factors
To improve Health Management Information system	Adequacy and suitability of ICT infrastructure	- Service Level Agreement with service provider, including penalty clause on non or late deliverable - Management of agreement and support form SITA - Training and skill transfer from service provider to perform maintenance in-house - Business Continuity Plan and Disaster Recovery Plan funded and implemented
	Ineffective and inappropriate internal and external communication	Broad consultation on integrated communication strategy Implementation and monitoring of integrated communication strategy
To improve human resources for health	Failure to attract, develop and retain Critical skills	- Develop and implement succession plan - Provide clear delegation of authority for human resources - Review and re-engineering of human resources process to meet strategic objectives of the department - Improve processes for dealing with Disciplinary cases - Accelerated awareness on submission of completed job description and Job Evaluation questionnaires - Develop strategy to share Employee health and wellness Strategic Framework with all employee - Review and communicate Employee Health and Wellness management practices to all employees to encourage compliance

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

2.1 PROGRAMME PURPOSE

The purpose is to render District Health Services through the following sub-programmes:

- Primary Health Care Services (District management, Community Health Centres, Clinics, Community Based Services).
- District hospitals;
- HIV and AIDS, Sexually Transmitted Infections (STI) and Tuberculosis (TB) Control Programmes;
- Mother and Child and Women's Health and nutrition(MCWHN) as well as youth and adolescent; and
- Disease Prevention and Control.

2.2 PRIORITIES

- Conduct National Core Standards and develop quality improvement plans in all district hospitals.
- Strengthening coordination and integration of existing Ward-based Outreach Teams in all districts
- Combating HIV and AIDS and TB through implementation and monitoring of 90-90-90 strategy.
- Decreasing the burden of diseases from Tuberculosis and other Communicable diseases
- Reduce institutional maternal mortality from 165.2/100 000 in 2013/2014 financial year to 159/100 000 in 2017/2018 financial year
- Improve the quality in the management of Childhood illness through training.
- Prevention and control of Non–communicable Diseases (NCDs)

2.3 SPECIFIC INFORMATION FOR DHS

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

Health district	Facility type	No.[5]	Population[3]	Population per facility[3] or per hospital bed	PHC Headcount Or Inpatient Separations	Per capita utilisation[3]
CAPRICORN	Non fixed clinics[1]	307	1 261 463			3.1
	Fixed Clinics operated by Local Government					
	Fixed Clinics operated by Provincial Government[2]	96				
	Fixed Clinics operated by NGOs					
	Total fixed Clinics	96				
	CHCs	4				
	Sub-total clinics + CHCs	100				
	District hospitals[4]	6		210 244		
MOPANI	Non fixed clinics[1]	1394	1 092 507			2.8
	Fixed Clinics operated by Local Government					
	Fixed Clinics operated by Provincial Government[2]	95				
	Fixed Clinics operated by NGOs					
	Total fixed Clinics	95				
	CHCs	8				
	Sub-total clinics + CHCs	103				
	District hospitals[4]	6				
SEKHUKHUNE	Non fixed clinics[1]	402	1 076 840			2.3
	Fixed Clinics operated by Local Government					
	Fixed Clinics operated by Provincial Government[2]	84				
	Fixed Clinics operated by NGOs					
	Total fixed Clinics	84				
	CHCs	3				
	Sub-total clinics + CHCs	87				
	District hospitals[4]	5		215 368		
VHEMBE	Non fixed clinics[1]	1 033	1 294 722			3.5
	Fixed Clinics operated by Local Government					

Health district	Facility type	No.[5]	Population [3]	Population per facility[3] or per hospital bed	PHC Headcount Or Inpatient Separations	Per capita utilisation[3]
	Fixed Clinics operated by Provincial Government[2]	116				
	Fixed Clinics operated by NGOs					
	Total fixed Clinics	116				
	CHCs	8				
	Sub-total clinics + CHCs	124				
	District hospitals[4]	6		215 787		
WATERBERG	Non fixed clinics[1]	1 337				2.1
	Fixed Clinics operated by Local Government					
	Fixed Clinics operated by Provincial Government[2]	61				
	Fixed Clinics operated by NGOs					
	Total fixed Clinics	61				
	CHCs	2				
	Sub-total clinics + CHCs	63				
	District hospitals[4]	7		97 048		
PROVINCE	Non fixed clinics[1]					
	Fixed Clinics operated by Local Government					
	Fixed Clinics operated by Provincial Government[2]	452				
	Fixed Clinics operated by NGOs					
	Total fixed Clinics	452				
	CHCs	25				
	Sub-total clinics + CHCs	477				
	District hospitals[4]	30		180 162		

2.4 SITUATIONAL ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

TABLE DHS 2: SITUATIONAL ANALYSIS INDICATORS FOR DISTRICT HEALTH SERVICES

Programme Performance Indicators	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
OHH registration visit coverage (annualised)	No	17.1% (144 664/845 697)	73.7% (56 193/76 202)	10.7% (71 574/666 084)	0.10% (31/26 038)	22% (11 147/50 193)	21.% (5 717/27 180)
PHC utilisation rate	No	2.5 (14 351 491/5 671 634)	2.6 (3 337 540/1 288 096)	2.8 (3 140 699/1 130 765)	2.2 (3 917 673/1 372 290)	2.9 (2 485 391/1 142 411)	2.0 (1 469 648/738 068)
Complaints resolution rate	%	75.6% (1 581/2 091)	64.4% (451/700)	85% (182/214)	73.6% (396/538)	77.5% (124/160)	89.4% (428/479)
Complaint resolution within 25 working days rate	%	96.4% (1 524/1 581)	94.9% (428/451)	97.8% (178/182)	96.2% (381/396)	94.4% (117/124)	98.1% (420/428)

2.4.1 PROVINCIAL STRATEGIC OBJECTIVES INDICATORS AND ANNUAL TARGETS FOR DHS

TABLE DHS3: PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES

Strategic objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
1.To re-engineer Primary Health Care services. 2.To improve access to quality health services	**Strategic Objectives/Provincial Indicators**								
	1. Number of PHC facilities open for 24 hours	No	53 of 443	44 of 65	52 of 65	53 of 65	100 of 150	130 of 150	150 of 150
	2. Number of PHC facilities implementing the on call service system	No	261 of 443	244 of 444	239 of 379	270 of 379	223 of 294	193 of 294	173 of 294
	3. Number of mobile clinics procured	No	New indicator	New indicator	0	30	10	20	25
	Programme Performance/Customized Indicators (Sector Indicators)								
	4. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	% (QPR)	New indicator	New indicator	New indicator	New indicator	100% (250/250)	100% (250/250)	100% (250/250)

Strategic objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	5. OHH registration visit coverage	% (QPR)	New indicator	20.9%	17.1% (144 664/845 697)	25%	26% (219881/845697)	27% (228339/845697)	30% (253709/845697)
	6. PHC utilisation rate	% (QPR)	2.6	2.6 (14343485/5602426)	2.5 (14 351 491/5671 634)	2.6	2.7 (15920402/5896445)	2.8 (16717350/5597048 2)	2.9 (17528798/6044413)
	7. Complaints resolution rate	% (QPR)	New indicator	New indicator	75.6% (1 581/2 091)	95%	76% (1589/2091)	76.5% (1600/2091)	77% (1610/2091)
	8. Complaints resolution within 25 working days rate	% (QPR)	91.7%	95% (5115/5381)	96.4% (1 524/1 581)	95%	97% (1534/1581)	97.5% (1541/1581)	98% (1549/1581)

Some baselines have been corrected according to the respective annual report.

2.4.2 QUARTERLY TARGETS FOR DHS

TABLE DHS 4: QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES FOR 2016/16

Performance Indicator	Frequency of reporting (Quarterly / bi-annual, Annual)	Indicator Type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Number of PHC facilities open for 24 hours	Quarterly	No	100 of 150	100 of 150	100 of 150	100 of 150	100 of 150
2. Number of PHC facilities implementing the on call service system	Quarterly	No	223 of 294	223 of 294	223 of 294	223 of 294	223 of 294
3. Number of mobile clinics procured	Annual	No	10	-	-	-	10
4. Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	Bi-annual	% (QPR)	100% (250/250)	-	50% (125/250)	-	100% (250/250)
5. OHH registration visit coverage	Quarterly	No (QPR)	26% (219881/845697)	6.5%	13%	19.5%	26%

Performance Indicator	Frequency of reporting (Quarterly / bi-annual, Annual)	Indicator Type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
6. PHC utilisation rate	Quarterly	% (QPR)	2.7 (15920402/ 5896445)	2.7	2.7	2.7	2.7
7. Complaints resolution rate (PHC)	Quarterly	% (QPR)	76% (1589/2091)	76%	76%	76%	76%
8. Complaint resolution within 25 working days rate (PHC)	Quarterly	% (QPR)	97% (1534/1581)	97%	97%	97%	97%

2.5 SUB – PROGRAMME DISTRICT HOSPITALS

TABLE DHS 5: SITUATION ANALYSIS INDICATORS FOR DISTRICT HOSPITALS

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Average Length of Stay	No	4.3 days	4.5 days	4.5 days	3.8 days	4.4 days	4.1 days
Inpatient Bed Utilisation Rate	%	70.4% (1 047 691of 1 487 750)	73.0% (205 572 of 281 445)	74.1% (228 257 of 308 185)	61.4% (152 159 of 247 862)	77.1% (297 865 of 386 303)	62.1% (163 837 of 263 954)
Expenditure per PDE	R	R3006.8	R2 728	R2 778.4	R2 735.3	R3 392.5	R3 292.7

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
Complaints resolution rate	%	89.8% (1 643 of 1829)	97.0% (355 of 366)	91.7% (411 of 448)	93.4% (354 of 379)	82.3% (251 of 305)	82.2% (272 of 331)
Complaint Resolution within 25 working days rate	%	97.7% (1606 of 1643)	100% (355 of 355)	93.4% (384 of 411)	98.3% (348 of 354)	100% (251 of 251)	98.5% (268 of 268)

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

TABLE DHS 6: PERFORMANCE INDICATORS FOR DISTRICT HOSPITALS

Strategic objective	_Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimate	Medium-term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Improve access to quality hospital services	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)	% (QPR)	New indicator	New indicator	New indicator	New indicator	33% (10 of 30)	66% (20 of 30)	100% (30 of 30)
	2. Average Length of Stay (District Hospitals)	No (QPR)	4.5 days	4.2 days (1046825.5/246348)	4.3 days (1047691.5/244100)	4.3	4.3 (1047691.5/244100)	4.3 (1047691.5/244100)	4.3 (1047691.5/244100)
	3. Inpatient Bed Utilisation Rate (District Hospitals)	% (QPR)	64.2%	69.1% (1046825.5/1513851.3)	70.4% (1 047 691/1 487 750)	70%	71% (1056303/1487750)	72% (1071180/1487750)	73% (1086057/1487750)
	4. Expenditure per PDE (District Hospitals)	R (QPR)	R2 241.1	R 3096.3 (5102696841/1648650.494)	R3006.8 (491 345 709/1 636 064)	R2200	R2781.36	R2962.15	R3154.68
	5. Complaints resolution rate (District Hospitals)	No (QPR)	New indicator	New indicator	89.8% (1 643 of 1829)	100%	90% (1646/1829)	90.5% (1655/1829)	91% (1664/1829)

Strategic objective	_Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimate	Medium-term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	6. Complaints Resolution within 25 working days rate (District Hospitals)	% (QPR)	100% (1695/1698)	100% (1830/1825)	97.7% (1606 of 1643)	100%	98%(1613 /1646)	99% (1638/16 55)	100% (1664/1664)

2.5.2 QUARTERLY TARGETS FOR DISTRICT HOSPITALS

TABLE DHS 7: QUARTERLY TARGETS FOR DISTRICT HOSPITALS

PROGRAMME PERFORMANCE INDICATOR	QUARTERLY / ANNUAL	INDICATOR TYPE	ANNUAL TARGET 2017/18	QUARTERLY TARGETS			
				Q1	Q2	Q3	Q4
1. Hospital achieved 75% and more on National Core Standards self-assessment rate (District Hospitals)	Quarterly	% (QPR)	33% (10 of 30)	10% (3 of 30)	17% (5 of 30)	23% (7 of 30)	33% (10 of 30)
2. Average Length of Stay (District Hospitals)	Quarterly	No (QPR)	4.3 (1047691.5/244100)	4.3	4.3	4.3	4.3
3. Inpatient Bed Utilisation Rate (District Hospitals)	Quarterly	% (QPR)	71% (1056303/1487750)	71%	71%	71%	71%

PROGRAMME PERFORMANCE INDICATOR	QUARTERLY / ANNUAL	INDICATOR TYPE	ANNUAL TARGET 2017/18	QUARTERLY TARGETS			
				Q1	Q2	Q3	Q4
4. Expenditure per PDE (District Hospitals)	Quarterly	R (QPR)	R2781.36	R2781.36	R2781.36	R2781.36	R2781.36
5. Complaints resolution rate (District Hospitals)	Quarterly	No (QPR)	90% (1646/1829)	90%	90%	90%	90%
6. Complaint Resolution within 25 working days rate (District Hospitals)	Quarterly	% (QPR)	98%(1613/1646)	98%	98%	98%	98%

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

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

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
ART client remain on ART end of month - total	No	260 843	52 868	69 514	47 493	52 408	38 560
TB/HIV co-infected client on ART rate	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
HIV test done – total	No	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
Male condom distribution coverage	No	51.2%	54.2%	54.2%	42.7%	51.8%	53.0%
Medical male circumcision performed – Total	No	71769	20 616	16 135	8 557	15 759	10 702
TB symptom 5yrs and older start on treatment rate	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
TB client treatment success rate	%	81.4% (4544/5582)	81% (877/1083)	87.9% (1038/1181)	80% (800/1000)	78.7% (837/1064)	80% (709/886)
TB client lost to follow up rate	%	4.9% (274/5582)	6% (65/1083)	3.4% (40/1181)	6.3% (63/1000)	4.3% (46/1064)	5.3% (47/886)
TB death rate	%	6.8% (379/5582)	6.8% (74/1083	5.6% (66/1181)	7.7% (77/1000)	4.7% (50/1064)	8.8% (78/886)
TB MDR treatment success rate	%	50% (213/427)					

2.6.1 PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR HAST

TABLE DHS 9: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR HIV & AIDS, STI AND TB CONTROL

Strategic objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To increase access to comprehensive HIV and AIDS, STIs and TB treatment, management and support.	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. ART client remain on ART end of month – total	No (QPR)	189002	232506	260 843	New Indicator	336 452	352 974	376 774
	2.TB/HIV co-infected client on ART rate	% (QPR)	New Indicator	New Indicator	New Indicator	87%	93% (10161/10925)	94% (10270/10925)	95% (10379/10925)
	3. HIV test done - total	No (QPR)	New indicator	New indicator	New indicator	New indicator	1024546	1024546	1024546
	4. Male condom distributed	No (QPR)	27.6%	New indicator	51.2%	7 885 221	87 085 290	88 826 995	90 603 535
	5.Medical male circumcision – Total	No (QPR)	68 516	67 205	71769	69 231	36 910	34 072	31 232
	6.TB symptom 5yrs and older start on treatment rate	% (QPR)	New Indicator	New indicator	New indicator	New indicator	80%	85%	90%
	7.TB client treatment success rate	% (QPR)	75.5% (4919/6514)	76.5% (4371/5710)	81.4% (4544/5582)	80%	83% (4634/5582)	87% (4857/5582)	90% (5024/5582)
	8.TB client lost to follow up rate	% (QPR)	New indicator	New indicator	4.9% (274/5582)	4.5%	4.3% (240/5582)	4.1% (229/5582)	4% (224/5582)
	9.TB death rate	% (QPR)	New indicator	New indicator	6.8% (379/5582)	7%	8.2% (458/5582)	7.4% (413/5582)	5.8% (324/5582)

Strategic objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	10.TB MDR treatment success rate	% (QPR)	New indicator	New indicator	50% (213/427)	60%	60% (257/427)	65% (278/427)	70% (299/427)

2.6.2 QUARTERLY TARGETS FOR HAST

TABLE DHS 10: QUARTERLY TARGETS FOR HIV & AIDS, STI AND TB CONTROL

Programme Performance Indicator	Frequency of reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. ART client remain on ART end of month - total	Quarterly	No (QPR - Cumulative)	336 452	295 645	309 248	322 850	336 452
2. TB/HIV co-infected client on ART rate	Quarterly	% (QPR)	93% (10161/10925)	93%	93%	93%	93%
3. HIV test done – total	Quarterly	No (QPR)	1024546	256 136	256 136	256 137	256 137
4. Male condom distributed	Quarterly	No (QPR)	87 085 290	21 771 322	21 771 322	21 771 323	21 771 323
5. Medical male circumcision – Total	Quarterly	No (QPR)	36 910	5 906	17 348	3 322	10 335
6. TB symptom 5yrs and older start on treatment rate	Quarterly	% (QPR)	80%	80%	80%	80%	80%
7. TB client treatment success rate	Quarterly	% (QPR)	83% (4634/5582)	83%	83%	83%	83%

Programme Performance Indicator	Frequency of reporting (Quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	Targets			
				Q1	Q2	Q3	Q4
8. TB client lost to follow up rate	Quarterly	% (QPR)	4.3% (240/5582)	4.3%	4.3%	4.3%	4.3%
9. TB death rate	Annual	% (QPR)	8.2% (458/5582)	-	-	-	8.2%
10. TB MDR treatment success rate	Annual	% (QPR)	60% (257/427)	-	-	-	60%

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

TABLE DHS 11: SITUATIONAL ANALYSIS INDICATORS FOR MCWH&N

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
1. Antenatal 1st visit before 20 weeks rate	%	60.7% (971257 of 117315)	56.6% (13 661 of 24 197)	63.3% (14 940 of 23 617)	59.2% (14 660 of 24 770)	63.5% (18 421 of 29 025)	61.0 (9 575 of 15 706)
2. Mother postnatal visit within 6 days rate	%	66.8% (80972 of 121159)	62.0% (16 391 of 26 451)	73.0% (18 184 of 24 907)	61.4% (15 428 of 25 121)	69.9% (21 105 of 30 194)	68.1 (9 864 of 14 486)
3. Antenatal client initiated on ART rate	%	92.8% (15 485 of 16 689)	95.7% (13 661 of 24 197)	94.1% (3 417 of 3 631)	91.3% (3 164 of 3 465)	90.8% (2 898 of 3 190)	91.4% (2 592 of 2 836)
4. Infant 1st PCR test positive around 10 weeks rate	%	2.1% (311 of 15 004)	1.6% (59 of 3 735)	1.7% (59 of 3 520)	2.6% (79 of 3 012)	2.1% (49 of 2 348)	2.7% (65 of 2 389)
5. Immunisation coverage under 1 year	%	79.2% (98 806 of 12 4744)	74% (21 805 of 29 449)	88.7% (19 807 of 22 334	74.4% (18 549 of 24 944)	88.3% (26 979 of 30 562)	66.7% (11 669 OF 17 484)
6. Measles 2nd dose coverage	%	87.9% 110542 of 125 689)	77.2% (22 867 of 29 604)	98.1% (22 427 of 22 852)	91.5% 22 575 of 24 659)	99.9% (31 069 of 31 022)	66.4% (11 604 of 17 486)
7. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	%	0% -26.2% -26 494 of 101085	-10.8% (-2 548 of 23 642)	-22.5% (-4 732 of 21 026)	-46.4% (-8665 of 18 655)	-33.6% (-8 547 of 25 448)	-16.3 (-2002 of 12 314)

