



LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

HEALTH – VOTE 7 ANNUAL PERFORMANCE PLAN 2023/24 - 2025/26

FINAL

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Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CCMDD	Centralised Chronic Medicines Dispensing and Distribution
COVID-19	Corona Virus Disease 2019
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
ICT	Information communication technology
LDoH	Limpopo Department of Health
MCWH&N	Mother, Child, Women, Health & Nutrition
MEC	Member of the Executive Council
MMC	Male Medical Circumcision
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NCD	Non-communicable Diseases
OPD	Out-Patient Department
OTP	Office of The Premier
PHC	Primary Health Care
TB	Tuberculosis

Executive Authority Statement

Over the past three years, our country and the world were gripped by a deadly and yet unpredictable virus that has disrupted our established tradition of doing things. The work of the department was severely affected.

Accordingly, this should allow us to render normal services, in pursuit of the creation of a better healthcare system for the benefit of the people of Limpopo. We are confident that this will allow us the necessary impetus to accelerate service delivery and improve the quality of care in all our facilities.

Central to our task for the coming financial year will be to reenergize and reengineer our primary healthcare, improve on the most fundamental task of restoring basic patient treatment in our clinics and hospitals, and ensure our PHCs and clinics are effectively and efficiently responsive to the needs of every patient.

It is worth noting that we have performed relatively well in the fight against the pandemic, preserving the lives of our people and taking care of their health needs in the mist of the deadly pandemic.

We have also done admirably well with regard to availability of medicines in our facilities and the response time of our emergency services.

This Annual Performance Plan reflects of our commitment to serve the people of Limpopo to the best of our collective abilities, effectively and efficiently.

We are deliberate in our efforts and commitment to the mission of bringing a long and healthy life for the people in Limpopo.

With the COVID-19 pandemic almost behind us, the Department will be moving with the necessary speed to restore 24-hour services at our various clinics and introduce new ones to the 24-hour operations mechanism. This work will go in tandem with the recruitment of nurses and other essential staff to complement the work done in our various facilities.

We will strengthen our Emergency Medical Services by procuring more than the normal number of vehicles we ordinarily procure. We will develop strategies to prolong the lifespan of these vehicles to ensure uninterrupted service to all our communities.

This document represents our service delivery model for the coming financial year and the contents of this Annual Performance Plan will serve as a barometer to gauge and assess the level of our performance.

The strategic objectives outlined in this Annual Performance Plan should help us to significantly improve the quality of care in our facilities and improve the living conditions of our people.

Together, moving Limpopo forward!

A handwritten signature in black ink, appearing to read 'P. Ramathuba', is written over a horizontal dotted line.

Dr. Ramathuba P. C.

Limpopo MEC of Health

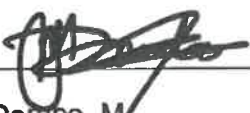
Accounting Officer Statement

In looking forward towards a better 2023/2024 f/y, it becomes imperative to reflect backward. The past years from 2020/2022 financial years have seen the World and South Africa in particular fight the impact of the COVID-19 through minimising infections and vaccination roll-out. The health sector having been at the forefront of efforts to quell the stem of the COVID-19 pandemic. This negatively affected the Limpopo provincial health department to the extent that it was unable to achieve set targets among different performance indicators and in some saw a regression during this period. This was largely, due to all efforts being directed to minimising the impact of the pandemic in the province. The 2022/2023 financial year leveraged for a recovery and resetting of the health system to return to the full provision of health care services going forward post the lifting of the national state of disaster on 05 April 2022.

This APP in alignment to the SDGs, NDP, and LDP outlines the immediate output performance targets against the outcomes as expressed in the five-year Strategic Plan. Hence, the provision of a patient-centred health care service remains our priority in realising our vision of *'A long and healthy life for people in Limpopo'*. Pending the approval of the Geographical Service Area (GSA) model post consultations, we will in the 2023/2024 f/y implement the model in improving the quality of care and access to health care services in consultation with health governance structures. The GSA model with all its components is a pivotal platform for health service delivery in promoting attainment of improved health outcomes including reduction of morbidity and mortality related to maternal, neonatal and childhood conditions, communicable and non-communicable diseases, and improved quality of care. Further, the GSA is an integral part of the district health care approach in the implementation of the National Health Insurance (NHI).

Improving the audit outcomes remains our priority towards being effective and efficient in the provision of health services. Therefore, an audit action plan is a key instrument in monitoring the implementation and progress of the determined actions whilst addressing the key audit findings. Like the fight we fought against COVID-19 through our collective resilience and competent workforce, we will ensure that all hands are on deck in implementing the audit action plan towards improving the audit outcomes.

Output performance targets set in this APP and over the MTEF period will be monitored on quarterly basis through the implementation of the operational plans at all levels. In consideration of the limited health resources, the plan has outlined the key interventions that will be effectively implemented to attain the set targets.



Dr Dombos, M.

Acting Head of Department

Official Sign-off

It is hereby certified that this Annual Performance Plan:

- Was developed by the management of the Limpopo Province Department of Health under the guidance of Dr Ramathuba P.C.
- Takes into account all the relevant policies, legislation and other mandates for which the Limpopo Province Department of Health is responsible for.
- Accurately reflects the Outcomes and Outputs which the Limpopo Province Department of Health will endeavour to achieve over the period 2023/24.