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
8. Child under 5 years diarrhoea case fatality rate	%	3.0% 154 of 5132)	3.4% (26 of 769)	4.0% (45 of 1 124)	3.2% (31 of 1 710)	2.2% (15 of 559)	2.7% (15 of 559)
9. Child under 5 years pneumonia case fatality rate	%	3.1% (178 of 5750) 9	3.7% (26 of 700)	2.9% (34 of 1155)	4.5% (40 of 897)	2.3% (51 of 2184)	3.3% (27 of 814)
10. Child under 5 years severe acute malnutrition case fatality rate	%	11.6% (222 of 1919)	13.9% (32 of 230)	12.9% (44 of 341)	13.0% (34 of 261)	13.0% (79 of 608)	6.9% (33 of 479)
11. School Grade 1 screening coverage	%	29.5% (42 808 of 145 069)	33.6 (10494 of 3 1226)	38.9% (11 669/ 30 031)	10.1 (3 310 of 32 855)	38.4 (13 593 of 35 354)	24 (3 742 of 15 605)
12. School Grade 8 screening coverage	%	11.1% (12994 of 116 580)	17.1 (4 570 of 26 803)	14.5 (3 427 of 23 655)	0	16 (4 842 of 30 235)	1.2 (148 of 12 212)
13. Delivery in 10 to 19 years in facility rate	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
14. Couple year protection rate (Int)	%	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator
15. Cervical Cancer Screening coverage for women 30 years and older	%	50.1% (62 568 of 124 779)	55.9% (15 182 of 27 149)	52.1% (13 648 of 26 184)	47.2% (11 578 of 24 551)	48.6% (14 989 of 30 836)	44.7% (7 171 of 16 057)
16. Human Papilloma Virus Vaccine 1st dose	%	68.2% (15 485 of 16 689)	117.4 (13384 of 11405)	99.1 (10982 of 11081)	120.5 (11319 of 9393)	120 (13392 of 12361)	108.3 (6659 of 5550)

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
17. Human Papilloma Virus Vaccine 2nd dose	%	80% (48 339 of 60 424)	84.4 (9621 of 11405)	73.7 (8170 of 11081)	79.5 (7472 of 9393)	73.7 (9104 of 12361)	87.3 (4844 of 5550)
18. Vitamin A 12-59 months coverage	%	50.0% (501570 of 1002709.5)	48.0% (113 237 of 235 905)	57.5% (106 148 of 184 659)	51.1% (98 799 of 193 163)	52.2% (130 848 of 250 427)	37.9% (52 538 of 138 555)
19. Infant exclusively breastfed at DTap-IPV-Hib-HBV 3rd dose rate	%	56.8%	81.9	43.7%	45.0%	52.6%	58.6%
20. Maternal mortality in facility ratio (annualised)	per 100 000 Live Births	140.1/100 000 (169 of 120 572)	316.9/100 000 (83 of 26 191)	120.7/10 0 000 (30 of 24 859)	96.3/100 000 (24 of 24 927)	66.2/100 000 (20 of 30 202)	83.4/100 000 (12 of 14 393)
21. Neonatal death in facility rate	per 1000	1.1/1000	22.0	10.1	8.5	9.4	13.5

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

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

Strategic Objective	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To reduce Maternal and child morbidity and mortality.	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Antenatal 1st visit before 20 weeks rate	% (QPR)	45.8%	50.7%	60.7% (71257/117315)	50%	65% (76255/117315)	68% (79774/117315)	70% (82127/117315)
	2. Mother postnatal visit within 6 days rate	% (QPR)	New indicator	New indicator	66.8% (80972/121159)	80%	80% (96927/121159)	83% (100562/121159)	85% (102985/121159)
	3. Antenatal client start on ART rate	% (QPR)	New indicator	New indicator	92.8% (15 485/16 689)	98%	95% (15855/16689)	97% (16188/16689)	98% (16355/16689)
	4. Infant 1st PCR test positive around 10 weeks rate	% (QPR)	New indicator	New indicator	New indicator	1.4%	1.3% (195/15004)	1.25% (188/15004)	1.2% (180/15004)
	5. Immunisation under 1 year coverage	% (QPR)	70.3%	82.2%	79.2% (98 806/124744)	90%	85% (108123/127203))	87% (111524/128188)	90% (116708/129675)
	6. Measles 2nd dose coverage	% (QPR)	New indicator	New indicator	87.9% (110542 of 125 689)	85%	85% (106836/125689)	87% (109349/125689)	90% (113120/125689)
	7. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	% (QPR)	New indicator	New indicator	0% (-26.2%) (-26 494/101085)	6%	6%	5%	4%

Strategic Objective	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	8. Child under 5 years diarrhoea case fatality rate	% (QPR)	New indicator	4.7%	3.0% (154/5132)	4.5%	3.5% (180/5132)	3% (154/5132)	2.75% (141/5132)
	9. Child under 5 years pneumonia case fatality rate	% (QPR)	New indicator	4.2% (232/5517)	3.1% (178/5750)	4.5%	2.9% (167/5750)	2.8% (161/5750)	2.7% (155/5750)
	10. Child under 5 years severe acute malnutrition case fatality rate	% (QPR)	New indicator	14.9% (291/1950)	11.6% (222/1919)	14%	12% (230/1919)	11% (211/1919)	10% (192/1919)
	11. School Grade 1 – learners screened	No (QPR)	New indicator	New indicator	29.5% (42 808/145 069)	35 435	45 717	47 917	50 417
	12. School Grade 8 – learners screened	No (QPR)	New indicator	New indicator	11.1% (12994/116 580)	16 214	17 835	19 619	21 403
	13. Delivery in 10 to 19 years in facility rate	% (QPR)	New indicator	New indicator	New indicator	New indicator	12% (15418/128 483)	10% (12848/128483)	9% (11563//128483)
	14. Couple year protection rate (Int)	% (QPR) (Annualised)	New indicator	New indicator	New indicator	New indicator	75% (102989/137318)	78% (108098/138588)	80% (111897/139871)
	15. Cervical Cancer Screening coverage for women 30 years and older	% (QPR)	55.5%	47.9% (58166/1455 732)	50.1% (62 568/124 779)	57%	60% (76131/1268851*10)	65% (84999/1307670*10)	70% (111897/1347029*10)

Strategic Objective	Programme Performance Indicator	Indicator Type	Audited/ Actual performance			Estimated performance	Medium Term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	16. Human Papilloma Virus Vaccine 1st dose	No (QPR)	New indicator	98%	68.2% 15 485 of 16 689)	56 972	69 948	69 953	70 453
	17. Human Papilloma Virus Vaccine 2nd dose	No (QPR)	New indicator	90.4%	80% (48 339 of 60 424)	39 407	51 754	54 342	57 059
	18. Vitamin A 12-59 months coverage	% (QPR)	33.8% (1346560/ 47835120)	44.3% (444718/12 031638)	50.0% (501570 of 1002709.5)	45%	52% (521409/10 02709.5)	55% (551490/ 1002709. 5)	60% (601626/10 02709.5)
	19. Infant exclusively breastfed at DTap-IPV-Hib-HBV 3rd dose rate	% (QPR)	New indicator	New indicator	New indicator	New indicator	50% (27016/540 31)	55% (29717/5 4031)	60% (32419/540 31)
	20. Maternal mortality in facility ratio (annualised)	per 100 000 Live Births (QPR)	New indicator	167.4/100 000	140.1/100 000 (169 of 120 572)	164/100 000	159/100 000 (192/1205 72)	158/100 000 (191/12 0572)	157/100 000 (189/1205 72)
	21. Neonatal death in facility rate	Per 1000 (QPR)	New indicator	New indicator	12.6/1000 (1521 of 120572)	11/1000	12.5/1000 (1597/1277 47)	12/1000 (1533/12 7747)	11.5/1000 (1469/1277 47)

QUARTERLY TARGETS FOR MCWH&N

TABLE DHS13: QUARTERLY TARGETS FOR MCWH&N

Indicator	Frequency of Reporting (Quarterly, Bi annual)	Indicator Type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Antenatal 1st visit before 20 weeks rate	Quarterly	% (QPR)	65% (76255/117315)	65%	65%	65%	65%
2. Mother postnatal visit within 6 days rate	Quarterly	% (QPR)	80% (96927/121159)	80%	80%	80%	80%
3. Antenatal client initiated on ART rate	Annually	% (QPR)	95% (15855/16689)	-	-	-	95%
4. Infant 1st PCR test positive around 10 weeks rate	Quarterly	% (QPR)	1.3% (195/15004)	1.3%	1.3%	1.3%	1.3%
5. Immunisation under 1 year coverage	Quarterly	% (QPR)	85% (108123/127203))	85%	85%	85%	85%
6. Measles 2nd dose coverage	Quarterly	% (QPR)	85% (106836/125689)	85%	85%	85%	85%
7. DTaP-IPV-HepB-Hib 3 - Measles 1st dose drop-out rate	Quarterly	% (QPR)	6%	6%	6%	6%	6%
8. Child under 5 years diarrhoea case fatality rate	Quarterly	% (QPR)	3.5% (180/5132)	3.5%	3.5%	3.5%	3.5%
9. Child under 5 years pneumonia case fatality rate	Quarterly	% (QPR)	2.9% (167/5750)	2.9%	2.9%	2.9%	2.9%

Indicator	Frequency of Reporting (Quarterly, Bi annual)	Indicator Type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
10. Child under 5 years severe acute malnutrition case fatality rate	Quarterly	%(QPR)	12% (230/1919)	12%	12%	12%	12%
11. School Grade 1 screening coverage (annualised)	Quarterly	No (QPR)	45 717	23 776	13 600	6 950	1 391
12. School Grade 8 screening coverage (annualised)	Quarterly	No (QPR)	17 835	9 500	3 200	3 500	1 635
13. Delivery in 10 to 19 years in facility rate	Quarterly	% (QPR)	12% (15418/128483)	12%	12%	12%	12%
14. Couple year protection rate (Int)	Quarterly	% (QPR)	75% ((102989/137318)	75%	75%	75%	75%
15. Cervical Cancer Screening coverage for women 30 years and older	Quarterly	% (QPR)	60% (76131/1268851 *10)	60%	60%	60%	60%
16. Human Papilloma Virus Vaccine 1st dose	Annual	No (QPR)	69 948	-	-	-	69 948
17. Human Papilloma Virus Vaccine 2nd dose	Annual	No (QPR)	51 754	-	-	-	51 754
18. Vitamin A 12-59 months coverage	Quarterly	% (QPR)	52% (521409/1002709.5)	52%	52%	52%	52%
19. Infant exclusively breastfed at DTap-IPV-Hib-HBV 3rd dose rate	Quarterly	% (QPR)	50% (27016/54031)	50%	50%	50%	50%
20. Maternal mortality in facility ratio	Annual	per 100 000 Live Births (QPR)	159/100 000 (192/120572)	-	-	-	159/100 000

Indicator	Frequency of Reporting (Quarterly, Bi annual)	Indicator Type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
21. Neonatal death in facility rate	Annual	per 1000 (QPR)	12.5/1000 (1597/127747)	-	-	-	12.5/1000

b. DISEASE PREVENTION AND CONTROL (DPC)

TABLE DHS14: SITUATION ANALYSIS INDICATORS FOR DISEASE PREVENTION AND CONTROL

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg
1. Cataract Surgery Rate (annualized)	Rate per 1 Million	612.5					
2. Malaria case fatality rate	%	1.04	1.40	1.36	1.44	0.80	1.76

i. PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DPC

TABLE DHS 15: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR DISEASE PREVENTION AND CONTROL

Strategic Objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium Term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To prevent and control Communicable and non-communicable Disease (NCDs).	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Cataract Surgery Rate	Rate per 1 Million (QPR)	1 326	751.1 (4200/5 602 426)	612.5	1 500	1 752	2 000	2 250
	2. Malaria case fatality rate	%	1.37% (27 deaths of 1977 cases)	1.68% (135 deaths of 8045 cases)	1.04% (16 deaths of 1538 cases)	1.2%	1.2%	1.1%	0.6%

QUARTERLY TARGETS FOR DPC

TABLE DHS 16: QUARTERLY TARGETS FOR DISEASE PREVENTION AND CONTROL

Programme Performance indicator	Frequency	Type	Annual Targets 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Cataract Surgery Rate annualized	Quarterly	Rate per 1 Million (uninsured population) (QPR)	1 752	438	438	438	438
2. Malaria case fatality rate	Quarterly	% (QPR)	1.2%	1.2%	1.2%	1.2%	1.2%

c. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE DHS17: DISTRICT HEALTH SERVICES

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
R' thousand	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
District Management	619 349	668 239	699 710	386 994	658 994	1 049 051	442 354	520 142	549 272
Clinics	1 912 759	2 133 223	2 332 550	2 470 687	2 617 598	2 626 416	2 887 587	2 894 965	3 058 621
Community Health Centres	349 690	404 109	446 460	524 678	549 578	510 945	572 645	598 088	631 583
Community-based Services	121 219	317 664	269 634	160 409	165 409	136 125	168 572	178 349	188 337
Other Community Services	132 159	1 911	101 253	246 303	94 278	97 321	118 526	91 804	96 945
HIV and AIDS	859 438	962 844	1 065 528	1 176 489	1 190 823	1 190 823	1 354 308	1 540 098	1 778 883
Nutrition	4 007	5 764	4 448	11 766	12 210	6 887	12 368	13 085	13 817
District Hospitals	3 869 732	4 786 558	4 929 978	5 272 892	5 551 059	5 606 356	5 865 565	6 280 600	6 682 397
TOTAL	**7 868 353**	**9 280 312**	**9 849 561**	**10 250 218**	**10 839 949**	**11 223 924**	**11 421 926**	**12 117 131**	**12 999 855**

Summary of Provincial Expenditure Estimates by Economic Classification[4]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	7 525 180	8 853 694	**9 400 858**	**9 798 176**	**10 238 501**	**10 614 225**	**10 758 434**	**11 564 178**	**12 451 266**
Compensation of employees	5 980 549	6 590 525	7 307 222	7 752 710	7 959 910	7 959 910	8 281 252	8 892 709	9 416 347
Goods and services	1 544 631	2 263169	2 093 636	2 045 466	2 278 591	2 654 315	2 477 182	2 671 468	3 034 919
Communication	30 507	30 766	34 147	15 132	36 589	40 279	31 841	36 561	38 608
Computer Services	69 574	158 836	81 473	70 205	76 290	158 311	94 799	100 041	108 682
Consultants, Contractors and special services	696 387	378 460	367 528	268 867	456 183	496 975	333 096	427 793	472 334
Inventory	460 796	1 077 594	970 296	1 204 677	1 243 385	1 303 448	1 382 784	1 442 694	1 731 457
Operating leases	9 955	8 106	6 784	21 925	23 516	13 713	29 496	24 892	26 244
Travel and subsistence	56 844	66 120	896	315	33 536	53 052	39 420	41 399	41 641
Maintenance , repair and running costs	60 873	128 813	125 102	77 952	74 081	121 932	95 675	91 695	96 831
Financial transactions in assets and liabilities	-	-	-	-	-	-	-	-	
Specify other	159 695	414 474	507 410	386 393	335 011	466 605	470 071	506 393	519 122
Transfers and subsidies to	312 478	386 648	**398 914**	**384 511**	**497 270**	**505 557**	**504 210**	**492 536**	**485 082**
Provinces and municipalities	–	6 108	16 328	23 108	23 262	23 051	24 743	15 594	565

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Departmental agencies and accounts	20	34 323	9 623	15 841	60 234	72 234	15 841	13 112	13 847
Non-profit institutions	282 515	297 334	332 290	305 060	367 870	367 870	421 398	419 211	423 552
Households	29 943	48 883	40 673	40 501	45 904	42 402	42 228	44 619	47 118
Payments for capital assets	30 695	39 970	**49 789**	**67 531**	**104 179**	**104 141**	**159 282**	**60 418**	**63 507**
Buildings and other fixed structures	-	-	-	-					
Software and other intangible assets	-	-	-	-					
Machinery and equipment	30 695	39 970	49 789	67 531	104 179	104 141	159 282	60 418	63 507
Total economic classification	**7 868 353**	**9 280 312**	**9 849 561**	**10 250 218**	**10 839 949**	**11 223 924**	**11 421 926**	**12 117 131**	**12 999 855**

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

d. PERFORMANCE AND EXPENDITURE TRENDS

The funding has been aligned to the various key strategic focus of the programme. The allocated budget has a direct impact on the achievements of targets in the following ways:

- Acceleration of the comprehensive primary health care services package
- Improve quality of care at District hospital level, e.g. reduction of patient waiting time and conducting doctors’ visits to clinics

- Intensify the rendering of MCWH and nutrition programme, e.g. increased immunisation rate, reduction in maternal death and increase in greenery projects
- intensify the rendering of prevention and disease control programme, e.g. the coverage of provision of health services at ports is increasing, whist malaria fatality rate is decreasing
- Improve the rendering of a comprehensive HIV and AIDS, STI and TB programme, e.g. the treatment coverage of people with HIV/AIDS and TB is increasing as the funding increases

The department has spent a total of R26.9 billion from 2013/14 to 2015/16 while the 2016/17 budget amounts to R10.5 billion, adjusted to R10.8 billion. The proposed MTEF from 2017/18 to 2019/20 projected at R36.5billion, which will be used to maintain and improve the current services.

e. RISK MANAGEMENT

The key risks that may affect the realisation of the objectives for the budget programme District Health Services and the measures to mitigate the impact of the risks are indicated below:

Strategic Objective	Risk	Mitigating factors
To reduce Maternal and child morbidity and mortality	Missed opportunity (vaccination of children at any given time: presentation of road to health card with each consultation)	Raise awareness to medical staff to always demand road to health charts to detect missed opportunities Raise awareness to the parents of the under 6's to present the road to health charts at every consultation.
To reduce Maternal and child morbidity and mortality	Complications during birth due to Late bookings by pregnant women	Strengthen community outreach through media, community mobilisation
Improve access to quality district hospital service	Shortage of equipment to implement the full District hospital package	Motivate for funds in respect of non negotiables
To Prevent and control Communicable and Non-communicable Diseases (NCDs)	Risky lifestyles	Promote healthy lifestyles
To increase access to comprehensive HIV and AIDS, STIs and TB treatment, management and support	Lack of patient unique identifier	LDoH will liaise with NDoH to fast track development of patient unique identifier

3. BUDGET PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

3.1 PROGRAMME PURPOSE

The purpose of the programme is to improve the quality of emergency medical services.

3.2 PRIORITIES

- Increase accessibility and response time by improving ratio of ambulances per population

TABLE EMS 1: SITUATION ANALYSIS INDICATORS FOR EMS

Programme Performance Indicator	Indicator Type	Province wide value 2015/16	Capricorn	Waterberg	Sekhukhune	Vhembe	Waterberg
EMS P1 urban response under 15 minutes rate	%	79.42%	84%	79%	68%	78%	59%
EMS P1 rural response under 40 minutes rate	%	68.19%	77%	64%	78%	75%	58%
EMS inter-facility transfer rate	%	18.59%	12%	10%	19%	25%	19%

3.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGET FOR EMS

TABLE EMS 2: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR THE EMS AND PATIENT TRANSPORT

Strategic Objective	Programme Performance Indicator	Indicator Type	Audited/actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To improve access to emergency medical services.	**Strategic Objectives/Provincial Indicators**								
	1. Ratio of ambulance per population	No	1:47 290	1: 34 838	1:22 614	1:30 000	1: 29 000	1:28 000	1:27 000
	2. Number of ambulances procured	No	New indicator	50	100	50	50	50	50
	Programme Performance/Customized Indicators (Sector Indicators)								
	3. EMS P1 urban response under 15 minutes rate	% (QPR)	57% (99/173)	50.32 %	79.42%	68%	72%	74%	75%
	4. EMS P1 rural response under 40 minutes rate	% (QPR)	57% (508/882)	76.73 %	68.19%	70%	72%	74%	75%
	5. EMS inter-facility transfer rate	% (QPR)	New indicator	New indicat or	18.59%	22%	18%	17.5 %	17%

3.4 QUARTERLY TARGETS FOR EMS-

TABLE EMS 3: QUARTERLY TARGETS FOR EMS

Programme Performance Indicator	Frequency of reporting (quarterly, Bi-annual, Annual)	Indicator Type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Ratio of ambulance per population	Quarterly	%	1:29 000	1:29 000	1:29 000	1:29 000	1:29 000
2. Number of ambulances procured	Bi-annual	No	50	-	25	-	25
3. EMS P1 urban response under 15 minutes rate	Quarterly	% (QPR)	72%	72%	72%	72%	72%
4. EMS P1 rural response under 40 minutes rate	Quarterly	% (QPR)	72%	72%	72%	72%	72%
5. EMS inter-facility transfer rate	Quarterly	% (QPR)	18%	18%	18%	18%	18%

3.3 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE EMS 4: EXPENDITURE ESTIMATES: EMERGENCY MEDICAL SERVICES

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
R' thousand									
Emergency Transport	522 003	548 264	645 108	686 647	**684 147**	**684 147**	**728 879**	**755 573**	**797 887**
Planned Patient Transport	-	-							
TOTAL	**522 003**	**548 264**	**645 108**	**686 647**	**684 147**	**684 147**	**728 879**	**755 573**	**797 887**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	**521 498**	**525 900**	**597 569**	**662 343**	**659 174**	**659 137**	**700 290**	**726 486**	**767 172**
Compensation of employees	443 171	465 766	542 463	565 407	564 737	564 737	603 855	623 877	658 815
Goods and services	78 327	60 134	55 106	96 936	94 437	94 400	96 435	102 609	108 357
Communication	6 115	5 916	5 768	3 972	3 972	6 097	5 972	6 144	6 489
Consultants, Contractors and special services	20 847	15 964	13 923	10 831	8 831	12 792	14 792	16 999	17 951
Inventory	3 848	3 306	4778	6654	6 154	5 609	4 026	4 245	4 482
Operating leases		129	101	150	150	156	150	159	168
Travel and subsistence	764	1 412	1 087	165	165	484	173	183	193
Maintenance , repair and running costs	45 761	23 637	18 118	55 310	55 310	50 443	50 138	53 234	56 215
Specify other	992	9,770	11 331	19 854	19 855	18 819	21 184	21 645	22 859
Transfers and subsidies to	**505**	**1 285**	**376**	**214**	**884**	**884**	**225**	**238**	**251**
Provinces and municipalities	-	-	84	-	–	137	–	–	–
Departmental agencies and accounts	-	750	-	-					
Non-profit institutions	-	-	-	-					
Households	505	535	292	214	884	747	225	238	251
Payments for capital assets	**-**	**21 079**	47 163	24 089	**24 089**	**24 126**	**28 364**	**28 849**	**30 464**
Machinery and equipment	-	21 079	47 163	24 089	24 089	24 126	28 364	28 849	30 464
Total economic classification	**522 003**	**548 264**	**645 108**	**686 647**	**684 147**	**684 147**	**728 879**	**755 573**	**797 887**

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

3.4 PERFORMANCE AND EXPENDITURE TRENDS

The allocated budget has a direct impact on the achievements of the targets in the following ways:

- Improve the functioning of Planned Patient Transport services, e.g. the acquisition of vehicles to transport patients between hospitals.
- Procure ambulances to improve the response time
- Improve quality of care at pre-hospital level, e.g. reduction of response times and recruitment of qualified staff, purchase of ambulances and communication equipment.
- Strengthen Obstetric Ambulances services.

The department has spent a total of R1.7 billion in 2013/14 to 2015/16 while the 2016/17 budget amounts to R686.6 million, adjusted to R684.1 million. The MTEF from 2017/18 to 2019/20 is projected at R2.3 billion. This amount will be used to maintain and improve the current services.

3.5 RISK MANAGEMENT

The key risks that may affect the realisation of the objectives for the budget programme Emergency Medical Services and the measures to mitigate the impact of the risks are indicated below:

Strategic Objective	Risk	Mitigating factors
To improve access to Emergency Medical Services	Underfunding of EMS	Proper analysis of needs based on information
	Inadequate EMS practitioners and high Staff turnover	Recruitment of staff and provision of training for all EMS categories
	Inadequate EMS vehicles	Implementation of the EMS optimization plan Procure EMS vehicles
	Inadequate infrastructure	Fast-track infrastructure development
	Inadequate information and communication technology	Migrate from Analogue to Digital system

4. BUDGET PROGRAMME 4: PROVINCIAL HOSPITALS SERVICES

4.1 PROGRAMME PURPOSE

The purpose is to provide secondary and specialised hospital services within 5 regional and 3 specialised hospitals, which are accessible, appropriate and effective. It also provides a platform for training health professionals.

4.2 PRIORITIES

- Conduct National Core Standards and develop quality improvement plans in all facilities.
- Improve quality of Mental health care services

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

TABLE PHS1: STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

Strategic Objective	Programme Performance Indicator	Indicator Type	Audited /actual performance			Estimated performance	Medium term Targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Improve access to quality hospital services.	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Hospital achieved 75% and more on National Core Standards self-assessment rate (Regional hospitals)	% (QPR)	New indicator	New indicator	New indicator	New indicator	100% (5 of 5)	100% (5 of 5)	100% (5 of 5)
	2. Average Length of Stay (Regional hospitals)	No (QPR)	5.2 days	5.3 days	5 days (405095.5/80757)	5 days	5 days (405095.5/80757)	5 days (405095.5/80757)	5 days (405095.5/80757)
	3. Inpatient Bed Utilisation Rate (Regional hospitals)	% (QPR)	65.6%	68%	74.2% (405 095.5 of 546 069.4)	70%	72% (393170/546069.4)	74% (404091.4/546069.4)	74.5% (406821.7/546069.4)
	4. Expenditure per PDE (Regional hospitals)	R (QPR)	R2,464.1	R 2 565.6 (379544.5/72478)	R2 716.1 (1 587 673 of 5 845 46.1649)	R2700	R2864.7	R3039.45	R3224.85
	5. Complaints resolution rate (Regional hospitals)	% (QPR)	New Indicator	New indicator	85.7% (541 of 631)	100%	86% (543/631)	86.5% (546/631)	87% (549/631)
	6. Complaint Resolution within 25 working days rate (Regional hospitals)	% (QPR)	100% (628 of 628)	97.7% (424/434)	98.7% (534 of 541)	95%	98.5% (535/543)	99% (541/546)	100% (549/549)

4.4 QUARTERLY TARGETS FOR REGIONAL HOSPITALS

TABLE PHS 2: QUARTERLY TARGETS FOR REGIONAL HOSPITALS

Programme Performance Indicator	Frequency of reporting (Quarterly, bi-annual, Annual)	Indicator type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Hospital achieved 75% and more on National Core Standards self-assessment rate (Regional hospitals)	Quarterly	% (QPR)	100% (5 of 5)	40% (2 of 5)	60% (3 of 5)	80% (4 of 5)	100% (5 of 5)
2. Average Length of Stay (Regional hospitals)	Quarterly	No (QPR)	5 days (405095.5/80757)	5 days	5 days	5 days	5 days
3. Inpatient Bed Utilisation Rate (Regional hospitals)	Quarterly	% (QPR)	72% (393170/546069.4)	72%	72%	72%	72%
4. Expenditure per PDE (Regional hospitals)	Quarterly	R (QPR)	R2864.7	R2864.7	R2864.7	R2864.7	R2864.7
5. Complaints resolution rate (Regional hospitals)	Quarterly	% (QPR)	86% (543/631)	86%	86%	86%	86%
6. Complaints Resolution within 25 working days rate (Regional hospitals)	Quarterly	% (QPR)	98.5% (535/543)	98.5%	98.5%	98.5%	98.5%

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

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

Strategic objective	Performance indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Improve access to hospital services.	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Hospital achieved 75% and more on National Core Standards self-assessment rate (Specialised hospitals)	% (QPR)	New indicator	New indicator	New indicator	New indicator	100% (3 of 3)	100% (3 of 3)	100% (3 of 3)
	2. Complaints resolution rate (Specialised hospitals)	% (QPR)	New indicator	New indicator	New indicator	100%	85%	87%	89%
	3. Complaints Resolution within 25 working days rate (Specialised hospitals)	% (QPR)	New indicator	100%	New indicator	100%	90%	92%	95%
	Strategic Objectives/Provincial Indicators								
	4. Number of Districts with functional Mental Health review boards	No	New indicator	2 of 3	4	5	5	5	5

4.6 QUARTERLY TARGETS FOR SPECIALISED HOSPITALS

TABLE PHS 4: PROVINCIAL QUARTERLY TARGETS FOR SPECIALISED HOSPITALS

Indicator	Frequency of reporting (quarterly, bi-annual, annual)	Indicator type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Hospital achieved 75% and more on National Core Standards self-assessment rate (Specialised hospitals)	Quarterly	% (QPR)	100% (3 of 3)	33% (1 of 3)	67% (2 of 3)	100% (3 of 3)	100% (3 of 3)
2. Complaints resolution rate	Quarterly	% (QPR)	85%	85%	85%	85%	85%
3. Complaints Resolution within 25 working days rate	Quarterly	% (QPR)	90%	90%	90%	90%	90%
4. Number of Districts with functional Mental Health review boards	Quarterly	No	5	5	5	5	5

4.7 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE PHS 5: EXPENDITURE ESTIMATES: PROVINCIAL HOSPITAL SERVICES

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
R' thousand									
General (regional) hospitals	1 308 406	1 544 981	1 569 686	1 550 915	1 614 222	1 709 338	1 820 929	1 899 713	2 006 095
Psychiatric hospitals	379 797	408 951	440 902	587 527	604 165	550 193	543 514	546 459	577 061
TOTAL	**1 688 203**	**1 953 932**	**2 010 588**	**2 138 442**	**2 218 387**	**2 259 531**	**2 364 442**	**2 446 172**	**2 583 156**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	**1 677 760**	**1 942 350**	**2 001 519**	**2 135 559**	**2 204 691**	**2 243 877**	**2 349 916**	**2 433 499**	**2 569 773**
Compensation of employees	1 504 829	1 678 858	1 776 771	1 919 866	1 914 835	1 914 835	2 050 417	2 124 341	2 243 304
Goods and services	172 931	263 492	224 748	215 693	289 856	329 042	299 499	309 158	326 469
Communication	5 579	5 445	6 140	1 999	2 039	5 873	6 599	6 662	7 035
Consultants, Contractors and special services	62 641	116 325	66 482	28 402	50 689	75 040	70 459	72 022	76 055
Inventory	67 104	91 839	97 322	107 263	156 590	169 711	137 132	144 300	152 380
Operating leases	1 943	1 659	1 274	1 488	72 591	67 394	73 065	75 291	79 508
Travel and subsistence	2 242	1 799	1 635	377	377	2 116	1 840	1 716	1 812
Maintenance , repair and running costs	5 862	2 140	4 116	4 911	4 911	5 425	3 707	3 810	4 023
Specify other	27 560	44 285	47 779	71 253	2 659	3 483	6 697	5 357	5 656
Transfers and subsidies to	**9 611**	**9 091**	**7 262**	**1 074**	**6 105**	**8 063**	**628**	**665**	**702**
Provinces and municipalities		31	12	0	0	**0**	0	0	0
Households	9 611	9 060	7 250	1 074	**6 105**	**8 063**	**628**	**665**	**702**
Payments for capital assets	**832**	**2 491**	**1 807**	**1 808**	**7 591**	**7 591**	**13 899**	**12 009**	**12 681**
Buildings and other fixed structures									
Machinery and equipment	832	2 491	1 807	1 808	7 563	7 563	13 899	12 009	12 681
Software and other intangible assets	–	–	–	–	28	28	–	–	–
Total economic classification	**1 688 203**	**1 953 932**	**2 010 588**	**2 138 442**	**2 218 387**	**2 259 531**	**2 364 442**	**2 446 172**	**2 583 156**

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

4.8 PERFORMANCE AND EXPENDITURE TRENDS

The allocated budget has a direct impact on the achievements of targets in the following ways:

- Expand the secondary hospital services, e.g. referrals to the tertiary hospital will drop as secondary services are performed at regional hospitals
- Improve quality of care at regional and specialised hospital level, e.g. reduction in patient waiting time due to the availability of health professionals and implementation of nursing care package.

The department has spent a total of R5.7 billion in 2013/14 to 2015/16 while the 2016/17 budget amounts to R2.1 billion, adjusted to R2 2 billion. The MTEF from 2017/18 to 2019/20 is projected at R7.3 billion. This amount will be used to maintain and marginally improve other services.

4.9 RISK MANAGEMENT

The key risks that may affect the realization of the strategic objectives for Provincial Hospital Services and the measures to mitigate the impact of the risks are indicated below:

Strategic Objective	RISK	MITIGATING FACTORS
Improve access to quality hospital services	Poor quality of mental health care	• Strengthen Mental Health Review Boards • Establishment of Mental Health Care institutions in each district with emphasis on child psychiatry.
	Increased Cost per patient day equivalent due to prolonged stay.	Appointment of more specialists
	Misinterpretation of the Mental health care policy	Conduct capacity building workshops on the Mental Health Care policy
	Overcrowding in facilities due to families abandoning patients	Expedite the building/revitalization projects
	Shortage of specialists	Implement the recruitment and retention strategy

5 BUDGET PROGRAMME 5: CENTRAL HOSPITALS SERVICES

5.1 PROGRAMME PURPOSE

The purpose of the programme is to strengthen tertiary/academic services and to create a platform for training of health professionals and research.

5.2 PRIORITIES

- Increase access to tertiary services
- Training of health professionals
- Improve quality of tertiary services

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

TABLE C&THS1: STRATEGIC OBJECTIVES AND ANNUAL TAGETS FOR TERTIARY HOSPITALS

Strategic Objective	Programme Performance Indicator	Indicator Type	Audited/ actual performance			Estimate	MTEF projection		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To improve quality hospital services.	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Hospital achieved 75% and more on National Core Standards self-assessment rate (Tertiary Hospitals)	% (QPR)	New indicator	New indicator	New indicator	New indicator	100% (2 of 2)	100% (2 of 2)	100% (2 of 2)
	2. Average Length of Stay (Tertiary Hospitals)	No (QPR)	7.2 days	7 days	7.1 days (283 579.5/ 40137)	7days	7days (283 579 /40137)	7days (283 579 /40137)	7days (283 579/4 0137)
	3. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	% (QPR)	75.9%	74.9%	77.5% (283 579.5/3 66135.12)	78%	76.5% (280093. 4/36613 5.12)	75% (274601. 3/36613 5.12)	75% (274601.3/ 366135.12)
	4. Expenditure per PDE (Tertiary Hospitals)	R (QPR)	R3 366.6	R3 756.2	R4 323.3 (1 662 716 321/384 597.8323)	R3800	R3972.4 0	R4211	R4485
	5. Complaints resolution rate (Tertiary Hospitals)	% (QPR)	New indicator	New indicator	93.5% (302/323)	100%	94% (304/323)	95% (307/323)	96% (310/323)
	6. Complaint Resolution within 25 working days rate	% (QPR)	93.2% (689/739)	100%	99.3% (300/302)	100%	100% (302/302)	100% (302/302)	100% (302/302)

5.2.2 QUARTERLY TARGETS FOR TERTIARY AND CENTRAL HOSPITALS

TABLE THS2: QUARTERLY TARGETS FOR TERTIARY HOSPITALS

PROGRAMME PERFORMANCE INDICATOR	Frequency of Reporting (Quarterly / Annual)	Indicator Type	ANNUAL TARGET 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Hospital achieved 75% and more on National Core Standards self-assessment rate (Tertiary Hospitals)	Quarterly	% (QPR)	100% (2 of 2)	100% (2 of 2)	100% (2 of 2)	100% (2 of 2)	100% (2 of 2)
2. Average Length of Stay (Tertiary Hospitals)	Quarterly	No (QPR)	7days (283 579/40 137)	7days	7days	7days	7days
3. Inpatient Bed Utilisation Rate (Tertiary Hospitals)	Quarterly	% (QPR)	76.5% (280093.4/366135.12)	76.5%	76.5%	76.5%	76.5%
4. Expenditure per PDE (Tertiary Hospitals)	Quarterly	R (QPR)	R3972.40	R3972.40	R3972.40	R3972.40	R3972.40
5. Complaints resolution rate (Tertiary Hospitals)	Quarterly	% (QPR)	94% (304/323)	94%	94%	94%	94%
6. Complaint Resolution within 25 working days rate (Tertiary Hospitals)	Quarterly	% (QPR)	100% (302/302)	100%	100%	100%	100%

5.3 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

TABLE C&TH 3: EXPENDITURE ESTIMATES: CENTRAL AND TERTIARY SERVICES

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
R' thousand	1 244 436	1 356 562	1 467 011	1 593 372	1 593 372	1 593 372	1 681 007	1 774 753	1 874 140
Central Hospitals									
Tertiary Hospitals									
TOTAL	1 244 436	1 356 562	1 467 011	1 593 372	1 593 372	1 593 372	1 681 007	1 774 753	1 874 140

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	**1 191,064**	**1 330,074**	**1 432 238**	**1 541 484**	**1 596 077**	**1 651 892**	**1 713 705**	**1 813 008**	**1 936 129**
Compensation of employees	970 109	1 036 399	1 120 808	1 201 328	1 225 878	1 225 878	1 299 115	1 349 465	1 425 035
Goods and services	220 955	293 675	311 430	340 156	370 199	426 014	414 590	463 543	511 094
Communication	4 210	4 089	3 505	7 520	7 520	7 644	3 820	4 156	4 389
Consultants, Contractors and special services	73 670	75 312	79 961	103 115	109 115	105 298	95 079	99 596	105 173
Inventory	106 788	175 587	193 322	174 314	196 848	270 832	241 402	309 058	326 366
Operating leases	16 207	8 112	4 954	1 560	5 573	4 197	6 138	6 182	6 528
Travel and subsistence	1 744	2 024	1 406	284	284	1 175	298	315	333
Maintenance , repair and running costs	26	145	136	9 460	6 956	5 241	733	770	813
Specify other	18 310	28 406	28 146	43 903	43 903	31 627	67 120	43 466	67 492
Transfers and subsidies to	**2 907**	**6 448**	**5 355**	**617**	**3 467**	**3 467**	**648**	**685**	**724**

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Provinces and municipalities	-	16							
Households	2 907	6 432	5 355	617	3 467	3 467	648	685	724
Payments for capital assets	**50 465**	**20 040**	**29 418**	**51 271**	**71 413**	**71 413**	**53 834**	**56 526**	**59 803**
Buildings and other fixed structures	3 008								
Machinery and equipment	47 457	20 040	29 418	51 271	**71 413**	**71 413**	**53 834**	**56 526**	**59 803**
Total economic classification	**1 244 436**	**1 356 562**	**1 467 011**	**1 593 372**	**1 670 957**	**1 726 772**	**1 768 187**	**1 870 220**	**1 996 656**

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

5.4 PERFORMANCE AND EXPENDITURE TRENDS

The allocated budget has a direct impact on the achievements of targets in the following ways:

- Reduction of referrals outside the province, e.g. tertiary services are being increased in the hospital through the current budget and MTEF and this reduces the referrals outside the province.
- Improve quality of care at tertiary hospital level, e.g. reduction in patient waiting time due to the availability of health professionals.
- Modernisation of the tertiary services, e.g. the purchase of highly technical equipment to render the tertiary services is done using the allocation under this programme

The department has spent a total of R4.1 billion from 2013/14 to 2015/16 while the 2016/17 budget amounts to R1.6 billion, adjusted to R1.7billion. The MTEF from 2017/18to 2019/20 is projected at R5.6 billion which will be used to maintain and improve the current service.