Mr Mudau M.J

Signature: 

Manager Programme 1: Administration

Dr Lekoloana M.A

Signature: 

Manager Programme 2: District Health Services

Dr Ndwamato N.N

Signature: 

Manager Programme 3: Emergency Medical Services

Dr Ndwamato N.N

Signature: 

Manager Programme 4: General (Regional) Hospitals

Dr Ndwamato N.N

Signature: 

Manager Programme 5: Tertiary and Central Hospitals

Dr Ndwamato N.N

Signature: 

Manager Programme 6: Health Science and Training

Dr Ndwamato N.N

Signature: 

Manager Programme 7: Health Care Support

Mr Ramawa P.J

Signature: 

Manager Programme 8: Health Facilities Management

Mr Mudau M.J

Chief Financial Officer

Signature: _____



Mr Molokwane M.J

Head Official responsible for Planning

Signature: _____



Dr Dombo M

Acting Accounting Officer

Signature: _____



Approved by:

Dr Ramathuba P.C

Executive Authority

Signature: _____



Part A: Our Mandate

1. Constitutional Mandate

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

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

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

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

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

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

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

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

2. Legislative and Policy Mandates

2.1 Legislation falling under the Department of Health's Portfolio

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

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

- unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2 Other legislation applicable to the Department

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

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

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

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

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

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

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

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

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

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

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

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000)

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

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

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

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

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

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

3.1 National Health Insurance Bill

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

In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator and a proxy outcome of any country's progress towards Universal Health Coverage. The phased implementation of NHI is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable and quality health services.

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

3.2 National Development Plan: Vision 2030

The National Development Plan (Chapter 10) has outlined 9 goals for the health system that it must reach by 2030 (see Figure 1).

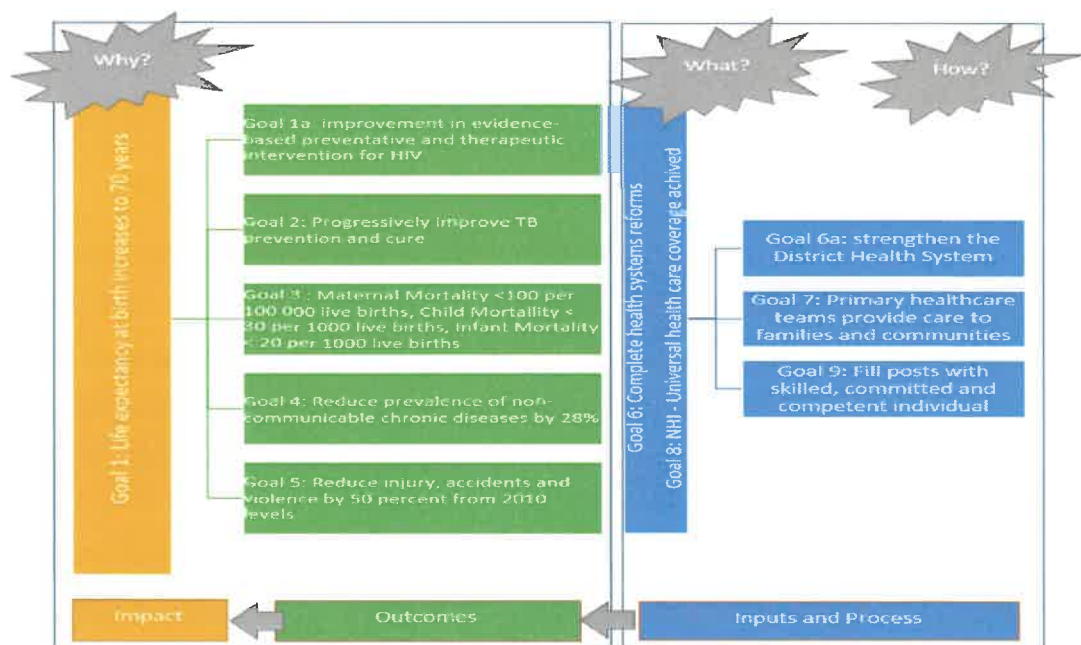


Figure 1. NDP Goals

The **NDP goals** are best described using conventional public health logic framework. The **overarching goal** that measures impact is "Average male and female life expectancy at birth increases to at least 70 years". The **next 4 goals measure health outcomes**, requiring

the health system to **reduce premature mortality and morbidity**. Last 4 goals are tracking the health system that essentially measure inputs and processes to derive outcomes

3.3 Sustainable Development Goals

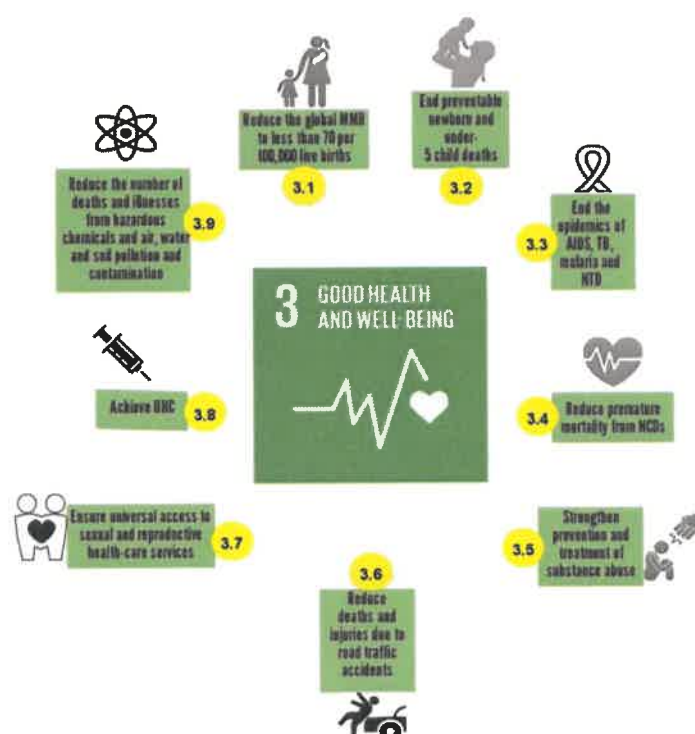


Figure 2. Sustainable Development Goals

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

- (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 new-borns and children under 5 years of age**, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- (3) 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
- (5) Strengthen the **prevention and treatment of substance abuse**, including narcotic drug abuse and harmful use of alcohol

- (6) By 2020, **halve the number of global deaths and injuries from road traffic accidents**
- (7) By 2030, **ensure universal access to sexual and reproductive health-care services**, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- (8) Achieve **universal health coverage, including financial risk protection**, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- (9) By 2030, **substantially reduce the number of deaths and illnesses from hazardous chemicals** and air, water and soil pollution and contamination
- (10) Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- (11) **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
- (12) Substantially **increase health financing and the recruitment, development, training and retention of the health workforce** in developing countries, especially in least developed countries and small island developing States
- (13) Strengthen the capacity of all countries, in particular developing countries, for **early warning, risk reduction and management of national and global health risks**

3.4 Medium Term Strategic Framework and NDP Implementation Plan 2019-2024

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

Over the next 5 years, the Provincial Department of Health's response is structured into 4 goals and 10 sector strategies (as per Table 1 below). These goals and strategic objectives are well aligned to the Pillars of the Presidential Health Summit compact, as outlined in the table below.