5.5 RISK MANAGEMENT

The key risks that may affect the realisation of the objectives for the budget programme tertiary hospitals and the measures to mitigate the impact of the risks are indicated below:

Strategic Objective	Risks	Mitigating factors
Improve access to quality hospital services	Dilapidated infrastructure i.e. building and plants	Implement the recommendations of assessment report
	Shortage of specialists in surgery, and orthopaedics	- Intensify recruitment and retention of specialists - Building strong relationship with private sector specialists to deal with backlog - Increase number of registrars
	Lack of maintenance contract for equipment	- Procure term maintenance contracts for existing equipment - Procure equipment with appropriate maintenance contracts
	Shortage of clinical engineers	Intensify recruitment of clinical engineers
	Unreliable information management systems (financial, human and patient information systems)	Upgrading the information management systems

6 BUDGET PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

6.1 PROGRAMME PURPOSE

The purpose of the programme is to provide training and development of actual and potential employees of the department through the sub-programme, Nurse, EMS training Colleges and Human resource development training.

6.2 PRIORITIES

- Training and development of personnel in the following skills programmes: 180 health professionals in PHC; 1920 professionals and support staff in HIV/AIDS and TB; 100 support staff in litigation; 2000 employees in Compulsory Induction Programme (CIP); 200 support staff in transversal public finance management; 261 Artisans on Artisan training.
- Awarding bursaries to new medical students and clinical associates.

Training Programme	Target Group (Professional Nurses; Data Capturers; Senior Managers; etc.)	Estimated Number of Beneficiaries	Q1	Q2	Q3	Q4
Primary Health Care Training	180 Health professionals	180	45	45	45	45
HIV/AIDS and TB Training	1920 Professionals and support staff	1920	480	480	480	480
Litigation	100 Support staff	100	25	25	25	25
Compulsory Induction Programme (CIP)	2000 Employees	2000	500	500	500	500
Transversal Public Finance Management	200 Support staff	200	50	50	50	50
Artisan Training	261 Artisans	261	65	65	65	66

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

TABLE HST 1: PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR HST

Strategic objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To increase production for and develop human resources for health	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Number of Bursaries awarded for first year medicine students***	No (QPR)	New indicator	New indicator	New indicator-	60	-	-	-
	2. Number of Bursaries awarded for first year nursing students***	No (QPR)	New indicator	New indicator	-	-	-	-	-
	Strategic Objectives/Provincial Indicators								
	3. Number of Post basic professional nurses enrolled	No	New indicator	New indicator	New indicator	120	120	120	120
	4. Number of direct basic student nurses enrolled	No	New indicator	New indicator	New indicator	190	133	150	200
	5. Number of direct basic student nurses graduated	No	New indicator	New indicator	New indicator	186	185	200	220
	6. Number of Ambulance Emergency Care Assistant	No	New indicator	New indicator	New indicator	New indicator	24	24	24

*** – ***The Department does not award bursaries to the medicine & nursing students***

6.4 QUARTERLY TARGETS FOR HEALTH SCIENCES AND TRAINING

TABLE HST2: QUARTERLY TARGETS FOR HEALTH SCIENCES AND TRAINING FOR 2016/17

Indicator	Frequency of Reporting (Quarterly, bi-annual, Annual)	Indicator type	Annual Target 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Number of Bursaries awarded for first year medicine students	Annual	No (QPR)	-	-	-	-	-
2. Number of Bursaries awarded for first year nursing students	Annual	No (QPR)	-	-	-	-	-
3. Number of Post basic professional nurses enrolled	Bi-Annual	No	120	-	80	-	40
4. Number of direct basic student nurses enrolled	Annual	No	133	-	-	-	133
5. Number of direct basic student nurses graduated	Annual	No	185	-	185	-	-
6. Number of Ambulance Emergency Care Assistant	Bi-Annual	No	24	-	12	12	-

6.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HST 3: EXPENDITURE ESTIMATES: HEALTH SCIENCES AND TRAINING

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
R' thousand									
Nurse training colleges	181 524	192 550	208 557	279 750	238 722	236 241	301 057	302 942	319 907
EMS training colleges	4 845	5 212	2 994	3 739	6 058	6 058	5 912	4 139	4 372
Bursaries	121 889	143 264	141 516	146 476	147 504	261 428	201 164	192 097	150 659
PHC training	433	247	192	6 863	6 863	6 103	6 727	7 117	7 514
Other training	123 624	136 858	131 443	134 664	135 491	135 491	145 616	158 933	175 638
TOTAL	432 315	478 131	484 702	571 492	**534 638**	**645 321**	**660 476**	**665 228**	**658 090**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	268 975	313 254	326 700	416 747	**374 782**	**374 782**	**452 023**	**455 925**	**487 785**
Compensation of employees	222 085	281 130	302 399	381 847	339 909	339 909	406 905	397 866	426 475
Goods and services	46 890	32 124	24 301	34 900	34 873	34 873	45 119	58 059	61 310
Communication	581	582	532	800	775	779	821	1 245	1 314
Computer Services	0	0	0	50	50	32	0	0	–
Consultants, Contractors and special services	12 633	2 075	159	528	529	318	289	303	320
Inventory	12 627	15 552	9 632	8 236	8 235	8 331	15 954	11 859	12 523
Operating leases	487	375	235	600	600	573	789	1 335	1 410
Travel and subsistence	7 191	5 822	5 506	5 107	5 107	10 624	8 147	8 673	9 159
Maintenance , repair and running costs	1 308	640	1 100	1 462	1 461	899	800	846	893

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Specify other	12 063	7 078	7 137	18 117	18 116	13 317	18 319	33 798	35 691
Transfers and subsidies to	**157 025**	**164 652**	**153 347**	**147 196**	**148 961**	**259 643**	**200 526**	**200 971**	**160 030**
Provinces and municipalities	–	85	20	–					
Non-profit institutions									
Households	157 025	164 567	153 327	147 196	148 961	259 643	200 526	200 971	160 030
Payments for capital assets	**6 315**	**225**	**4 655**	**7 549**	**10 895**	**10 896**	**7 927**	**8 332**	**10 275**
Buildings and other fixed structures									
Machinery and equipment	6 315	225	4 655	7 549	10 895	10 896	7 927	8 332	10 275
Total economic classification	**432 315**	**478 131**	**484 702**	**571 492**	**534 637**	**645 321**	**660 476**	**665 229**	**658 090**

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

6.6 PERFORMANCE AND EXPENDITURE TRENDS

Reduction of shortage of doctors e.g. the department offers bursaries to students for medical related qualifications with an agreement to recruit them after their completion of studies. However, the budget allocated over the MTEF is insufficient to fund new intake of Cuban Scholarship Programme.

Reduction in the shortage of EMS practitioners, e.g. the department utilises the current budget and MTEF to train the required EMS practitioners at different categories.

Reduction in the shortage of nursing staff, e.g. nursing colleges are funded to train the potential nurses that after completion of their studies work to improve quality of care.

The department has spent a total of R1.4 billion in 2013/14 to 2015/16 while the 2016/17 budget amounts to R571.4 million, adjusted R534.6 million. The proposed MTEF from 2017/18 to 2019/20 is projected at R1.9 billion which will be used to maintain and improve the current services

6.7 RISK MANAGEMENT

The key risks that may affect the realisation of the objectives of the budget programme: Health sciences and training and the measures to mitigate the impact of the risks are indicated below:

Strategic Objective	Risk	Mitigating factors
To increase production for and develop human resources for health	High staff turnover of trained personnel.	Improve working conditions of health professionals
	In-secured examination papers	All campuses and facilities to have safes to store examination papers
	Overcrowding in residence	Temporary erect structures to relieve congestion
	Release of privileged information to outside companies for bidding of training tenders	Vetting of service providers and officials. Raising awareness and signing of the oath of secrecy by all officials within HRD Disciplinary measures to be instituted against officials proven to have breached confidentiality
	Shortage of nurse specialist compromising quality of student output	Implementation of recruitment and retention strategy
	Shortage of qualified Emergency care lecturer Long and complex process of obtaining accreditation and registration of new health qualifications and training college	

7. BUDGET PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

7.1 PROGRAMME PURPOSE

The purpose of the programme is to render support services as required by the Department to realise its objectives of incorporating all aspects of rehabilitation through the sub-programmes:

- Pharmaceutical Services; and
- Rehabilitation services (Allied Health Care Support Services).

7.2 PRIORITIES

- Provide essential pharmaceutical supplies; and
- Strengthen rehabilitation services.

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

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

Strategic objective	Performance indicator		Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
				2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To provide all essential medicines	**Strategic Objectives/Provincial Indicators**									
	Availability of essential medicines	Depot	%	71.71%	74.66%	70.6%	82% (532/649)	72% (236/328)	72.5% (238/328)	73% (239/328)
		Hospitals		84.5%	86.7%	86.7%	90% (256/284)	91% (269/295)	92% (271/295)	93% (274/295)
		PHC		80.37%	84.88%	87.05%	88% (93/106)	89% (151/170)	90% (153/170)	91 % (155/170)
To provide rehabilitation services in facilities and communities	Number of districts providing community based rehabilitation services		No	New indicator	New indicator	5	5	5	5	5
	Number of health facilities providing rehabilitation services	Hospitals	No	New indicator	New indicator	36 of 40	30 of 40	32 of 40	33 of 40	36 of 40
		PHC	No	New indicator	New indicator	New indicator	41 of 477	43 of 477	45 of 477	48 of 477

7.3.1 QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

TABLE HCSS 2: QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES FOR 2016/17

Programme Performance Indicator		Frequency of reporting (quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	QUARTERLY TARGETS			
					Q1	Q2	Q3	Q4
Availability of essential medicines	Depot	Quarterly	%	72% (236/328)	72% (236/328)	72% (236/328)	72% (236/328)	72% (236/328)
	Hospitals	Quarterly	%	91% (269/295)	91% (269/295)	91% (269/295)	91% (269/295)	91% (269/295)

Programme Performance Indicator		Frequency of reporting (quarterly, Bi-annual, Annual)	Indicator Type	ANNUAL TARGET 2017/18	QUARTERLY TARGETS			
					Q1	Q2	Q3	Q4
	PHC	Quarterly	%	89% (151/170)	89% (151/170)	89% (151/170)	89% (151/170)	89% (151/170)
Number of districts providing community based rehabilitation services		Quarterly	No	5	5	5	5	5
Number of health facilities providing rehabilitation services	Hospitals	Quarterly	No	32 of 40	32 of 40	32 of 40	32 of 40	32 of 40
	PHC	Quarterly	No	43 of 477	43 of 477	43 of 477	43 of 477	43 of 477

7.4 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HCSS 4: EXPENDITURE ESTIMATES: HEALTH CARE SUPPORT SERVICES

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
R' thousand	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Forensic services	33 266	35 726	35 482	40 719	40 719	40 719	39 385	39 761	41 988
Orthotic and prosthetic services	8 212	9 695	6 371	12 251	12 251	12 251	12 975	13 727	14 493
Medicines trading account	712 558	46 591	65 646	60 789	75 788	75 788	88 087	98 848	104 383
TOTAL	**754 036**	**92 012**	**107 499**	**113 758**	**128 758**	**128 758**	**140 446**	**152 336**	**160 864**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	**753 204**	**89 623**	**105 396**	**111 416**	**126 369**	**126 371**	**137 987**	**149 734**	**158 118**
Compensation of employees	65 398	69 460	74 694	78 756	78 757	78 757	84 111	83 952	88 653
Goods and services	687 806	20 163	30 702	32 660	47 612	47 614	53 875	65 783	69 465
Communication	1 511	1 142	677	36	10	528	638	598	632
Computer Services	1 013	405	1 823	0	5 196	1 014	1 299	1 390	1 469
Consultants, Contractors and special services	17 035	13 279	14 033	11 137	20 894	21 918	30 649	40 485	42 751
Inventory	665 758	5	8 290	14 849	14 849	14 849	13 367	15 370	16 686
Operating leases	167	307	807	400	400	664	700	900	950
Travel and subsistence	540	640	499	416	415	532	197	208	220
Maintenance , repair and running costs	36	4	0	0	–	–	–	–	–
Specify other	1 746	4 381	4 573	5 822	5 848	8 109	7 025	6 832	6 757
Financial transactions in assets and liabilities	0	1,000	0	0					
Transfers and subsidies to	**741**	**118**	**149**	**215**	**215**	**213**	**225**	**238**	**251**
Provinces and municipalities	16	14	14	0					
Households	725	104	135	215	**215**	**213**	**225**	**238**	**251**
Payments for capital assets	**91**	**1 271**	**1 954**	**2 127**	**2 174**	**2 174**	**2 234**	**2 363**	**2 495**
Machinery and equipment	91	1 271	1 954	2 127	**2 174**	**2 174**	**2 234**	**2 363**	**2 495**
Total economic classification	**754 036**	**92 012**	**107 499**	**113 758**	**128 758**	**128 758**	**140 446**	**152 336**	**160 864**

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

7.5 PERFORMANCE AND EXPENDITURE TRENDS

The purpose is to render health care support services to the entire Health Care Services. The allocated budget has a direct impact on the achievements of targets in the following ways:

- Provision of all essential medicines. The allocated budget is used to purchase all these medicines and the MTEF will ensure availability.
- Provision of forensic pathology services.
- Provision of orthotic and prosthetic services e.g. the purchase of assistive devices is done using this allocation.

The department has spent a total of R953.4 million from 2013/14 to 2015/16 while the 2016/17 budget amounts to R113.8 million\\. The MTEF from 2017/18 to 2019/20 is projected at R453.6. million which will be used to maintain and improve the current services.The Department intends to realise this programme's strategic objectives and targets through effective and economic utilization of the resources, regular monitoring of the programme performance and stakeholders participation.

7.6 RISK MANAGEMENT

The key risks that may affect the realisation of the objectives of the budget programme: Health Care Support Services and measures to mitigate the impact of the risks are indicated below.

Strategic Objectives	Risk	Mitigating factors
To provide all essential medicines	Poor performance by suppliers	• Impose penalties to suppliers who do not meet required standards
	Increased number of items on quotation	• Award provincial tenders or use other provincial tenders
	Increase in Expired stock	• Put systems in place to monitor expiry dates
	No compliance with regulatory standards	• Develop and implement quality improvement plan
To provide rehabilitation services in facilities and communities	Development of permanent disability	• Put systems in place for early rehabilitation intervention

8 BUDGET PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8.1 PROGRAMME PURPOSE

The purpose of the programme is to plan, provide for and equip new facilities/assets, and upgrade, rehabilitate and maintain hospitals, clinics and other facilities.

8.2 PRIORITIES

- Upgrading of PHC facilities
- Upgrading of hospitals
- Upgrade nursing colleges and nursing schools
- Provide water, sanitation and electrical services (new and upgrade)
- Implement maintenance programme.

8.3 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HFM

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

Strategic objective	Indicator	Indicator Type	Audited/ actual performance			Estimated performance	Medium term targets		
			2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
To improve quality of health infrastructure	**Programme Performance/Customized Indicators (Sector Indicators)**								
	1. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	No (QPR)	New indicator	New indicator	New indicator	10	8	4	4
	2. Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District (excluding facilities in NHI Pilot District)	No (QPR)	New indicator	New indicator	New indicator	16	16	16	16
	Strategic Objectives/Provincial Indicators								
	3. Number of districts spending more than 90% of the maintenance budgets (preventative and unplanned)	No	New indicator	2	New indicator	5	5	5	5
	4. Number of projects completed	No	New indicator	New indicator	New indicator	18	10	10	10

8.4 QUARTERLY TARGETS FOR HFM

TABLE HFM 2: QUARTERLY TARGETS FOR HEALTH FACILITES MANAGEMENT FOR 2016/17

INDICATOR	Frequency of reporting (quarterly, bi-annual, annual)	Indicator type	ANNUAL TARGET 2017/18	Targets			
				Q1	Q2	Q3	Q4
1. Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Annual	No	8	-	-	-	8
2. Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District (excluding facilities in NHI Pilot District)	Annual	No	16	-	-	-	16
3. Number of districts spending more than 90% of the maintenance budgets (preventative and unplanned)	Quarterly	No	5	5	5	5	5
4. Number of projects completed	Quarterly	No	10	2	2	2	4

8.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

TABLE HFM 4: EXPENDITURE ESTIMATES: HEALTH FACILITY MANAGEMENT

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
R' thousand	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Community Health facilities	140 613	333 689	506 819	203 067	203 067	346 470	539 383	490 202	517 654
District Hospital Services	69 084	42 594	42 573	52 942	54 035	54 035	63 272	111 928	118 181
Provincial Hospitals Services	17 258	16 384	39 965	41 819	41 819	41 819	24 460	46 009	48 585
Tertiary Hospitals Services	17 447	16 052	12 740	56 099	56 099	56 099	23 000	25 421	26 845
Other Facilities	111 488	155 194	109	381 741	381 141	237 738	2 057	2 010	2 123
Total	**355 890**	**563 913**	**602 206**	**735 668**	**736 161**	**736 161**	**652 172**	**675 570**	**713 388**

Summary of Provincial Expenditure Estimates by Economic Classification[1]

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Current payments	**136 604**	**156 728**	**238 050**	**247 944**	**508 472**	**508 472**	**267 131**	**388 773**	**463 881**
Compensation of employees	3 050	9 962	8 949	25 600	9 288	9 288	10 788	12 946	15 532
Goods and services	133 554	146 766	229 101	222 344	499 184	499 184	256 343	375 827	448 349
Communication	-15	2	15	0	–	–	–	–	–
Computer	49	0	0	0	–	–	–	–	–
Consultants, Contractors and special services	121 576	135 496	219 686	215 412	492 252	490 285	231 792	344 767	405 879
Inventory	2 321	3 477	1 212	0	0	421	6 500	7 500	7 920
Operating leases	0	0	0	0	–	–	–	–	–
Travel and subsistence	767	705	794	0	–	622	1 300	1 500	2 000
Maintenance , repair and running costs	910	0	135	0	–	–	–	–	–
Specify other	7 946	7 086	7 259	6 932	6 932	7 856	16 751	22 060	32 550
Transfers and subsidies to	**–**	**53**	**–**	**–**					
Households	–	53	–	–					
Payments for capital assets	**219 286**	**407 132**	**364 156**	**487 724**	**227 689**	**227 689**	**385 042**	**286 797**	**249 507**
Buildings	204 115	379 212	301 410	467 625	211 816	211 816	184 609	208 796	218 928

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20
Other fixed structures									
Machinery and equipment	15 171	27 920	62 746	20 099	15 873	15 873	200 433	78 001	30 579
Total economic classification	**355 890**	**563 913**	**602 206**	**735 668**	**736 161**	**736 161**	**652 172**	**675 570**	**713 388**

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

8.6 PERFORMANCE AND EXPENDITURE TRENDS

The allocated budget has a direct impact on the achievements of targets in the following ways:

- Maintenance of health facilities .e.g. boilers and equipment at hospitals and other institutions.
- Building and upgrading of health facilities. E.g. clinics, health centres, forensic pathology, nursing colleges and hospitals as well as the building of new malaria, new academic hospital and EMS stations are provided for in the budget and MTEF.

The department has spent a total of R1.5 billion from 2013/14 to 2015/16 while the 2016/17 budget amounts to 735.7 million to R736.1 million. The MTEF from 2017/18 to 2019/20 is projected at R2.0billion. This amount will be used to maintain and improve the current services. The Department intends to realise this programme's strategic objectives and targets through effective and economic utilization of the resources, regular monitoring of the programme performance and stakeholders participation.

8.7 RISK MANAGEMENT

The key risks that may affect the realisation of the objectives of the budget programme: Health facilities management and measures to mitigate the impact of the risks are indicated below.

Strategic Objective	Risk	Mitigating factors
To improve quality of health infrastructure	The cut in infrastructure funding over the recent past and the limited availability of funding over the MTEF to achieve health infrastructure mandates.	Motivate for additional funding both provincially and nationally. Produce good quality planning documentation to bid for any available extra funding.
	Limited capacity to implement infrastructure projects by the provinces implementing agents.	Undertake close management of IA's and provide supportive technical personnel where possible to aide IA's.
	Procurement delays and bottlenecks within LDPWR&I in particular.	Support the establishment and the development of capacity within the Infrastructure Hub, being established in the Province.
	Contractor related challenges	Monitor that contractors are paid regularly and that other problems that they face are responded to.
	Insufficient attention and budget availability to undertake sufficient maintenance of the provinces health facilities.	DBSA has been brought in to support the Department manage short term interventions and to develop a longer term strategy and implement it for a five year period.

PART C

PART C: LINKS TO OTHER PLANS

No	Project Name	Programme	Municipality/ Region	Outputs	Outcome 15/16	Main Appropriation 2016/17	Adjusted Appropriation	Revised Estimate	MTEF 2017/18	MTEF 2018/19	MTEF 2019/20
1. New Infrastructure Assets											
1	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital: OPD, Casualty, X-Ray, Pharmacy, Health Support and Helipad	Design	16 000			-	-	
2	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital:OPD, Casualty, X-Ray, Pharmacy, Health Support and Helipad	Design	8 406			10 000	8 000	**20 000**
3	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital- Health Technology for the Revitalization Site	Feasibility	2 000			3 500	2 500	**3 000**
4	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: Ward Blocks, Theatre, Maternity, Kitchen Block, Linen Store, Laboratory and Transport Control	Retention	7 000			-	-	
5	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: Forensic Mortuary	Construction 26%-50%	8 264			2 600	862	**200**
6	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital-Health Technology: Forensic Mortuary	Feasibility	500			-	-	**6 000**
7	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital- Health Technology: Substance Abuse & Adolescent Ward / Facility	Retention	1 500			1 000	-	
8	**Musina Hospital**	**Programme 8**	**Waterberg**	Musina Hospital: Replacement of existing hospital on a new Site including EMS, malaria centre, mother lodge, NEI, Furniture, equipment, HT	Feasibility	4 000			43 000	45 000	**60 000**

9	**Evuxakeni Hospital**	**Programme 8**	**Mopani**	Evuxakeni Hospital: Health brief and Initial Project Implementation Phase	Feasibility	200			23	-	**10 000**
10	**George Masebe Hospital**	**Programme 8**	**Waterberg**	George Masebe Hospital - Enabling Works Program: Maternity & Theatre: 2nd Contract	Construction 76%-99%	7 000			-	-	
11	**Voortrekker Hospital**	**Programme 8**	**Waterberg**	Voortrekker Hospital - Enabling Works Program: OPD, X-Ray, Casualty & Pharmacy; 3rd Contractor	Construction 76%-99%	2 000			-	-	
12	**Mecklenburg Hospital**	**Programme 8**	**Sekhukhune**	Mecklenburg Hospital - Enabling Works Program: OPD, X-Ray, Casualty & Pharmacy and Entrance Gate House: 2nd Contractor	Construction 76%-99%	2 000			-	-	
13	**WF Knobel Hospital**	**Programme 8**	**Capricorn**	WF Knobel Hospital - Enabling Works Program: Maternity, Theatre Complex	Retention	500			500		
14	**Dr CN Phatudi Hospital**	**Programme 8**	**Mopani**	Dr C N Phatudi Hospital - Enabling Works Program: OPD, X-Ray and Pharmacy: 2nd Contractor	Construction 76%-99%	4 000			3 031		
15	**Matlala Hospital**	**Programme 8**	**Sekhukhune**	Matlala Hospital - Enabling Works Program: Upgrade and Additions Health Support, OPD, X-Ray, Casualty & Pharmacy; 3rd Contractor	Construction 51%-75%	10 000			2 000		
16	**Matlala Hospital**	**Programme 8**	**Sekhukhune**	Matlala Hospital - Enabling Works Program: Access Road Connection from District Road into Main Hospital Entrance	Design	4 000			-	-	
17	**Mokopane Hospital**	**Programme 8**	**Waterberg**	Mokopane Hospital - Enabling Works Program: Theatre Complex	Retention	1 500			-	-	
18	**Malamulele Hospital**	**Programme 8**	**Vhembe**	Malamulele Hospital: Domestic Furniture for the Staff Accommodation - 10 single rooms' block	Feasibility	100			-	-	
19	**HC Boshoff Community Health Centre**	**Programme 8**	**Sekhukhune**	New H.C. Boschoff Community Health Centre: Heating, Ventilation and Air Conditioning	Retention	100			-	-	
20	**HC Boshoff Community Health Centre**	**Programme 8**	**Sekhukhune**	New H.C. Boschoff Community Health Centre: Hot Water	Retention	100			-	-	
21	**HC Boshoff Community Health Centre**	**Programme 8**	**Sekhukhune**	New H.C. Boschoff Community Health Centre: Kitchen Equipment	Retention	100			-	-	

22	**HC Boshoff Community Health Centre**	**Programme 8**	**Sekhukhune**	New H.C. Boschoff Community Health Centre: Medical Gas: 1st Contractor	Construction 75%-100%	300			-	-	
23	**HC Boshoff Community Health Centre**	**Programme 8**	**Sekhukhune**	New H.C. Boschoff Community Health Centre: Medical Gas: 2nd Contractor	Construction 76%-99%	300			-	-	
24	**Thabaleshoba Community Health Centre**	**Programme 8**	**Waterberg**	New Thabaleshoba Community Health Centre	Retention	2 407			300	-	
25	**Mamone Clinic**	**Programme 8**	**Sekhukhune**	Mamone clinic: Replacement of existing clinic on the same site. 2nd Contractor	Retention	1 000			-	-	
26	**Vlakplaats Clinic**	**Programme 8**	**Sekhukhune**	Vlakplaats-Malebitsa: New Clinic : 2nd Contractor	Retention	500			-	-	
27	**Loloka Clinic**	**Programme 8**	**Mopani**	Loloka Clinic: New Clinic: 2nd Contractor	Retention	300			-	-	
28	**Chromite-Smashersblock Clinic**	**Programme 8**	**Waterberg**	Smashersblock (Chromite) Clinic: Replacement of existing Chromite clinic on a new site	Retention	500			-	-	
29	**Phalaborwa Busstop Clinic**	**Programme 8**	**Mopani**	Phalaborwa Busstop Clinic: Replacement of existing clinic on a new site	Retention	438			-	-	
30	**Muyexe Clinic**	**Programme 8**	**Mopani**	Muyexe Clinic: Replacement of existing on a new site	Retention	500			-	-	
31	**Lebowakgomo Unit B Clinic**	**Programme 8**	**Capricorn**	Lebowakgomo Unit B Clinic: New Clinic	Retention	358			-	-	
32	**Soetfontein Clinic**	**Programme 8**	**Capricorn**	Soetfontein Clinic: Replacement of existing on a new site	Retention	1 000			-	-	
33	**Sereni Clinic**	**Programme 8**	**Vhembe**	Sereni Clinic: Replacement of existing on new site	Retention	356			-	-	
34	**Midoroni Clinic**	**Programme 8**	**Waterberg**	Midoroni Clinic: Replacement of existing on a new site	Retention	450			-	-	
35	**Marulaneng Clinic**	**Programme 8**	**Sekhukhune**	Marulaneng Clinic: New Clinic	Retention	591			-	-	
36	**Shotong Clinic**	**Programme 8**	**Mopani**	Shotong Clinic: Replacement of existing on a new site	Retention	500			-	-	
37	**Rooiberg Clinic**	**Programme 8**	**Waterberg**	Rooiberg Clinic: Replacement of existing on the same site	Retention	725			-	-	
38	**Nkomo B Clinic**	**Programme 8**	**Mopani**	Nkomo B Clinic: Replacement of existing clinic on the same site incorporating the adjacent site	Construction 76%-99%	8 617			-	-	
39	**Nkomo B Clinic**	**Programme 8**	**Mopani**	Nkomo B Clinic: Health Technology, Domestic Furniture and Equipment	Construction 76%-99%	500			-	-	
40	**Tshikundamalema Clinic**	**Programme 8**	**Vhembe**	Tshikundamalema Clinic: Replacement of existing clinic on the same site incorporating adjacent site	Construction 76%-99%	10 601			-	-	

41	**Tshikundamalema Clinic**	**Programme 8**	**Vhembe**	Tshikundamalema Clinic: Health Technology, Domestic Furniture and Equipment	Feasibility	500			-	-	
42	**Homulani Clinic**	**Programme 8**	**Mopani**	Homulani Clinic: Replacement of existing clinic on the same site	Construction 76%-99%	11 626			-		
43	**Homulani Clinic**	**Programme 8**	**Mopani**	Homulani Clinic: Health Technology, Domestic Furniture and Equipment	Feasibility	500			-		
44	**Schoongezicht Clinic**	**Programme 8**	**Capricorn**	Schoongezicht Clinic: Replace existing clinic on a new site	Tender	8 128			7 000	5 000	**3 000**
45	**Mamushi Clinic**	**Programme 8**	**Capricorn**	Mamushi Clinic: Replacement of existing clinic on the same site	Tender	7 903			7 000	6 000	**3 000**
46	**Mothiba Clinic**	**Programme 8**	**Capricorn**	Mothiba Clinic: Replacement of existing clinic on a new site	Design	4 000			6 000	5 000	**3 000**
47	**Mothiba Clinic**	**Programme 8**	**Capricorn**	Mothiba Clinic: Replacement of existing clinic on a new site	Design	1 909			5 000	4 000	
48	**Sterkspruit Clinic**	**Programme 8**	**Sekhukhune**	Sterkspruit: Replacement of the existing clinic on the same site	Tender	8 180			4 000	4 000	**3 000**
49	**Phagameng Clinic**	**Programme 8**	**Waterberg**	Phagameng Clinic: Replacement of the existing clinic on a new site	Design	2 000			6 000	5 000	**5 000**
50	**Phagameng Clinic**	**Programme 8**	**Waterberg**	Phagameng Clinic: Replacement of the existing clinic on a new site	Design	2 053			9 000	5 000	
51	**Makeepsvlei Clinic**	**Programme 8**	**Sekhukhune**	Makeepsvlei Clinic: Replacement of existing clinic on the same site	Tender	8 162			4 500	3 000	**5 000**
52	**Roedtan Clinic**	**Programme 8**	**Waterberg**	Roedtan Clinic: Replacement of existing clinic on a new site adjacent to the old clinic	Design	2 000			7 000	5 000	**5 000**
53	**Roedtan Clinic**	**Programme 8**	**Waterberg**	Roedtan Clinic: Replacement of existing clinic on a new site adjacent to the old clinic	Design	500			8 000	6 000	
54	**Marble Hall Clinic**	**Programme 8**	**Sekhukhune**	Marble Hall: Replacement of existing clinic on a new site. Retain existing clinic for EMS. Furniture & Equipment.	Pre-Feasibility	500			8 000	7 000	**5 000**
55	**Mmamokgasefoka Clinic**	**Programme 8**	**Sekhukhune**	Mamokgasefoka: New Clinic . Furniture & Equipment.	Pre-Feasibility	500			15 000	11 000	**3 000**
56	**Mahale Clinic**	**Programme 8**	**Mopani**	Mahale Clinic: Replacement of existing clinic on the same site. Furniture & Equipment.	Pre-Feasibility	500			12 000	25 000	**3 000**
57	**Bela Bela Clinic**	**Programme 8**	**Waterberg**	Bela Bela Clinic: Replacement of existing clinic within the original site	Design	1 000			-	-	
58	**Bela Bela Clinic**	**Programme 8**	**Waterberg**	Bela Bela Clinic: Replacement of existing clinic within the original site	Design	4 001			5 000	4 000	**8 000**

59	**Sekgakgapeng Clinic**	**Programme 8**	**Waterberg**	Sekgakgapheng Clinic: Replacement of existing clinic on a new site	Design	1 000			-	-	
60	**Sekgakgapeng Clinic**	**Programme 8**	**Waterberg**	Sekgakgapheng Clinic: Replacement of existing clinic on a new site	Design	4 001			5 000	4 000	**10 000**
61	**Pienaarsrivier Clinic**	**Programme 8**	**Waterberg**	Pienaarsrivier: New clinic	Design	1 250			-	-	
62	**Pienaarsrivier Clinic**	**Programme 8**	**Waterberg**	Pienaarsrivier: New clinic	Design	4 001			5 000	6 000	**10 000**
63	**Malemati Clinic**	**Programme 8**	**Capricorn**	Malemati Clinic: Replacement of exisitng clinic on the same site. Furniture & Equipment.	Identified	700			5 000	5 000	**7 000**
64	**Phaahla Manoge Clinic**	**Programme 8**	**Sekhukhune**	Phaahla Manoge: New Clinic	Retention	100			300	-	**10 000**
65	**Percy Clinic**	**Programme 8**	**Capricorn**	Percy Clinic: Replacement of existing clinic on the same site	Retention	100			300	-	
66	**Uitkyk Clinic**	**Programme 8**	**Capricorn**	Uitkyk Clinic: Replacement of existing clinic on the same site	Retention	100			300	-	
67	**Nthabiseng Clinic**	**Programme 8**	**Capricorn**	Nthabiseng Clinic: New clinic	Retention	300			-	-	**10 000**
68	**Matoks Cinic**	**Programme 8**	**Capricorn**	Matoks Clinic: Replacement of existing clinic at a new site	Handed over	200			-	-	
69	**Groblersdal Clinic**	**Programme 8**	**Sekhukhune**	Groblersdal Clinic: Replacement of existing clinic on a new site	Retention	546			-	-	**10 000**
70	**Masisi EMS Station**	**Programme 8**	**Vhembe**	Masisi Clinic: New EMS Station at the current existing Masisi Clinic site	Construction 76%-99%	3 887			-	-	**200**
71	**Masisi EMS Station**	**Programme 8**	**Vhembe**	New Masisi EMS Station: Furniture and Equipment	Feasibility	100			-	-	
72	**Old Nkhensani EMS Station**	**Programme 8**	**Mopani**	Old Nkhensani EMS Station: Furniture and Equipment	Feasibility	100			-	-	
72	**Grace Mugodeni EMS Station**	**Programme 8**	**Sekhukhune**	Grace Mugodeni EMS Station: New EMS Station within the existing Grace Mugodeni community health centre's site	Construction 76%-99%	2 035			441	-	
74	**Grace Mugodeni EMS Station**	**Programme 8**	**Mopani**	Grace Mugodeni New EMS Station: Furniture and Equipment	Feasibility	100			-	-	
75	**Leboeng EMS Station**	**Programme 8**	**Mopani**	Leboeng EMS Station: New EMS Station within the government complex at Leboeng	Retention	301			-	-	
76	**Siloam EMS Station**	**Programme 8**	**Mopani**	Siloam EMS Station: New EMS Station within the existing Siloam Hospital Site.	Retention	240			-	-	
77	**Philadelphia EMS Station**	**Programme 8**	**Sekhukhune**	Philadelphia EMS Station: New EMS Station within the existing Philadelphia Hospital site	Handed over	194			-	-	

78	**Thohoyandou EMS Station**	**Programme 8**	**Vhembe**	Thohoyandou EMS Station: New EMS Station within the exsting Thohoyandou Health Centre site	Retention	150			-		
79	**Bosele EMS Station**	**Programme 8**	**Sekhukhune**	Bosele EMS Station: New EMS Station on a new site in Monsterloos - Hlogotlou. Furniture & Equipment.	Design	1 289			3 862	3 000	**6 000**
80	**Lebowakgomo EMS Station**	**Programme 8**	**Capricorn**	Lebowakgomo EMS Station: Renovations of the Fire Station into an EMS Station: 2nd Project	Feasibility	800			1 100	1 100	**6 000**
81	**Matlala EMS Station**	**Programme 8**	**Sekhukhune**	Matlala EMS Station: New EMS Station within the Matlala Hospital's site. Furniture & Equipment.	Identified	500			5 000	6 000	**6 000**
82	**Mookgophong EMS Station**	**Programme 8**	**Waterberg**	Mookgophong EMS Station: New EMS Station . Furniture & Equipment.	Identified	30			6 000	5 000	**6 000**
83	**Modimolle EMS Station**	**Programme 8**	**Waterberg**	Modimolle EMS Station: New EMS Station . Furniture & Equipment.	Design	0			6 000	5 000	**6 000**
84	**Provincial Office Complex**	**Programme 8**	**Capricorn**	Provincial Office Complex: New EMS Office Building : 1st Contractor	Terminated	0			-	-	
85	**Provincial Office Complex**	**Programme 8**	**Capricorn**	Provincial Office Complex: New EMS Office Building: 2nd Contractor	Construction 76%-99%	3 000			-	-	
86	**Waterpoort Malaria Unit**	**Programme 8**	**Mopani**	Team Waterpoort-Makuya Malaria Unit: New Malaria Facility within the existing Makuya Clinic site: 2nd Contractor	Construction 76%-99%	495			-	-	
87	**Waterberg Malaria Unit**	**Programme 8**	**Waterberg**	Waterberg Malaria Unit: New Malaria Unit within the existing Witpoort Hospital site: 2nd Contractor	Retention	500			-	-	
88	**Dr. MMM Nursing School**	**Programme 8**	**Capricorn**	Replacement of Dr MMM Nursing School (Groothoek) at Thabamoopo Hospital Site	Identified	4 600			1 400	1 400	
89	**Dr. MMM Nursing School**	**Programme 8**	**Capricorn**	Replacement of Dr MMM Nursing School (Groothoek) at Thabamoopo Hospital Site	Identified	0			30 000	47 000	
90	**Limpopo Nursing College**	**Programme 8**	**Capricorn**	Limpopo Nursing College: Purchase Office Accomodation in Polokwane	Identified	1 000			-	-	**10 000**
91	**Modimolle Town Clinic**	**Programme 8**	**Waterberg**	Modimolle Town Clinic: Purchase property to replace existing Modimolle Town clinic accommodated in the municipal offices	Identified	1 000			-	-	
92	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: Purchase remaining staff accommodation units/flats in the building block already occupied by LDoH	Feasibility	6 000			3 000	-	**2 000**