Table 1. Health Sector Goals

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
Survive and Thrive	Life expectancy of South Africans improved to 70 years by 2030	Goal 1: Increase Life Expectancy improve Health and Prevent Disease	1. Improve health outcomes by responding to the quadruple burden of disease of South Africa 2. Inter sectoral collaboration to address social determinants of health	N/A
Transform	Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030	Goal 2: Achieve UHC by Implement NHI	3. Progressively achieve Universal Health Coverage through NHI	Pillar 4: Engage the private sector in improving the access, coverage and quality of health services; and Pillar 6: Improve the efficiency of public sector financial management systems and processes
		Goal 3: Quality Improvement in the Provision of care	4. Improve quality and safety of care	Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care.
			5. Provide leadership and enhance governance in the health sector for improved quality of care	Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels
			6. Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health	Pillar 8: Engage and empower the community to ensure adequate and appropriate community based care
			7. Improve equity, training and enhance management of Human Resources for Health	Pillar 1: Augment Human Resources for Health Operational Plan
			8. Improving availability to medical products, and equipment	Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery Pillar 6: Improve the efficiency of public sector financial management systems and processes
			9. Robust and effective health information systems to automate	Pillar 9: Develop an Information System that will guide the health

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
			<i>business processes and improve evidence based decision making</i>	<i>system policies, strategies and investments</i>
		Goal 4: Build Health Infrastructure for effective service delivery	10. <i>Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities</i>	<i>Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities</i>

Part B: Our Strategic Focus

4. Vision

A long and healthy life for people in Limpopo.

5. Mission

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

6. 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

7. Stakeholder analysis

Internal Stakeholders				
Stakeholder	Characteristics	Influence	Interest	Linkages with other stakeholders
Executive management	Key point of accountability on overall departmental performance	High	High	Strong linkages of accountability with both internal and external stakeholders
Programme managers	Highly knowledgeable on subject matter in line with areas of responsibility	High	High	Accountable to the executive management on performance matters
District offices	Key drivers of policy and strategy implementation	Low	High	Closely relates with the beneficiaries or service users

Internal control	Ensure compliance to audit standards	Low	High	A link between department and both internal and external auditors including other oversight bodies (i.e. audit committee and SCOPA)
Trade unions	Politically inclined and represent employees	Low	High	Advocate for employees interests
External Stakeholders				
Stakeholder	Characteristics	Influence	Interest	Linkages with other stakeholders
Oversight bodies (Portfolio committee on health, audit committee, SCOPA, AGSA etc.)	-Politically oriented -Experts in areas of study -Strongly opinionated	High	High	Serves as a linkage between department and the community on health service delivery matters
Treasury	Plays an oversight role for departmental accountability on financial management and performance issues	Low	High	Link with oversight bodies in particular audit committee on departmental financial and performance issues
Beneficiaries (communities)	Strongly advocates for their interests	Low	High	Links with portfolio committee on matters of community interest in the department
National Department of Health	Policy development driven	High	High	Direct link with AGSA
Office of health standards compliance	Interested in ensuring that facilities comply to legislated norms and standards	Low	Low	Link with NDoH and provincial health departments

8. Updated Situational Analysis

8.1 Overview of the Province

Limpopo, South Africa's northernmost province, borders onto Mozambique, Zimbabwe and Botswana. It also borders the Mpumalanga, Gauteng and North West provinces. Named after the Limpopo River, which flows along its northern border, it is a region of contrasts, from true Bushveld country to majestic mountains, primeval indigenous forests, unspoiled wilderness,

and patchworks of farmland. In the eastern region lies the northern half of the magnificent Kruger National Park.

Limpopo ranks fifth in South Africa in both surface area and population, covering an area of 125 754km² and being home to a population estimate of 5 941 439 (refer to Table 2). The capital is Polokwane (previously Pietersburg). Other major cities and towns include Bela-Bela (Warmbad), Lephalale (Ellisras), Makhado (Louis Trichardt), Musina (Messina), Thabazimbi and Tzaneen (see the Limpopo map). Mining is the primary driver of economic activity. Limpopo is rich in mineral deposits, including platinum-group metals, iron ore, chromium, high and middle-grade coking coal, diamonds, antimony, phosphate and copper, as well as mineral reserves such as gold, emeralds, scheelite, magnetite, vermiculite, silicon and mica. The province is a typical developing area, exporting primary products and importing manufactured goods and services.

The climatic conditions in the province allow for double harvesting seasons, which results in it being the largest producer of various crops in the agricultural market. Sunflowers, cotton, maize and peanuts are cultivated in the Bela-Bela–Modimolle area. Bananas, litchis, pineapples, mangoes and pawpaws, as well as a variety of nuts, are grown in the Tzaneen and Makhado areas. Extensive tea and coffee plantations create many employment opportunities in the Tzaneen area. The Bushveld is cattle country, where controlled hunting is often combined with ranching. Shows that medical aid covered was most common in Gauteng (24,9%) and Western Cape (24,1%), and least common in Limpopo (9,9%) and Eastern Cape (10,8%).