93	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific: Health Technology, Domestic Furniture, , Equipment and Fittings	Feasibility	200			-	-	
94	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific - Limpopo Nursing College Campuses & Nursing Schools: Furniture, equipment, and fittings	Feasibility	2 000			-	-	**5 000**
95	**Provincial Office**	**Programme 8**	**Capricorn**	Provincial Office-IDMS Capacitation Fund: Machinery and Equipment	Feasibility	1 000			5 000	4 000	**4 000**
96	**Provincial Office**	**Programme 8**	**Capricorn**	Provincial Office-Equitable Share: Machinery and Equipment	Feasibility	400			0	0	**1 000**
97	**Botlokwa Hospital**	**Programme 8**	**Capricorn**	Botlokwa Hospital: Replacements-Mechanical Electrical Programme	Feasibility	1 558			-	-	
98	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: Replacements-Mechanical Electrical Programme	Feasibility	1 232			-	-	**2 000**
99	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: Replacements- Health Technology	Feasibility	683			-	-	**2 000**
100	**FH Odendaal MDR - XDR Facility**	**Programme 8**	**Waterberg**	FH Odendaal MDR-XDR Facility: Replacements- Mechanical Electrical Programme	Feasibility	280			-	-	
101	**FH Odendaal South Hospital**	**Programme 8**	**Waterberg**	FH Odendaal South Facility: Replacements- Mechanical Electrical Programme	Feasibility	116			-	-	
102	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Replacements-Mechanical Electrical Programme	Feasibility	377			-	-	**3 000**
103	**Witpoort Hospital**	**Programme 8**	**Waterberg**	Witpoort Hospital: Replacements-Mechanical Electrical Programme	Feasibility	454			-	-	**4 000**
104	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Upgrade and Additions of steam reticulation systems	Identified	1 000			-	-	**2 000**
105	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Replacement of critical life saving equipment	Identified	2 000			-	-	
106	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Replacement or Refurbishment of Stand By Generators & Related Infrastructure	Feasibility	8 000			-	-	
107	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Provision of Mobile Standby Generators & Related Infrastructure Units	Identified	4 000			-	-	**10 000**
108	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Alternative back up power supply & Related Infrastructure for Ideal Clinic Programme	Identified	5 200			-	-	**10 000**
109	**Mninginisi Clinic**	**Programme 8**	**Mopani**	New Clinic and including furniture and equipment	Feasibility	0			500	10 000	**20 000**
110	**New Clinic Projects [5 in total]**	**Programme 8**	**All districts**	Planning, design and construction of new clinics and including furniture and equipment	Feasibility	0			-	-	**10 000**

111	**New EMS Projects**		**All districts**	Planning, design and construction of new EMS facilities and including furniture and equipment	Feasibility	0			-	-	**10 000**
112	**New Staff Accommodation**	**Programme 8**	**All districts**	Planning, design and construction of new Staff accommodation and including furniture and equipment	Feasibility	0			-	-	
113	**Malaria Control Facilities**	**Programme 8**	**Various**	Planning, design and construction of additional malaria control facilities	Feasibility	0			-	-	
114	**2. Upgrades and Additions**										
115	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital- Contract A5: 72 hours Water Standby Storage, Civil & Mechanical Works, rehabilitate Workshop	Design	6 000			936	-	
116	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital- Contract A5: 72 hours Water Standby Storage, Civil & Mechanical Works, rehabilitate Workshop	Design	11 545			10 000	8 000	**1 000**
117	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital- Contract A6: Burnt Female Surgical Ward, waste store, etc	Design	500			1 000	500	**10 000**
118	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital- Contract A6: Burnt Female Surgical Ward, waste store, etc	Design	1 500			14 883	15 000	
119	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Central Mini-Hub Laundry	Design	17 876			-	-	**2 000**
120	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Medical and Admissions Records' Facility and equipment	Design	4 500			10 000	11 000	
121	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Medical and Admissions Records' Facility and equipment	Design	3 537			9 500	7 000	
122	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital A2-4: Gynaecology Ward, New Nurses Residence and Nurses College, Prosthetic Centre, Upgrading and additions of Staff Houses, Rehabilitation of Casualty, Theatre, Wards 1&2	Design	1 215			4 377	-	
123	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital A2-3: Gynaecology Ward, New Nurses Residence and Nurses College, Prosthetic Centre, Upgrading and additions of Staff Houses, Rehabilitation of Casualty, Theatre, Wards 1&2: LDPW-B/14002	Construction 26%-50%	600			600	-	
124	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Maternity Ward, Walkways, Victim Empowerment Centre	Construction 76%-99%	1 000			-	-	

125	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital-Contract B3-New Admin, Visitors Waiting, Gate House, etc.	Retention	2 160			-	-	
126	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital A1 - Construction of Recreation and Residential Facilities (B/06018)	Litigation	600			-	-	
127	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Organisational Development	Construction 1%-25%	300			700		
127	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital: Completion of linen store, ring roads, flooring, paving and storm water drainage. Platforms, paving and services for relocatable units. Relocatable units and repurposing of the dining hall into meeting hall. Renovation of the burnt staff accommodation unit. Commissioning of kitchen equipment.	Tender	12 222			4 000	5 000	
129	**Maphutha Malatji Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital-Contract A2: Renovations & Alterations to gen. wards, pediatric ward, maternity ward;	Retention	3 905			-	-	
130	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital: Organisational Development for Revitalization Site	Feasibility	300			-	-	
131	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie: Quality Improvement for Revitalization Site	Feasibility	250			-	-	
132	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: New Hospital Laundry	Project Initiation	2 060			-	-	
133	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: New Hospital Laundry	Project Initiation	1 500			5 000	3 000	
134	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: Organisational Development for Revitalization Site	Planning	300			-	-	
135	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: Quality Improvement for Revitalization Site	Feasibility	450			-	-	
136	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Health Support Facility 2nd Contractor	Design	6 000			3 500	5 000	
137	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Substance Abuse & Adolescent Ward / Facility: 3rd Contractor, LDPW-B/09004	Retention	1 121			2 102	-	
138	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: New Forensic Ward Facility	Identified	500			7 000	5 000	
139	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Central Mini-Hub Laundry and Linen Bank.	Identified	1 500			10 000	11 000	
140	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Medical & Geriatric Wards & Upgrading of steam reticulation system; LDPW-B/070509	Retention	100			1 078	-	
141	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Male Security Ward; LDPW-B09006	Retention	100			484	-	

142	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Female Acute, Sub-Acute & Chronic Ward; LDPW-B/09005	Retention	100			1 272	-	
144	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Kitchen, Staff Dining & Bulk Stores; LDPW-B/08108	Retention	1 300			-	-	
145	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Male Chronic, Sub-Acute & Acute Wards; LDPW-B/08103	Retention	100			540	-	
146	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Residential Accommodation, Half Way House, Pharmacy & Kiosk; LDPW-B/09007	Retention	100			171	-	
147	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Transport Control Office; LDPW-B/10108	Handed over	100			65	-	
148	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Organisational Development for the Revitalization Site	Feasibility	300			-	-	
149	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Quality Improvement for the Revitalization Site	Tender	450			-	-	
150	**Musina Hospital**	**Programme 8**	**Vhembe**	Musina Hospital: Replacement of Hospital Laundry Equipment	Identified	3 500			-	-	
151	**Witpoort Hospital**	**Programme 8**	**Waterberg**	Witpoort Hospital: Replacement of Hospital Laundry Equipment	Identified	1 500			-	-	
152	**Louis Trichardt Hospital**	**Programme 8**	**Vhembe**	Louis Trichardt Hospital: Replacement of Hospital Laundry Equipment	Identified	1 500			-	-	
153	**Warmbad Hospital**	**Programme 8**	**Waterberg**	Warmbath Hospital: Health brief and Initial Project Implementation Phase	Feasibility	200			449	-	
154	**Pietersburg Hospital**	**Programme 8**	**Capricorn**	Pietersburg Hospital: Upgrading and additions of Theatres, ICU, High Care and Lift	Feasibility	2 000			-	-	
155	**Pietersburg Hospital**	**Programme 8**	**Capricorn**	Pietersburg Hospital: Central Mini-Hub Laundry	Identified	4 500			-	-	
156	**Tshilidzini Hospital**	**Programme 8**	**Vhembe**	Tshilidzini Hospital: Central Mini-Hub Laundry	Identified	4 500			-	-	
157	**St Rita's Hospital**	**Programme 8**	**Sekhukhune**	St Rita's Hospital: Central Mini-Hub Laundry	Identified	5 000			-	-	
158	**Mokopane Hospital**	**Programme 8**	**Waterberg**	Mokopane Hospital: Central Mini-Hub Laundry	Identified	3 500			-	-	
159	**Philadelphia Hospital**	**Programme 8**	**Sekhukhune**	Philadelphia Hospital - Enabling Works Program: Completion of OPD, X-Ray, Casualty: 3rd Contractor	Construction 76%-99%	5 000			-	-	
160	**Philadelphia Hospital**	**Programme 8**	**Sekhukhune**	Philadelphia Hospital: Central Mini-Hub Laundry	Identified	3 500			-	-	
161	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific: Enabling Works Program: Organisational Development	Feasibility	500			-	-	
162	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific: Enabling Works Program: Quality Improvements	Feasibility	300			-	-	

163	**Jane Furse Hospital**	**Programme 8**	**Sekhukhune**	Jane Furse Hospital: Gateway Clinic & Linen Store	Retention	700			-	-	
164	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: New Hospital Laundry	Identified	3 000			5 000	6 000	
165	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: Sub-acute ward A & B	Litigation	70			330	-	
166	**New Nkhensani Hospital**	**Programme 8**	**Mopani**	Nkhensani Hospital: New Ward	Retention	1 093			-	-	
167	**New Nkhensani Hospital**	**Programme 8**	**Mopani**	Nkhensani Hospital: New Hall and Kitchen	Retention	900			-	-	
168	**F.H Odendaal Hospital**	**Programme 8**	**Waterberg**	F.H Odendaal Hospital: Health Support, Maternity Complex, Re-organization of Casualty/OPD	Identified	0			20 000	40 000	
169	**Sekororo Hospital**	**Programme 8**	**Mopani**	Sekororo Hospital: Maternity Complex; Medical Gas Plant Room	Identified	0			18 000	35 000	
170	**Mankweng Hospital**	**Programme 8**	**Capricorn**	Mankweng Hospital: New Mankweng Forensic Laboratory and Upgrading and additions of Existing Hospital Mortuary: 1st Contractor	Terminated	0			-	-	
171	**Mankweng Hospital**	**Programme 8**	**Capricorn**	Mankweng Hospital: New Mankweng Forensic Laboratory and Upgrading and additions of Existing Hospital Mortuary: 2nd Contractor	Construction 76%-99%	1 000			-	-	
172	**Mankweng Hospital**	**Programme 8**	**Capricorn**	Mankweng Hospital: Health Technology for the New Mankweng Forensic Laboratory	Feasibility	850			-	-	
173	**Mankweng Hospital**	**Programme 8**	**Capricorn**	Mankweng Hospital: Central Mini-Hub Laundry	Identified	3 500			-	-	
174	**Zebediela Hospital**	**Programme 8**	**Sekhukhune**	Zebediela Hospital: New Hospital Mortuary Facility	Construction 76%-99%	500			-	-	
175	**Groblersdal Hospital**	**Programme 8**	**Sekhukhune**	Groblersdal Hospital: New Forensic Mortuary	Handed over	398			310		
176	**Seshego Hospital**	**Programme 8**	**Capricorn**	Seshego Hospital: Upgrading and additions of the existing Hospital Mortuary	Identified	0			6 000	7 000	
177	**Botlokwa Hospital**	**Programme 8**	**Capricorn**	Botlokwa Hospital: Upgrading and additions of the Storm Water Management	Identified	0			600	400	
178	**Elim Hospital**	**Programme 8**	**Vhembe**	Elim Hospital: Upgrading and additions of Boilers and New Boiler House: 2nd Contractor	Construction 26%-50%	10 000			-	-	
179	**WF Knobel Hospital**	**Programme 8**	**Capricorn**	WF Knobel Hospital: Staff Accommodation - 10 single rooms' block	Retention	513			-	-	
180	**Jane Furse Hospital**	**Programme 8**	**Sekhukhune**	Jane Furse Hospital: Staff Accommodation - 10 single rooms' block	Retention	500			-	-	

181	**Malamulele Hospital**	**Programme 8**	**Vhembe**	Malamulele Hospital: Staff Accommodation - 10 single rooms' block: 2nd Contractor	Construction 76%-99%	500			-	-	
182	**Sekororo Hospital**	**Programme 8**	**Mopani**	Sekororo Hospital: Staff Accommodation - 2X10 single rooms' blocks	Retention	500			-	-	
183	**Donald Fraser Hospital**	**Programme 8**	**Vhembe**	Donald Frazier Hospital: Upgrading and additions Hospital Laundry	Identified	1 500			-	-	
184	**Donald Fraser Hospital**	**Programme 8**	**Vhembe**	Donald Fraser Hospital: Staff Accommodation -10 single rooms' block: 2nd Contractor	Retention	500			-	-	
185	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: Staff Accommodation -10 single rooms' block	Retention	500			-	-	
186	**Philadelphia Hospital**	**Programme 8**	**Sekhukhune**	Philadelphia Hospital: Staff Accommodation -10 single rooms' block: 2nd Contractor	Retention	751			-	-	
187	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Staff Accommodation - 10 single rooms' block	Retention	500			-	-	
188	**FH Odendaal MDR-XDR Hospital**	**Programme 8**	**Waterberg**	FH Odendaal MDR-XDR Hospital: Upgrading and additions Hospital Laundry	Identified	900			-	-	
189	**Ellisras Hospital**	**Programme 8**	**Waterberg**	Ellisras Hospital: Upgrading and additions Hospital Laundry	Identified	1 224			-	-	
190	**Louis Trichardt Hospital**	**Programme 8**	**Vhembe**	Louis Trichardt Hospital: Staff Accommodation -10 single rooms' block	Retention	500			-	-	
191	**Zebediela Hospital**	**Programme 8**	**Sekhukhune**	Zebediela Hospital: Staff Accommodation -10 single rooms' block	Retention	325			-	-	
192	**Mokopane, Witpoort and George Masebe Hospitals-Waterberg**	**Programme 8**	**Waterberg**	Waterberg Staff Accommodation at Mokopane, Witpoort and George Masebe Hospitals	Retention	150			-	-	
193	**Matlala & Mecklenburg Hospitals; Sekhukhune District**	**Programme 8**	**Sekhukhune**	Sekhukhune Staff Accommodation at Matlala & Mecklenburg Hospitals	Retention	1 000			-	-	
194	**Mokopane Hospital**	**Programme 8**	**Waterberg**	Mokopane Hospital: Staff Accommodation -10 single rooms' block	Design	2 500			2 000	5 000	
195	**Ratshaatshaa Community Health Centre**	**Programme 8**	**Waterberg**	Ratshaatshaa Health Center:Staff Accommodation; 2x 10 single rooms blocks	Identified	3 500			-	-	
196	**Kutama Clinic**	**Programme 8**	**Vhembe**	Kutama Clinic: Upgrading and additions and Upgrading and additionss to existing clinic. 2nd Contractor	Retention	489			-	-	
197	**Shigalo Clinic**	**Programme 8**	**Vhembe**	Shigalo Clinic: Upgrading and additionsal Staff Accommodation (10 single rooms) and renovation of existing clinic	Retention	1 150			-	-	
198	**Nkomo B Clinic**	**Programme 8**	**Mopani**	Nkomo B Clinic: Organisational Development	Feasibility	10			-	-	
199	**Nkomo B Clinic**	**Programme 8**	**Mopani**	Nkomo B Clinic: Quality Improvements	Feasibility	100			-	-	

200	**Tshikundamalema Clinic**	**Programme 8**	**Vhembe**	Tshikundamalema Clinic: Organisational Development	Feasibility	10			-	-	
201	**Tshikundamalema Clinic**	**Programme 8**	**Vhembe**	Tshikundamalema Clinic: Quality Improvements	Feasibility	100			-	-	
202	**Homulani Clinic**	**Programme 8**	**Mopani**	Homulani Clinic: Organisational Development	Feasibility	10			-	-	
203	**Homulani Clinic**	**Programme 8**	**Mopani**	Homulani Clinic: Quality Improvements	Feasibility	100			-	-	
204	**Lekhureng Clinic**	**Programme 8**	**Capricorn**	Lekhureng Clinic: Upgrading and additions of Five (5) Bedroom Nurses' Accommodation Block plus renovation of existing clinic facilities. Furniture & Equipment.	Identified	700			4 000	6 000	
205	**Moutse East Clinic**	**Programme 8**	**Sekhukhune**	Moutse East Clinic: Upgrading and additions of Staff Accommodation (5 x single rooms)and renovation of existing clinic facilities. Furniture & Equipment.	Identified	200			3 000	2 000	
206	**Marulaneng & Moeding Clinics**	**Programme 8**	**Sekhukhune**	Marulaneng & Moeding Clinics: Upgrading and additions of electrical supply	Handed over	98			300	-	
207	**The Oaks Clinic**	**Programme 8**	**Sekhukhune**	The Oaks Clinic: Upgrading and additions of electrical supply	Handed over	18			300	-	
208	**Old Nkhensani EMS Station**	**Programme 8**	**Mopani**	Old Nkhensani EMS Station: Upgrading and additions / repurpose of existing buildings at the Old Nkhensani hospital Site into an EMS station	Construction 76%-99%	2 059			-	-	
209	**Roedtan EMS Station**	**Programme 8**	**Waterberg**	Roedtan EMS Station: Upgrading and additions / Repurpose old Roedtan clinic building into an EMS station. Furniture & Equipment.	Design	30			3 000	5 000	
210	**Vaalwater EMS Station**	**Programme 8**	**Waterberg**	Vaalwater EMS Station: Upgrading and additions / Repurpose old Vaalwater clinic facilities and site for a New EMS station . Furniture & Equipment.	Identified	500			3 000	6 000	
211	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific-Clinics and CHCs: Upgrading and additions Water Sources, Sanitation and Related Mechanical & Electrical Works	Construction 1%-25%	15 000			-	-	
212	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific - Hospitals and Other Health Facilities: Upgrading and additions Water Sources, Sanitation and Related Mechanical & Electrical Works	Construction 1%-25%	28 000			-	-	
213	**Tzaneen Malaria Control Institute**	**Programme 8**	**Mopani**	Tzaneen Malaria Control Institute: Upgrading and additions offices and Insectorium	Retention	500			-	-	
214	**Sovenga Nursing College Campus**	**Programme 8**	**Capricorn**	Student nurses residential accomodation for Sovenga Nursing College Campus in the Mankweng Hospital Site	Identified	3 800			2 000	-	