Table 2. Demographic data

Demographic Data	Limpopo	Unit of Measure
Geographical area	125,754	Km ²
Total population SA Mid-year estimates 2022	5 941 439	Number
Percentage of population with medical insurance (Stat SA)	8.2	%

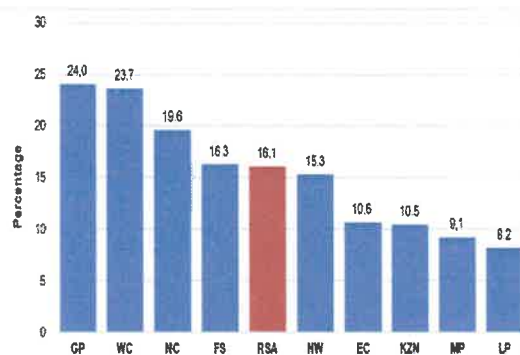
Source: Mid-year population estimates, 2022 & General household survey, 2021



Graph 1: GHS 2019



Graph 2: GHS 2020



Graph 3: GHS 2021

Figure 3. Percentage of individuals who are members of medical schemes per province

Source: General household survey 2019, 2020, & 2021

Medical aid coverage is least common in the Limpopo province than in other provinces (see Figure 3). There are fluctuations among those having medical aid coverage in the period 2019 – 2021. A decline from 9.9% in 2019 to 7.8% in 2020 is also noted. Further, an increase among those with medical aid coverage have been noted in 2021 standing at 8.2% from a 7.8% medical aid coverage in 2020. This can be attributed to the fluctuations in unemployment rate resulting in financial constraints experienced by individuals as well as the effect of Covid-19. Due to the larger share of the population in the province not being on a medical aid coverage; overwhelms the already constrained health system.

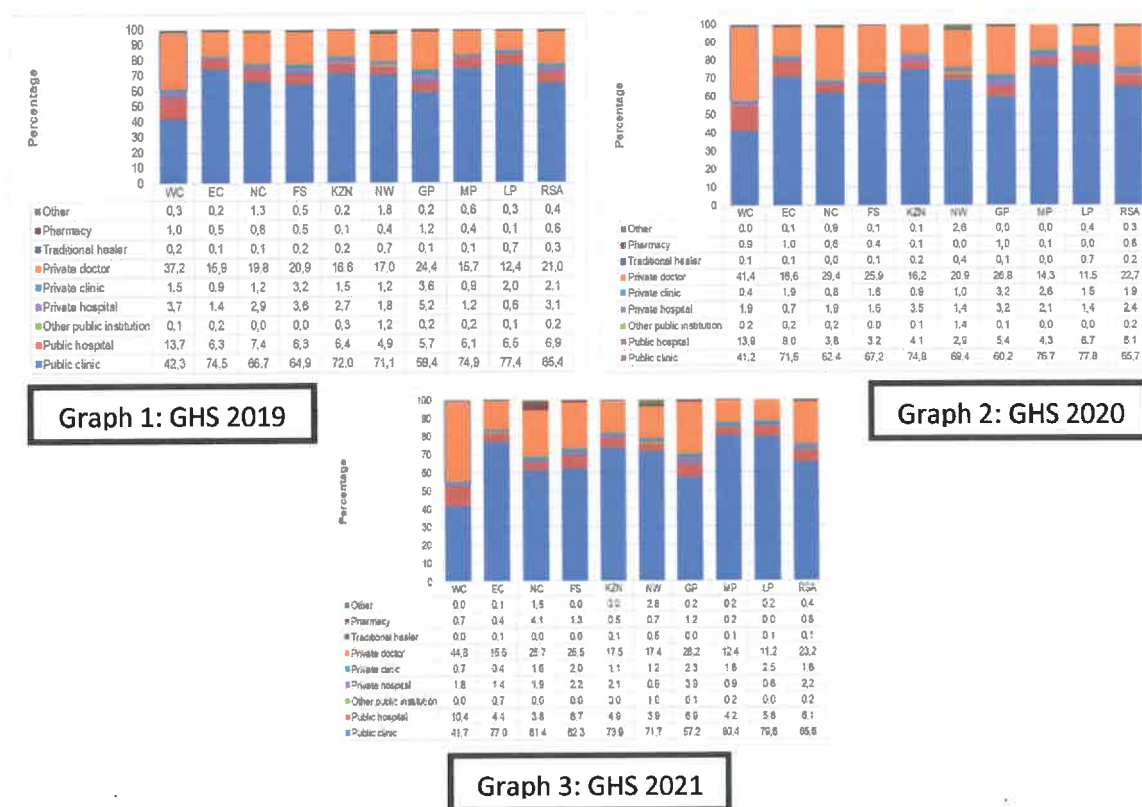


Figure 4: Percentage distribution of the type of health-care facility consulted first by households when members fall ill and get injured by province, 2021

Source: General household survey, 2021

Drawing from Figure (4) above wherein a fraction of the Limpopo province population is on a medical aid coverage, most of the population are dependent on public health services. Hence, the use of public health facilities is most common in Limpopo than in other provinces as depicted in Figure (4). Further noted is an increase on a year-to-year basis of those who use public health facilities from 83.9% in 2019, 84.5% in 2020, to 85.4% in 2021. As a result, public health services are in high demand in meeting the health needs of the increasing population in the province. Services accessibility and provision of good quality of care remain of paramount importance to the department. Health initiatives like rural health matters initiative which aims to reduce the backlog of surgeries in the province is being implemented. This has resulted in more patients accessing health facilities to undergo different surgical procedures towards improving their general wellbeing.

Limpopo is divided into five district municipalities (as shown in Figure 5), which are further subdivided into 22 local municipalities.



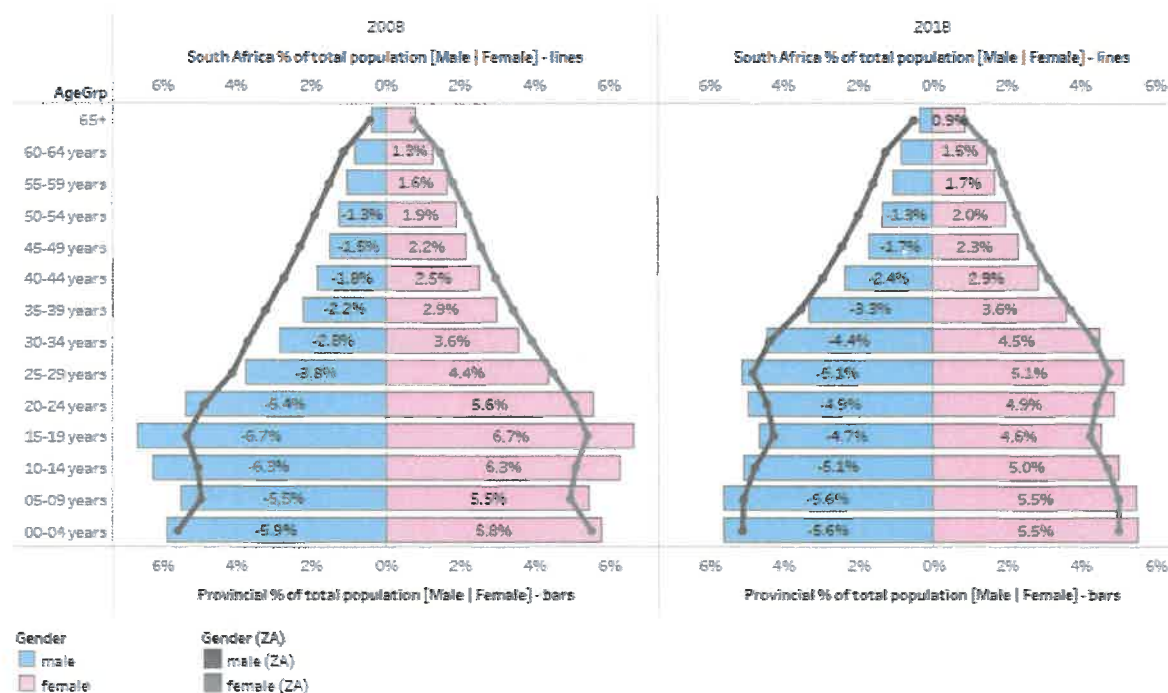
Figure 5. Limpopo geographical map

8.2 External Environmental Analysis

8.2.1 Demography

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

LP



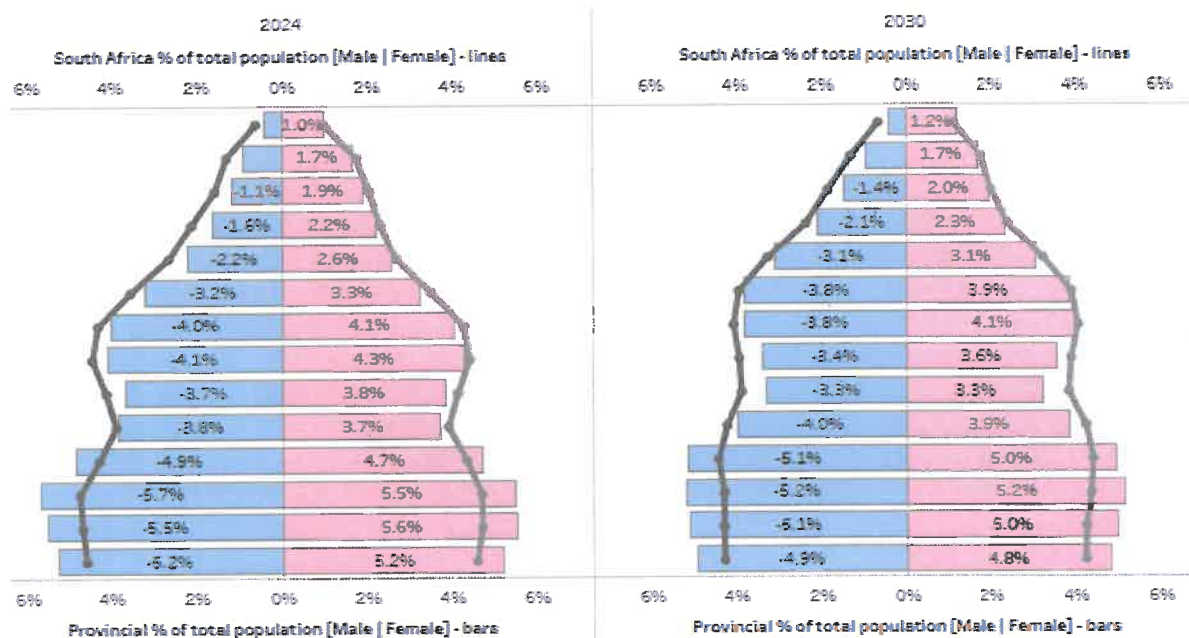


Figure 6. Population Pyramids 2008-2030

Despite a drop in the birth rate, Limpopo maintains a high birth rate than the country through to 2030 (see Figure 6). Comparatively, the age-sex distribution shows that the Limpopo population below 19 years remains higher than the country estimation. This makes Limpopo to be a youthful province.

In the medium to long term (refer to 2024 and 2030 graphics in Figure 6), the provincial age-group between 15 and 35 years as compared to the country, is depicted to be narrowing to below the national estimation. With key focus on ages 15 – 24, there is a significant reduction from current to future trends which might be attributed to death as a result of road injuries and interpersonal violence for males and HIV(AIDS) and TB for females. The age-group 40 – 54 years graphics shows an increase in population growth. In the same period, the graphics depict an expanding ageing population in the 55 years and above.

Implications on health

1. A trend between 20 to 39 years reveals the deaths of more males than females. The cause these deaths is mainly attributed to violence and injuries requiring intensified inter-sectoral collaboration.

The interventions put in place by the department are strengthening of inter-sectoral collaboration as well as health promotion, education, and prevention. These has resulted in an improved life expectancy wherein those who will exit the pyramid earlier turns to remain in the pyramid longer. While improved life expectancy may be as result of strengthened health system, this might come with a burden on the already constrained healthcare system. For an

example, living longer (or ageing population) often results in increased number of people with non-communicable diseases requiring healthcare services.