215	**Sovenga Nursing College Campus**	**Programme 8**	**Capricorn**	Student nurses residential accomodation for Sovenga Nursing College Campus in the Mankweng Hospital Site	Identified	0			8 000	13 000	
216	**Ellisras Hospital**	**Programme 8**	**Waterberg**	Ellisras Hospital: purchase of residential accommodation	Identified	1 000			-	-	
217	**Musina Hospital**	**Programme 8**	**Vhembe**	Musina Hospital: purchase of residential accommodation	Identified	1 000			-	-	
218	**Warmbath Hospital**	**Programme 8**	**Waterberg**	Warmbath Hospital: Purchase of residential accommodation	Identified	1 000			-	-	
219	**Groblersdal & Philadelphia Hospitals**	**Programme 8**	**Sekhukhune**	Groblersdal & Philadelphia Hospitals: Purchase of residential accommodation	Identified	1 000			-	-	
220	**Non Facility Specific**	**Programme 8**	**All districts**	Non-Facility Specific: Organisational Development	Feasibility	200			-	-	
221	**Non Facility Specific**	**Programme 8**	**All districts**	Non-Facility Specific: Quality Improvements	Feasibility	200			-	-	
222	**Provincial Office**	**Programme 8**	**Capricorn**	Provincial Office-IDMS Capacitation Fund: Compensation of Employees	On-Going	23 300			15 000	15 000	
223	**Provincial Office**	**Programme 8**	**Capricorn**	Provincial Office-IDMS Capacitation Fund: Goods and Services	On-Going	2 000			2 000	2 000	
223	**Provincial Office**	**Programme 8**	**Capricorn**	Provincial Office- Equitable Share-Compensation of Employees	On-Going	3 400			0	0	
225	**Provincial Office**	**Programme 8**	**Capricorn**	Provincial Office-: Equitable Share-Goods and Services	On-Going	600			0	0	
225	**Pietersburg hospital**	**Programme 8**	**Capricorn**	Pietersburg Hospital: Upgrading and additions Electrical System and provide Certificate of Compliance	Identified	2 200			0	0	
226	**Philadelphia hospital**	**Programme 8**	**Sekhukhune**	Philadelphia Hospital: Upgrading and additions Electrical System and provide Certificate of Compliance	Identified	1 700			0	0	
228	**Ellisras hospital**	**Programme 8**	**Waterberg**	Ellisras Hospital: Upgrading and additions Electrical System and provide Certificate of Compliance	Identified	1 300			0	0	
229	**WF Knobel hospital**	**Programme 8**	**Capricorn**	WF Knobel Hospital: Upgrading and additions Electrical System and provide Certificate of Compliance	Identified	1 300			0	0	
230	**St Ritas hospital**	**Programme 8**	**Sekhukhune**	St Ritas Hospital: Upgrading and additions Electrical System and provide Certificate of Compliance	Identified	1 300			0	0	
231	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific: Upgrading and additions to Water Storage Capacity	Identified	3 200			1 500	1 000	
232	**3. Refurbishment and Rehabilitation**										
234	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital-Contract B4: Upgrading of Existing Administration and Psychiatric Ward	Construction 1%-25%	20 956			3 461	2 000	

235	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Quality Improvements	Feasibility	500			-	-	
236	**Letaba Hospital**	**Programme 8**	**Mopani**	Letaba Hospital: Health Technology	Feasibility	3 000			500	500	
237	**Giyani Nursing College Campus**	**Programme 8**	**Mopani**	Giyani Nursing College Campus: Renovation of student nurses' residential accommodation and fencing.	Identified	2 000			-	-	
238	**Giyani Nursing College Campus**	**Programme 8**	**Mopani**	Giyani Nursing College Campus: Renovation of student nurses' residential accommodation and fencing.	Identified	3 000			7 000	6 000	
239	**4. Maintenance and Repairs**										
240	**Letaba Hospital**	**Programme 8**	**Mopani**	Letabca Hospital: Maintenance of Health Tehnology for the Revitalization Site	Feasibility	500			0	0	
241	**Maphutha Malatjie Hospital**	**Programme 8**	**Mopani**	Maphutha Malatjie Hospital: Maintenance of Health Technology for the Revitalization Site	Feasibility	500			0	0	
242	**Thabazimbi Hospital**	**Programme 8**	**Waterberg**	Thabazimbi Hospital: Maintenance of Health Technology for the Revitalization Site	Feasibility	500			0	0	
243	**Nkhensani Hospital**	**Programme 8**	**Mopani**	Nkhensani Hospital: Repair Termite damaged areas and Upgrade and Additions the Pharmacy Off-loading area	Identified	500			-	-	
244	**Nkhensani Hospital**	**Programme 8**	**Mopani**	Nkhensani Hospital: Repair Termite damaged areas and Upgrade and Additions the Pharmacy Off-loading area	Identified	1 500			-	-	
245	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific: Maintenance of Existing Water Infrastructure	Construction 1%-25%	22 000			0	0	
246	**Non Facility Specific**	**Programme 8**	**All districts**	Non Facility Specific - Limpopo Nursing College Campuses and Nursing Schools: Routine Maintenance	Identified	1 800			0	0	
247	**Botlokwa Hospital**	**Programme 8**	**Capricorn**	Botlokwa Hospital: Scheduled Maintenance- Mechanical Electrical Programme	Feasibility	1 300			0	0	
248	**Botlokwa Hospital**	**Programme 8**	**Capricorn**	Botlokwa Hospital: Scheduled Maintenance- Health Technology	Feasibility	130			0	0	
249	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: Scheduled Maintenance- Mechanical Electrical Programme	Feasibility	800			0	0	
250	**Dilokong Hospital**	**Programme 8**	**Sekhukhune**	Dilokong Hospital: Scheduled Maintenance-Health Technology	Feasibility	240			0	0	
251	**FH Odendaal MDR - XDR Facility**	**Programme 8**	**Waterberg**	FH Odendaal MDR-XDR Facility: Scheduled Maintenance- Mechanical Electrical Programme	Feasibility	210			0	0	

252	**FH Odendaal South Hospital**	**Programme 8**	**Waterberg**	FH Odendaal South Hospital: Scheduled Maintenance- Mechanical Electrical Programme	Feasibility	500			0	0	
253	**FH Odendaal South Hospital**	**Programme 8**	**Waterberg**	FH Odendaal South Hospital: Scheduled Maintenance- Health Technology	Feasibility	140			0	0	
254	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Scheduled Maintenance- Mechanical Electrical Programme	Feasibility	1 700			0	0	
255	**Thabamoopo Hospital**	**Programme 8**	**Capricorn**	Thabamoopo Hospital: Scheduled Maintenance- Health Technology	Feasibility	75			0	0	
256	**Witpoort Hospital**	**Programme 8**	**Waterberg**	Witpoort Hospital: Scheduled Maintenance- Mechanical Electrical Programme	Feasibility	270			0	0	
257	**Witpoort Hospital**	**Programme 8**	**Waterberg**	Witpoort Hospital: Scheduled Maintenance- Health Technology	Feasibility	135			0	0	
258	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Emergency Repairs- Mechanical Electrical Programme	Identified	4 800			0	0	
259	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Emergency Repairs- Health Technology	Identified	700			0	0	
260	**Non facility specific**	**Programme 8**	**Waterberg**	Non facility specific - Waterberg District: Maintenance of Clinics and CHCs	Identified	1 000			0	0	
261	**Non facility specific**	**Programme 8**	**Capricorn**	Non facility specific - Capricorn District: Maintenance of Clinics and CHCs	Identified	1 000			0	0	
262	**Non facility specific**	**Programme 8**	**Sekhukhune**	Non facility specific - Sekhukhune District: Maintenance of Clinics and CHCs	Identified	1 000			0	0	
263	**Non facility specific**	**Programme 8**	**Mopani**	Non facility specific - Mopani District: Maintenance of Clinics and CHCs	Identified	1 000			0	0	
264	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Service, Repair and or Replace Mechanical Electrical Equipment	Identified	1 500			0	0	
265	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Service, Repair and or Replace Civil Engineering Works	Identified	1 500			0	0	
266	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Service, Repair and or Replace Building Works	Identified	1 500			0	0	
267	**Non facility specific**	**Programme 8**	**All districts**	Non Facility Specific: Source Development, Fire Water, Storage, Reticulation and Waste Water Disposal inclusive of Service, Repair and or Replace - Water and Sanitation	Identified	1 500			0	0	
268	**Provincial Offices**	**Programme 8**	**Capricorn**	Provincial Offices: Repair, Service and Maintenance	Feasibility	3 000			0	0	

8. CONDITIONAL GRANTS

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2017/18
1. HPTD (Health Professionals)	To support the training of Medical and Allied Health professionals	Number and composition of health sciences students trained and developed	
		Number of registrars per discipline and per institution	6 per discipline
		Number of health facilities with expanded specialists and teaching infrastructure	10 facilities
2. National Tertiary Services Grant	To develop an Academic Health Service Complex with tertiary, secondary, and primary components;	% institutions with 75% equipment in line with (T1) tertiary service package	100%
	Increase accessibility to tertiary services	Percentage reduction of referrals to other provinces	80%
	make the facilities more accessible and to bring their activities and services in line with the level of care, (tertiary services)	% of tertiary institutions with health professional recruited and retained	90%
3. Comprehensive HIV and AIDS	•To enable the health sector to develop an effective response to HIV and Aids including universal	No. of facilities offering ART	523
		No. of new patients started on ART	61 078
		No. of patients on ART remaining in care	370 783
		No. of active home based carers receiving stipends	8 868

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2017/18
	access to HIV Counselling and Testing (HCT) •To support the implementation of the National Operational Plan for comprehensive HIV and Aids treatment and care •To subsidise in-part funding for antiretroviral treatment programme	No. of beneficiaries served by home based carers	382 680
		No. of HIV+ clients screened for TB	98 128
		No. of HIV positive clients started on IPT	37 660
		No. of Doctors trained on HIV/AIDS,TB, STIs and other chronic diseases	120
		No. of nurses trained on HIV/AIDS,TB, STIs and other chronic diseases	1 200
		No. of Non-Professional trained on HIV/AIDS,TB, STIs and other chronic diseases	600
		No. of Male Condom distributed	87 085 290
		No. of Female Condom distributed	3 500 000
		No. of HTA interventions Sites	350
		No. of active Lay counsellors on stipend	926
		No. of clients tested (including antenatal)	1 024 546
		No. of health facilities offering MMC	62
		No. of MMC performed	36 910
		No. of sexual assault cases offered ARV prophylaxis	3 500
		No. of antenatal clients initiated on ART	16 188
		No. of babies PCR tested at 10 weeks	15 200
Health Infrastructure Grant	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including, inter alia, health technology,	Number of health infrastructure projects planned	11
		Number of health infrastructure projects designed	9

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2017/18
	organisational systems (OD) and quality assurance (QA). • Supplement expenditure on health infrastructure delivered through public-private partnerships	• Number of health infrastructure projects under construction	52
National Health Insurance	• Develop frameworks and models that can be used to roll out the National Health Insurance (NHI) pilots in districts and central hospitals critical to achieving the phased implementation of NHI • Test innovations in health service delivery for implementing NHI, to interpret and design innovations relevant to its specific context in line with the vision for realising universal health coverage for all • To undertake health system strengthening activities in identified focus areas of interventions/activities; undertaken in the district funded through this grant	• No of Municipal Ward-based Outreach Teams • Number of mutiganti community feedback meetings • Number of users linked to the Referral communication system • Number of patients enrolled on to the Central Chronic Medication Dispensing and Distribution Programme (CCMDD) • Number of PHC facilities with GP's contracted on the HP contract	200 12 1000 40 000 100

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2017/18
	Strengthened district capacity for monitoring and evaluation, including research/impact assessment reports of selected interventions Strengthened coordination and integration of existing Municipal Ward-based Outreach teams within pilot districts Strengthened supply chain management		

9. PUBLIC ENTITIES

The Department does not have any public entities.

10. PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

NAME OF PPP	PURPOSE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF TERMINATION	MEASURES TO ENSURE SMOOTH TRANSFER OF RESPONSIBILITIES
1. Limpopo Renal Dialysis Unit	To form partnership for financing, constructing, equipping, maintaining, operating and co-staffing an enlarged and refurbished renal facility; and Provide full range of haemodialysis and provision of support to the peritoneal outpatients services by private parties	• High quality serviced health facility delivered • Facilities and management service consistent with the ethos, goals and values of the Department provided • High quality renal services consistent with the international standards provide	R33 million	November 2016	The department has requested an extension of 3 years with Clinix Renal Care through National Treasury (NT) within the same terms and conditions of the original Agreement. NT is currently finalizing the extension of the contract.
2. Phalaborwa Hospital	Acquire full PPP for financing, designing, upgrading, and refurbishment of the Phalaborwa Health Centre as a private hospital facility	Private hospital established through PPP	R110 000	November 2025	Joint Management Committee established
3. Limpopo Academic Hospital	Acquire full PPP for financing, designing and building the academic hospital	High quality serviced health facility delivered High quality renal services consistent with	R0.00		National Health and National Treasury opted to look into other procurement options/models

NAME OF PPP	PURPOSE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF TERMINATION	MEASURES TO ENSURE SMOOTH TRANSFER OF RESPONSIBILITIES
		the international standards provide			

11. CONCLUSIONS

Given that the development of the Annual Performance Plan (APP) was an inclusive process, it is therefore reasonable to conclude that all the Department's employees proudly take ownership of this strategic document. Meanwhile, Government's priorities in general and those of the health sector in particular have carefully been incorporated into the APP.

The following resource documents and priorities were considered in the development of the APP *inter alia* National Development Plan, Medium Term Strategic Framework (MTSF), the 10 Point Plan for the health sector, Government outcomes (Negotiated Service Delivery Agreement), Limpopo Development Plan, State of the Nation Address (SONA), State of the Province Address (SOPA), National Health Priorities and the MEC's budget speech. In addition, the APP has been developed using the format customised for the health sector and approved by Office of the Premier. It is also important to note that a great effort has been made in setting targets that will see to the achievement of the Department's strategic objectives.

The Department hereby commit itself to implementing the Annual Performance Plan (APP) for 2017/18 - 2018/19 (MTEF).

ANNEXURE A: StatsSA Population Estimates 2002-2018

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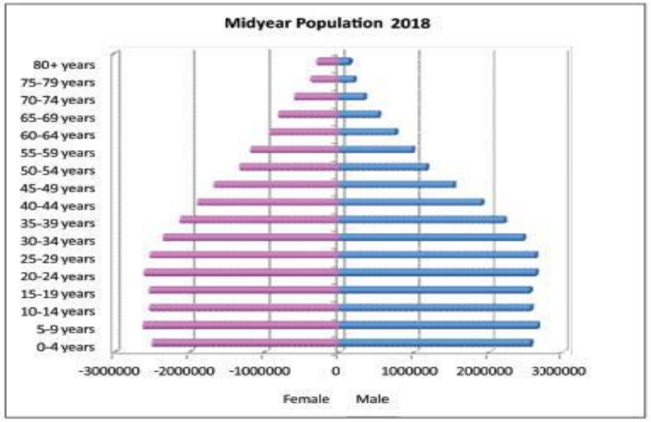

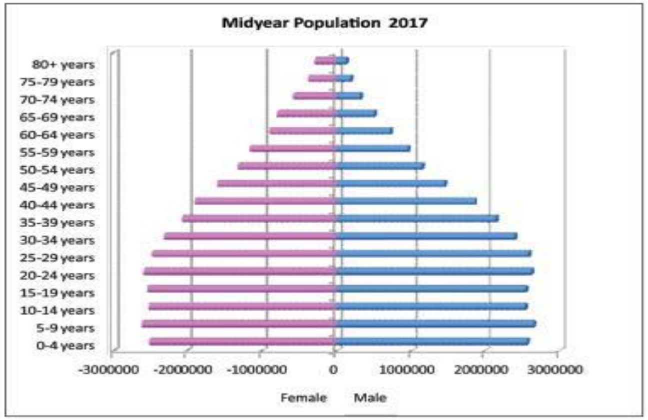

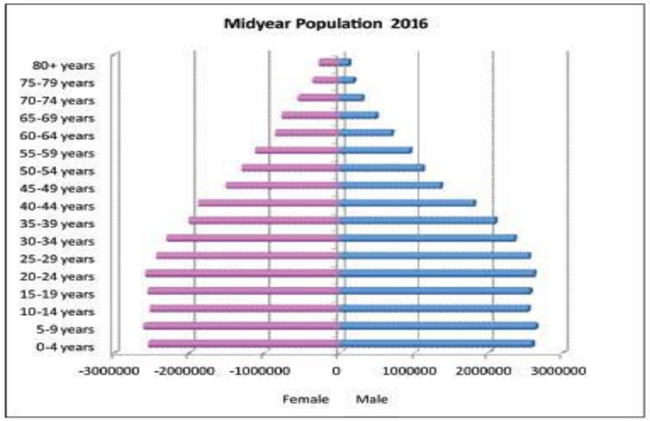

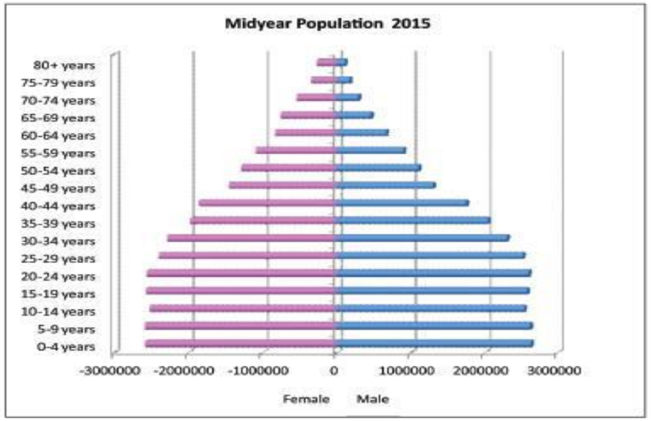

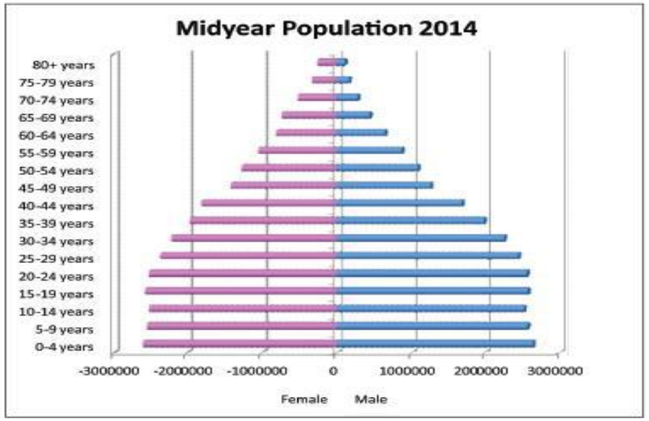

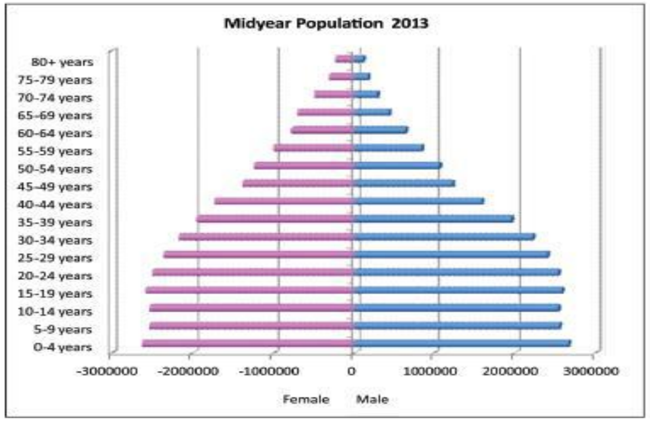

ANNEXURE B: MEDIUM TERM STRATEGIC FRAMEWORK 2014-2019

Revision to MTSF
2014-2019 - FINAL A

PS! See Departmental Website for Revised MTSF 2014-2019

ANNEXURE C: TECHNICAL INDICATOR DESCRIPTIONS

PROGRAMME 1: ADMINISTRATION

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Number of medical specialist appointed **	Staffing of medical specialists	Provision of medical specialists in the hospitals	Staff-establishments	Numbers per staff-establishment	Depending on accuracy of data in persal	Input	Numbers	Bi-annual	No	Reduction of vacancies	HR Planning
Number of medical doctors appointed**	Staffing of medical doctors	Provision of medical doctors	Staff-establishment	Numbers per staff-establishment	Depending on accuracy of data in persal	Input	Numbers	Bi-annual	No	Reduction vacancies	HR Planning
Number of professional nurses appointed	Staffing of professional nurses in the institutions	Provision of professional nurses in the institutions	Staff-establishments	Numbers per staff-establishment	Depending on accuracy of data in persal	Input	Numbers	Bi-annual	No	Reduction of vacancies	HR Planning
Number of cleaners appointed	Staffing of cleaners in the institutions	Provision of cleaners in the institutions	Staff-establishment	Number per staff-establishment	Depending on accuracy of data in persal	Input	Numbers	Bi-annual	No	Reduction of vacancies	HR Planning
Number of grounds men appointed	Staffing of grounds men in the institution	Provision of grounds men in the institutions	Staff-establishment	Number per staff establishment	Depend on the accuracy of data in persal	Input	Numbers	Bi-annual	No	Reduction of vacancies	HR Planing
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
Percentage Compliance to payment of suppliers within 30 days	Invoice paid within 30days	Settlement of invoices within 30days	BAS	<u>Numerator</u> No of valid invoices paid within 30days <u>Denominator</u>	Depends on the funds availability and BAS system	Output	Percentage	Quarterly	No	100%	Expenditure Management