8.2.2 Social Determinants of Health for Province and Districts

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

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

Table 3. Provincial and district social determinants of health

Factor		GHS 2019 Limpopo	GHS 2020 Limpopo	GHS 2021 Limpopo
Access to food	Food access severely inadequate	2.8	2.1	1.7
	Food access inadequate	2.7	2.3	4.0
	Food access adequate	94.5	95.6	94.3
Methods of cleaning hands after using the toilet	Do not clean hands	9.3	3.6	4.9
	Clean hand with sanitizer or wet wipes	1.1	2.5	1.3
	Wash hands with soap after using the toilet	28.4	40.6	44.5
	Rinse hands with water	61.2	53.3	49.3
	Access to hand washing facility	36.4	39.9	42.0
Factor		GHS 2018 Limpopo	GHS 2020 Limpopo	GHS 2021 Limpopo
Energy	Households connected to the mains supply	92.7	97.2	96.9
Sanitation	Households with access to sanitation	58.9	58.7	58.5
Drinking water	Households with access to piped or tap water in their dwellings	74.1	71.3	69.4

Source: General household survey, 2019, 2020, & 2021

The provision of safe and readily available water is important for public health and poverty reduction. However, it is observed that access to drinking water in the province has been on a decline since 2012 including the years depicted in Table 3. The decline in water access has

negative implications for health. Proper hygiene plays an essential role in the prevention of many diseases as such declining water access impacts on ways people clean their hands in reducing spreading of infections. Use of water to clean hands is the commonest method people clean their hands after using the toilet in the province though the province is the lowest nationally. When access of water is lowering, that increases an opportunity for spreading of infections. According to the General Household Survey, Limpopo households performed poorly in washing hands with soap and water after using the toilet at 44.5% against a national average of 59.1%. Further, there is steady decrease of up to 49.3% in 2021 as compared to 2019 and 2020 where performance was at 61.2% and 53.3% respectively when considering rinsing hands only with water.

Further, proper sanitation is one of the key elements in improving hygiene. However, households in Limpopo have the most limited access to sanitation impacting negatively on the wellbeing of the population. In addition, having adequate and affordable access to energy sources is key to addressing household poverty (Stats SA, 2022). Access to energy supply is most common among households in Limpopo.

Noteworthy, diversified livelihood strategies are important to reducing poverty and improving the livelihoods of households. Households in Limpopo rely on different sources of income to in improving their livelihoods (see Figure 7).

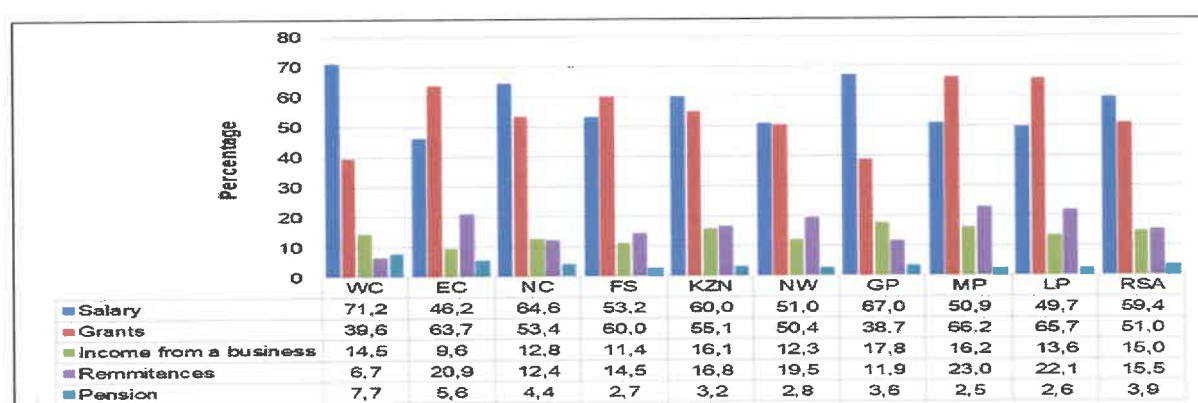


Figure 7. Limpopo annual income distribution

As depicted in Figure 7, grants are the commonest source of income among households in Limpopo. In consideration of the low medical aid coverage due to high dependency on grants, above a 91.8% of the population depend on the overburdened health system for their health needs. In overcoming the social determinants of health, the department participate different inter-governmental programmes (e.g., cluster approach and integrated development plan consultations). Through the cluster approach, the province aims at addressing the social determinants of health. Among others, the department participates in the IDP review meetings

as well as development and implementation of the district development model in all districts to drive health related imperatives in an integrated approach.

8.2.3 Epidemiology and Quadruple Burden of Disease

Epidemiologically South Africa is confronted with a quadruple BOD because of HIV and TB, high maternal and child morbidity and mortality, rising non-communicable diseases and high levels of violence and trauma. Despite the quadruple BOD, realisation of the increased life expectancy is vital towards achieving SDGs.

8.2.3.1 Life expectancy

The departmental strategic plan 2020 – 2025 points to the impact area of achieving a life expectancy of 70 years by 2030 for both males and females in alignment with the NDP and LDP. Interventions such as PMTCT, vaccination, access to ART, and reduction of non-communicable and communicable diseases have seen the life expectancy in the province improving steadily post the 2002 – 2006 impact of the HIV and AIDS epidemic. Figures 8 and 9 show the provincial comparative life expectancy for males and females per province in South Africa.

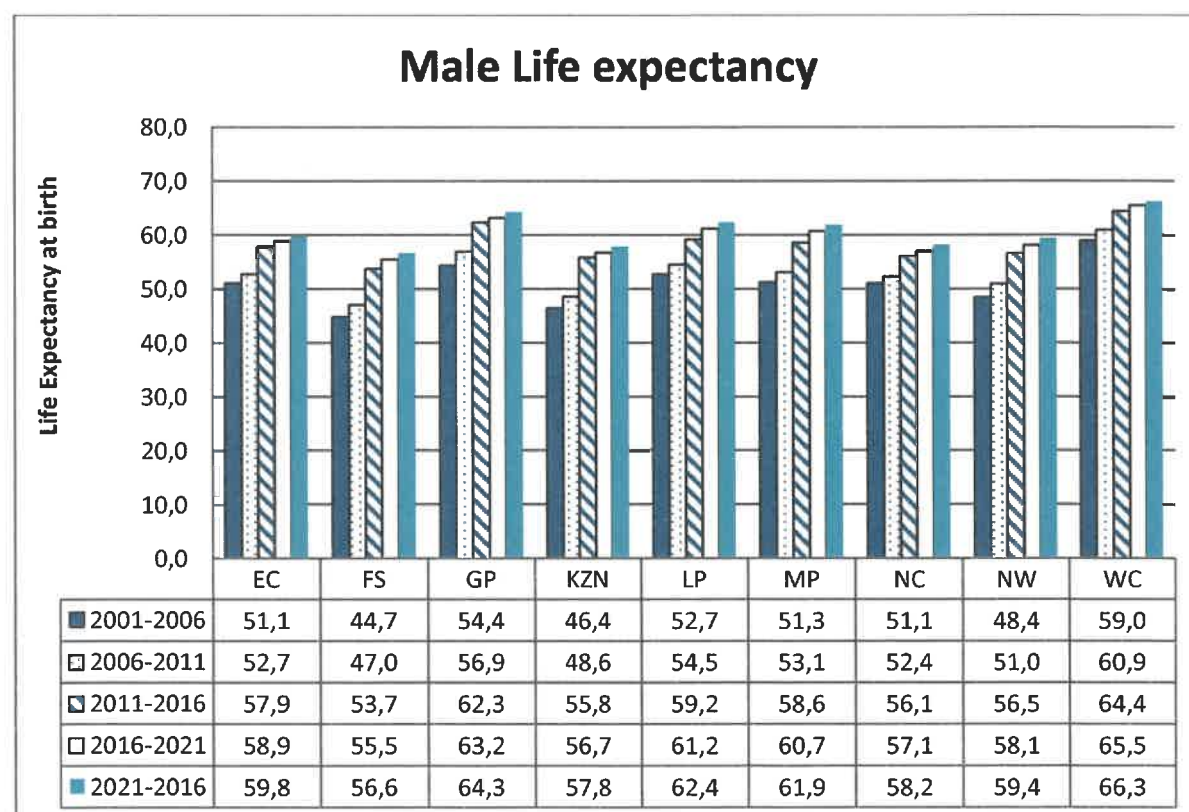


Figure 8: Male life expectancy, 2001 – 2026

Source: Mid-year population estimates, 2022

As showed in Figures 8 and 9 the province is experiencing a steady increase in both male and female life expectancy over the period 2001 to 2026.

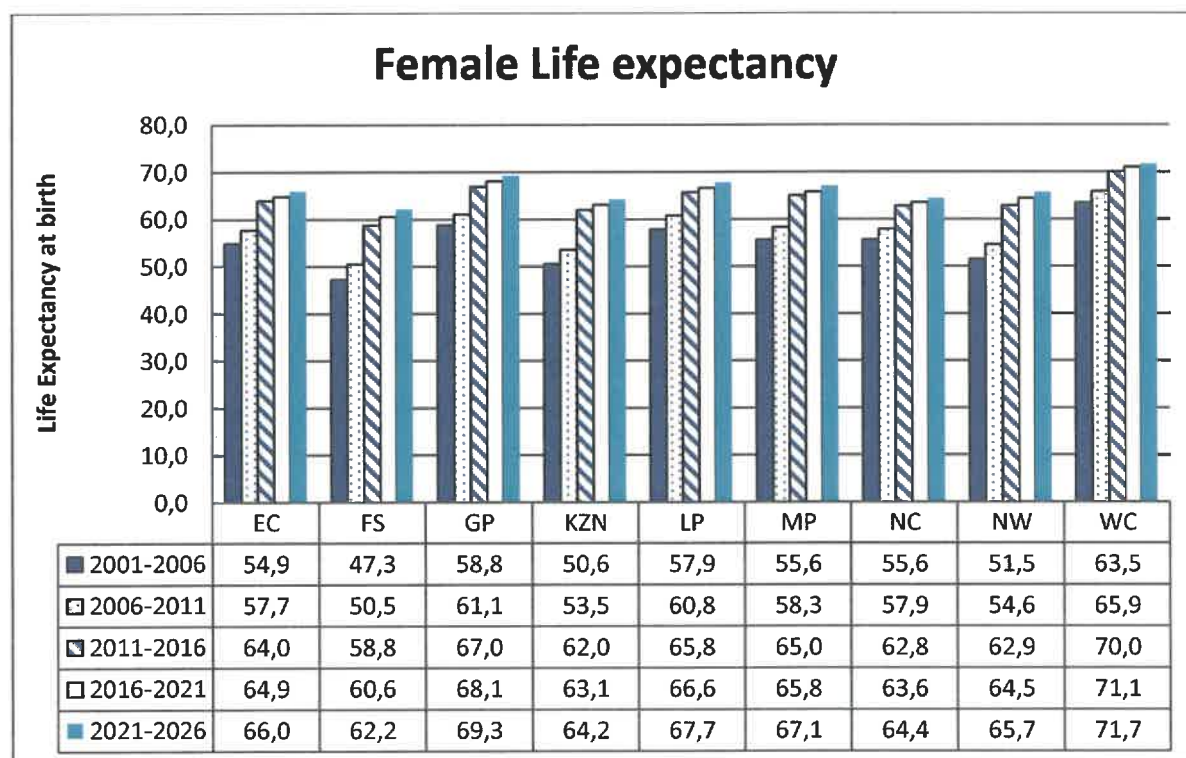


Figure 9: Female life expectancy, 2001 – 2026

Source: Mid-year population estimates, 2022

8.2.3.2 Leading causes of death

Although efforts put in place to reduce prevalence and improve management of diseases are yielding good results in terms of life expectancy, progress towards the achievement of the life expectancy has been slow.