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 valid invoices received by 100%							
Number institution with Credible Asset Register	Number of institutions with credible asset registers	Proper recording assets	Excel asset register BAS	Numerator Number of institutions with credible asset register Denominator Total number of institutions by 100%	Depended on the accuracy of data by institutions	Output	Number	Quarterly	No	Account for all government assets	Supply Chain Management
Revenue collected	Amount of revenue collected for the year	Supplement resources to implement government programmes	BAS	Amount collected against the set target	Rely on payment by patients	Output	Amount	Quarterly	No	Improved funding for delivering of services to the community	Financial budgeting and revenue
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
Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	Fixed clinics, CHCs and CDCs where Ideal clinic status determinations are conducted by PPTICRM as a proportion Fixed clinics plus fixed CHCs/CDCs	Monitors whether PHC health establishments are measuring their level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	Ideal Clinic review tools	**Numerator:** SUM([Ideal clinic status determinations conducted by PPTICRM]) **Denominator**: SUM([Fixed PHC clinics/fixed CHCs/CDCs])	The indicator measures self or peer assessment, and performance is reliant on accuracy of interpretation of ideal clinic data elements	Input	Percentage	Bi-annual	Yes	Higher percentage indicates greater level of ideal clinic principles	District Health Services and Quality Assurance Directorates
OHH registration	Outreach households	Monitors implementatio	DHIS, household	**Numerator:** SUM([OHH	Dependant on accuracy of	Output	Percentage	Quarterly	No	Higher levels of uptake may	CBS / Outreach

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
visit coverage	registered by Ward Based Outreach Teams as a proportion of OHH in population	n of the PHC re-engineering strategy	registration visits registers, patient records	registration visit]) **Denominator:** Household mid-year estimate	OHH in population					indicate an increased burden of disease, or greater reliance on public health system.	Services programme manager
PHC utilisation rate - total	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	Daily Reception Headcount register (or HPRS where available) and DHIS Denominator: Stats SA	**Numerator:** SUM ([PHC headcount under 5 years] + [PHC headcount 5-9 years] + [PHC headcount 10-19 years] + [PHC headcount 20 years and older]) **Denominator:** Sum([Population - Total)]	Dependant on the accuracy of estimated total population from StatsSA	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate underutilization of facility	DHS Manager
Complaints Resolution Rate	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	DHIS, complaints register,	**Numerator:** SUM([Complaint resolved]) **Denominator:** SUM([Complaint received])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Output	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC facilities	Quality Assurance
Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	DHIS, complaints register,	**Numerator:** SUM([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Output	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
Number of PHC facilities open for 24 hours	Number of PHC facilities open for 24 hours	Access PHC services	List of PHC facilities	Numerical	Manipulation of data	Output	Number	Quarterly	No	All PHC facilities to provide 24 hours service	Integrated Primary Health Care
Number of PHC facilities implementing the on call service system	Number of PHC facilities implementing the on call service system	Access PHC services	List of PHC facilities	Numerical	Manipulation of data	Output	Number	Quarterly	No	All PHC facilities to provide 24 hours on call system	Integrated Primary Health Care
Number of mobile clinics procured	Number of mobile clinics procured	Monitor number of mobile clinics available	Procurement documents	Numerical	None	Input	Number	Annual	No	Increased pool of mobile clinics to improve access to PHC services	Integrated Primary Health Care

SUB – PROGRAMME: DISTRICT HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Hospital achieved 75% and more on National Core Standards (NCS) self assessment rate (District Hospitals)	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of	DHIS - NCS Reports	Numerator: SUM([Hospital achieved 75% and more on National Core Standards self assessment]) Denominator: SUM([Hospitals conducted National Core Standards self assessment])	Reliability of data provided	Output	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		Health Standards Compliance									
Average Length of Stay (District Hospitals)	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, midnight census register	**Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator:** SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
Inpatient Bed Utilisation Rate (District Hospitals)	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Track the over/under utilisation of district hospital beds	DHIS, midnight census	**Numerator:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) **Denominator:** Inpatient bed days (Inpatient	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	Hospital Services Manager

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

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

HIV & AIDS, STI & TB (HAST) CONTROL

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
ART client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month - Any client without an outcome reported in the reporting month Clients remaining on	Monitors the total clients remaining on life-long ART at the month	ART Register; TIER.Net; DHIS	**Numerator:** SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period])	None	Output	Cumulative total	Quarterly	no	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager

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

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

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
TB MDR treatment success rate	TB MDR client successfully completing treatment as a proportion of TB MDR confirmed clients started on treatment	Monitors success of MDR TB treatment	TB Register; EDR Web	Numerator: SUM([TB MDR client successfully complete treatment]) Denominator: SUM([TB MDR confirmed client start 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

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Monitors early utilisation of antenatal services	PHC Comprehensive Tick Register	**Numerator:** SUM([Antenatal 1st visit before 20 weeks]) **Denominator:** SUM([Antenatal 1st visit 20 weeks or later]) + SUM([Antenatal 1st visit before 20 weeks])	Accuracy dependent on quality of data submitted health facilities	Activity	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used	PHC Comprehensive Tick Register	Numerator: SUM([Mother postnatal visit within 6 days after delivery]) Denominator: SUM([Delivery in facility total])	Accuracy dependent on quality of data submitted health facilities	Activity	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		postnatal visits within 6 days after delivery									
Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	Monitors implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients.	ART Register, Tier.Net	**Numerator:** SUM([Antenatal client start on ART]) **Denominator:** Sum([Antenatal client known HIV positive but NOT on ART at 1st visit]) + SUM([Antenatal client HIV 1st test positive]) + SUM([Antenatal client HIV re-test positive])	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment	MNCWH programme manager
Infant 1st PCR test positive around 10 weeks rate	Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 10 weeks	Monitors PCR positivity rate in HIV exposed infants around 10 weeks	PHC Comprehensive Tick Register	Numerator: SUM([Infant PCR test positive around 10 weeks]) Denominator: SUM([Infant PCR test around 10 weeks])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Lower percentage indicatefewer HIV transmissions from mother to child	PMTCT Programme
Immunisation under 1 year coverage	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year.	Track the coverage of immunization services	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA	Numerator: SUM([Immunised fully under 1 year new]) Denominator: SUM([Female under 1 year]) + SUM([Male under 1 year])	Road to Health charts are not retained by Health facility. Reliant on under 1 population estimates from StatsSA, and accurate recording of children under 1 year who are fully	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
					immunised at facilities (counted only ONCE when last vaccine is administered.)						
Measles 2nd dose coverage	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population..	Monitors protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	PHC Comprehensive Tick Register Denominator: StatsSA	Numerator: SUM([Measles 2nd dose]) Denominator: SUM([Female 1 year]) + SUM([Male 1 year])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher coverage rate indicate greater protection against measles	EPI
DTaP-IPV-Hib-HBV 3 - - Measles 1st dose drop-out rate	Children who dropped out of the immunisation schedule between DTaP-IPV-Hib-HBV 3rd dose, normally at 14 weeks and measles 1st dose, normally at 6 months as a proportion of	Monitors protection of children against diphtheria, tetanus, a-cellular pertussis, polio, Haemophilus influenza and Hepatitis B. DTaP-IPV-Hib-HBV	PHC Comprehensive Tick Register	Numerator: (SUM([DTaP-IPV/Hib (Pentavalent) 3rd dose]) + SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose])) - SUM([Measles 1st dose under 1 year]) Denominator: SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose]) + SUM([DTaP-IPV/Hib (Pentavalent) 3rd dose])	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Lower dropout rate indicates better vaccine coverage	EPI

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	population under 1 year	(known as Hexavalent) was implemented in 2015 to replace DTaP-IPV/Hib (Pentaxim) and HepB.									
Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Infants exclusively breastfed at 14 weeks as a proportion of the DTaP-IPV-Hib-HBV 3rd dose vaccination. Take note that DTaP-IPV-Hib-HBV 3rd dose (Hexavalent) was implemented in 2015 to include the HepB dose	Monitors infant feeding practices at 14 weeks to identify where community interventions need to be strengthened	PHC Comprehensive Tick Register	Numerator: SUM([Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose]) Denominator: SUM([HepB 3rd dose under 1 year]) + SUM([DTaP-IPV-Hib-HBV (Hexavalent) 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
Diarrhoea case fatality under 5 years rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with diarrhoea	Ward register	Numerator: SUM([Diarrhoea death under 5 years]) Denominator: SUM([Diarrhoea separation under 5 years])	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10).										
Cervical Cancer Screening coverage for women 30 years and older	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	Facility register Denominator: StatsSA	Numerator: SUM([Cervical cancer screening 30 years and older]) Denominator: (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])/10	Reliant on population estimates from StatsSA, and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager
HPV 1st dose	Girls 9 years and older that received HPV 1st dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 1st dose]) + SUM([Agg_Girl 10 yrs HPV 1st dose]) + SUM([Agg_Girl 11 yrs HPV 1st dose]) + SUM([Agg_Girl 12 yrs HPV 1st dose]) + SUM([Agg_Girl 13 yrs HPV 1st dose]) + SUM([Agg_Girl 14 yrs HPV 1st dose]) + SUM([Agg_Girl 15 yrs and older HPV 1st dose])	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager
HPV 2nd dose	Girls 9yrs and older HPV 2nd dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 2nd dose]) + SUM([Agg_Girl 10 yrs HPV 2nd dose]) + SUM([Agg_Girl 11 yrs HPV 2nd dose]) + SUM([Agg_Girl 12 yrs HPV 2nd dose]) + SUM([Agg_Girl 13 yrs HPV	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

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

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	(around 30% of all maternal mortality). Provides indication of health system results in terms of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services									
Neonatal death in facility rate	Neonatal 0-28 days who died during their stay in the facility as a proportion of live births in facility	Monitors treatment outcome for admitted children under 28 days	Delivery register, Midnight report	**Numerator:** SUM([Inpatient death 0-7 days]) + SUM([Inpatient death 8-28 days]) **Denominator:** SUM([Live birth in facility])	Quality of reporting	Impact	Percentage	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

DISEASE PREVENTION AND CONTROL (DPC)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Cataract Surgery Rate	Clients who had cataract surgery per 1 million uninsured population	Accessibility of theatres. Availability of human resources and consumables	Numerator: Theatre Register Denominator: DHIS based on StatsSA proportions	**Numerator:** SUM([Cataract surgery total]) **Denominator:** SUM([Total population]) - SUM([Total	Accuracy dependant on quality of data from health facilities	Output	Rate	Quarterly	No	Higher number of cataract surgery rate indicated greater proportion of the population received	NCD Programme Manager

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
				population (MedicAid)])						cataract surgery	
Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported	Monitor the number deaths caused by Malaria	Malaria Information System	**Numerator:** Deaths from malaria **Denominator:** Total number of Malaria cases reported	Accuracy dependant on quality of data from health facilities	Outcome	Rate	Quarterly	No	Lower percentage indicates a decreasing burden of malaria	Communicable Diseases

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
EMS P1 urban response under 15 minutes rate	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time that the first dispatched medical resource arrives on scene	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	**Numerator:** SUM([EMS P1 urban response under 15 minutes]) **Denominator:** SUM([EMS P1 urban calls])	Accuracy dependant on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban areas	EMS Manager

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 rural response under 40 minutes rate	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of EMS P1 rural call	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 40 minutes in rural areas	DHIS, institutional EMS registers Patient and vehicle report.	**Numerator:** SUM([EMS P1 rural response under 40 minutes]) **Denominator:** SUM([EMS P1 rural calls])	Accuracy dependant on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses	DHIS, institutional EMS registers Patient and vehicle report.	**Numerator** SUM([EMS emergency urban inter-facility transfer under 30 minutes])+SUM([EMS emergency rural inter-facility transfer under 60 minutes]) **Denominator** SUM([EMS clients total])	Accuracy dependant on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals.	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists at the appropriate level of care.	EMS Manager
Ratio of ambulance per population	Ratio of ambulances per population 1:18 000	Monitor number of ambulances per population ratio	EMS Information Systems	Numerator Total number of ambulances rostered Denominator Total Provincial Population	Accuracy dependant on quality of data from reporting EMS station	Output	Number	Quarterly	No	Higher number of ambulances per population improves response times	Director: Emergency Medical Services (EMS)
Number of ambulances procured	Number of ambulances procured	Monitor number of ambulances available per population ratio	Procurement documents	Numerical	None	Input	Number	Bi-annual	No	Increased pool of operational ambulances will improve response times	Director: 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
											Director Transport

PROGRAMME 4 and 5: REGIONAL / TERTIARY / CENTRAL HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Hospital achieved 75% and more on National Core Standards self - assessment rate (Regional Hospitals)	Hospitals that achieved a performance of 75% or more on National Core Standards self assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	**Numerator:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year **Denominator:** Total number of public Hospitals	Reliability of data provided	Output	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
Average Length of Stay (Regional / Tertiary / Central Hospitals)	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out.	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting	DHIS, midnight census	<u>Numerator</u> Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) <u>Denominator</u> SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatie	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
	Include all specialities	month. Use in all hospitals and CHCs with Inpatient beds		nt transfers out-total])							
Inpatient Bed Utilisation Rate (Regional / Tertiary / Central Hospitals)	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Monitors effectiveness and efficiency of inpatient management	DHIS, midnight census	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
Expenditure per patient day equivalent (PDE) (Regional / Tertiary / Central Hospitals)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Monitors effective and efficient management of inpatient facilities. Note that multiplied by 0.5 is the same as division by 2, and multiplied by 0.33333333 is the same as division by 3	BAS, Stats SA, Council for Medical Scheme data, DHIS, midnight census	**Numerator** SUM([Expenditure - total]) **Denominator** Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD headcount follow-up x 0.3333333])+([Emergency headcount -	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				total x 0.3333333])							
Complaint Resolution Rate (Regional / Tertiary / Central Hospitals)	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	complaints register,	Numerator SUM([Complaint resolved]) Denominator SUM([Complaint received])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Output	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
Complaint resolution within 25 working days rate (Regional / Tertiary / Central Hospitals)	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	Complaints register	**Numerator** SUM([Complaint resolved within 25 working days]) **Denominator** SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Output	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
Number of Districts with functional Mental Health review boards	Number of mental health review boards per five district established in terms of Section 18 of Mental health care Act. No 17 of 2002	Ensure the protection of human rights of people with mental disability	Programme for review meetings, attendance register	Sum of districts with mental functional mental health review boards	Reliability of data provided	Input	No	Quarterly	No	Desire to have five functional metal health review boards	District Executive Managers

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

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

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 to first year nursing students	Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	SANC Registration form	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager
Number of Post basic professional nurses enrolled	Number of professional nurses enrolled on post-basic nursing programmes	Professional nurses enrolled for development of all levels of care	College records	No of post basic nurses trained	Dependent on study leave and availability of posts	Output	Sum total	Bi-annual	No	Desired pass rate on all programmes	Director: Nursing Education
Number of direct basic student nurses enrolled	Number of nurses entering the first year of nursing college	Tracks the training of nurses	College/campus records and satellites campus (Nursing school records)	Number of professionals trained	Authenticity of the Matric certificate	Output	Sum total	Annual	Yes	Desired pass rate on all programmes	Director: Nursing Education
Number of direct basic student nurses graduated	Number of students who graduate from the basic nursing course	Tracks the production of nurses	College records	Number of student nurses graduated	-	Output	Sum total	Annual	Yes	Desired pass rate on all programme	Director: Nursing Education
Number of Emergency Care Assistants	Number of students enrolled in Emergency Care Assistant	Tracks the training of Emergency Care Practitioners	College records	Number of students enrolled	Authenticity	Output	Sum total	Bi-Annual	Yes	Desired pass rate on the programme	Principal EMS College

Programme 7: Health Care Support Services

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 availability of essential medicines in Depot, Hospital and Clinics	This is the percentage of essential medicines and surgical sundries monitored at the depot, hospitals and clinics	To ensure that essential medicines and surgical sundries are available at the depot, hospitals and clinics	Quarterly reports	**Numerator:** Totals number of medicines available at depot, Hospitals and clinics. **Denominator:** Total number of medicines to be monitored. Total for Depot= 328 Hospitals= 295 Clinics= 170	Data quality from hospitals and clinics depend on good record keeping by hospital Pharmacies.	Outcome	Percentage	Quarterly	No	High percentage indicates the availability of ordered medicines and surgical sundries from the suppliers	Director: Pharmaceutical Services
Number of districts providing community based rehabilitation services	Districts with Community based Rehabilitation workers providing rehabilitation services	Monitors provision of rehabilitation services in the districts	District health report	Sum of Districts providing community rehabilitation services	Accuracy depend on quality of data submitted by districts	Output	Number	Quarterly	No	Higher number indicate that more districts are covered in provision of community based rehabilitation services	Chief Director: Health Care Support Services
Number of health facilities providing rehabilitation services (hospitals and PHC)	Number of health facilities providing rehabilitation services in hospitals and PHC	Monitors the extent of coverage in provision of rehabilitation services in hospitals and PHC	District health report	Sum of hospitals and PHC rendering community rehabilitation services	Accuracy is dependent on quality of data submitted health facilities	Output	Number	Quarterly	No	Higher number indicates that more hospitals and PHC are providing rehabilitation services	Chief Director: Health Care Support Services

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	Number of existing health facilities in NHI Pilot District	Tracks overall improvement and maintenance	Practical Completion Certificate or equivalent,	Number of health facilities in NHI Pilot District that have undergone	Accuracy dependent on reliability of information	Input	Number	Annual	No	A higher number will indicate that more facilities	Chief Director: Infrastructure and

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
refurbishment 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).	of existing facilities.	Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	major and minor refurbishment	captured on project lists.					were refurbished.	Technical Management
Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District	Number of existing health facilities outside NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities outside NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
Number of districts spending more than 90% of maintenance budget	Number of districts spending more than 90% of maintenance budget	To monitor that infrastructure budgets are being used to improve health infrastructure	DoH	No denominator	None	Output	Sum total	Quarterly	No	Districts should spend their allocated budget to improve health care infrastructure	Infrastructure Programme Manager
Number of projects completed	Number of projects completed	Improving health outcomes. High	IRM	Completed	None	Output	No	Quarterly	No	Performance as per IA's programme	FPWI

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