Narrative on provincial ten leading causes of death:

Though influenza and pneumonia present as leading communicable diseases causing deaths in the province, non-communicable diseases remain high in the hierarchy of leading causes of deaths in all age categories (see Table 4). Among the non-communicable diseases claiming most of the people' lives in the province are diabetes mellitus, cerebrovascular diseases, and hypertension. As a result of of interventions targeted at increasing access to testing and treatment of HIV/AIDS, deaths due to human immunodeficiency virus lie sixth in the top ten leading causes of deaths. It is still a concern that deaths from opportunistic diseases (TB, Pneumonia, intestinal infectious diseases) still feature prominently in the top ten leading causes of death. Integration of services will be strengthened to tackle both communicable and non-communicable diseases.

Table 4. Provincial leading causes of death 2018

	LP, all ages	No	%
1	Influenza and pneumonia (J09-J18)	2654	6,8
2	Diabetes mellitus (E10-E14)	2787	6,6
3	Cerebrovascular diseases (I60-I69)	2607	6,2
4	Hypertensive diseases (I10-I15)	2319	5,5
5	Tuberculosis (A15-A19)	2226	5,3
6	Human immunodeficiency virus [HIV] disease (B20-B24)	1962	4,6
7	Other viral diseases (B25-B34)	1447	3,4
8	Other forms of heart disease (I30-I52)	1286	3
9	Intestinal infectious diseases (A00-A09)	1204	2,8
10	Renal failure (N17-N19)	1147	2,7
	Other Natural	18658	44,1
	Non-natural	3773	8,9
	All causes	42270	99,9

Source: Stats SA, 2018 Mortality and causes of death in South Africa: Findings from death notifications

Narrative on districts' ten leading causes of death:

From the districts' perspective (see Table 5), Vhembe, Capricorn and Sekhukhune districts are having the non-communicable diseases as the leading causes of deaths followed by the communicable diseases mainly tuberculosis as well as influenza and pneumonia. However, in Waterberg and Mopani districts communicable diseases mainly tuberculosis as well as influenza and pneumonia are found to be the leading causes of deaths. Despite this view, it cannot be overridden that non-communicable among the districts are ranked high as the leading cause of deaths.

Table 5. Districts ten leading causes of death 2018

Capricorn				Mopani				Greater Sekhukhune			
	No	%		No	%			No	%		
Influenza and pneumonia (J09-J18)	1	827	7,4	Diabetes mellitus (E10-E14)	1	534	7,1	Cerebrovascular diseases (I60-I69)	1	1114	13,8
Human immunodeficiency virus [HIV] disease (B20-B24)	2	668	7,0	Influenza and pneumonia (J09-J18)	2	500	5,8	Influenza and pneumonia (J09-J18)	2	882	10,9
Diabetes mellitus (E10-E14)	3	844	6,8	Renal failure (N17-N19)	3	443	5,0	Hypertensive diseases (I10-I15)	3	621	7,7
Hypertensive diseases (I10-I15)	4	817	8,5	Tuberculosis (A15-A19)	4	418	4,7	Diabetes mellitus (E10-E14)	4	473	5,8
Tuberculosis (A15-A19)	5	688	4,8	Human immunodeficiency virus [HIV] disease (B20-B24)	5	401	4,5	Other viral diseases (B25-B34)	5	436	5,4
Cerebrovascular diseases (I60-I69)	6	537	4,3	Cerebrovascular diseases (I60-I69)	6	390	4,4	Tuberculosis (A15-A19)	6	364	4,5
Intestinal infectious diseases (A00-A09)	7	360	2,9	Other forms of heart disease (I30-I52)	7	373	4,2	Intestinal infectious diseases (A00-A09)	7	261	3,2
Chronic lower respiratory diseases (J40-J47)	8	296	2,4	Hypertensive diseases (I10-I15)	8	327	3,7	Other forms of heart disease (I30-I52)	8	253	3,1
Other viral diseases (B25-B34)	9	280	2,2	Other viral diseases (B25-B34)	9	323	3,6	Human immunodeficiency virus [HIV] disease (B20-B24)	9	189	2,3
Other forms of heart disease (I30-I52)	10	278	2,2	Intestinal infectious diseases (A00-A09)	10	231	2,6	Other bacterial diseases (A30-A49)	10	126	1,5
Other Natural		6496	44,1	Other Natural		4147	46,8	Other Natural		2671	33,0
Non-natural		1202	8,5	Non-natural		718	8,1	Non-natural		388	4,8
All causes		12474	100,0	All causes		9993	100,0	All causes		8099	100,0
Vhembe				Waterberg							
	No	%		No	%						
Diabetes mellitus (E10-E14)	1	454	6,2	Tuberculosis (A15-A19)	1	487	8,8				
Tuberculosis (A15-A19)	2	561	5,0	Hypertensive diseases (I10-I15)	2	398	7,2				
Renal failure (N17-N19)	3	262	3,5	Diabetes mellitus (E10-E14)	3	382	6,9				
Cerebrovascular diseases (I60-I69)	4	251	2,4	Influenza and pneumonia (J09-J18)	4	263	6,6				
Other viral diseases (B25-B34)	5	204	2,5	Human immunodeficiency virus [HIV] disease (B20-B24)	5	322	5,8				
Influenza and pneumonia (J09-J18)	6	182	2,5	Cerebrovascular diseases (I60-I69)	6	315	5,7				
Human immunodeficiency virus [HIV] disease (B20-B24)	7	181	2,5	Intestinal infectious diseases (A00-A09)	7	210	3,8				
Other forms of heart disease (I30-I52)	8	174	2,4	Other forms of heart disease (I30-I52)	8	208	3,8				
Hypertensive diseases (I10-I15)	9	168	2,1	Other viral diseases (B25-B34)	9	204	3,7				
Intestinal infectious diseases (A00-A09)	10	142	2,0	Chronic lower respiratory diseases (J40-J47)	10	138	2,6				
Other Natural		4268	68,8	Other Natural		1988	35,8				
Non-natural		656	8,0	Non-natural		530	9,8				
All causes		7280	100,0	All causes		5523	100,0				

Source: Stats SA, 2018 Mortality and causes of death in South Africa: Findings from death notifications

8.3 Internal Environmental Analysis

8.3.1 Service Delivery Platform/Public Health Facilities

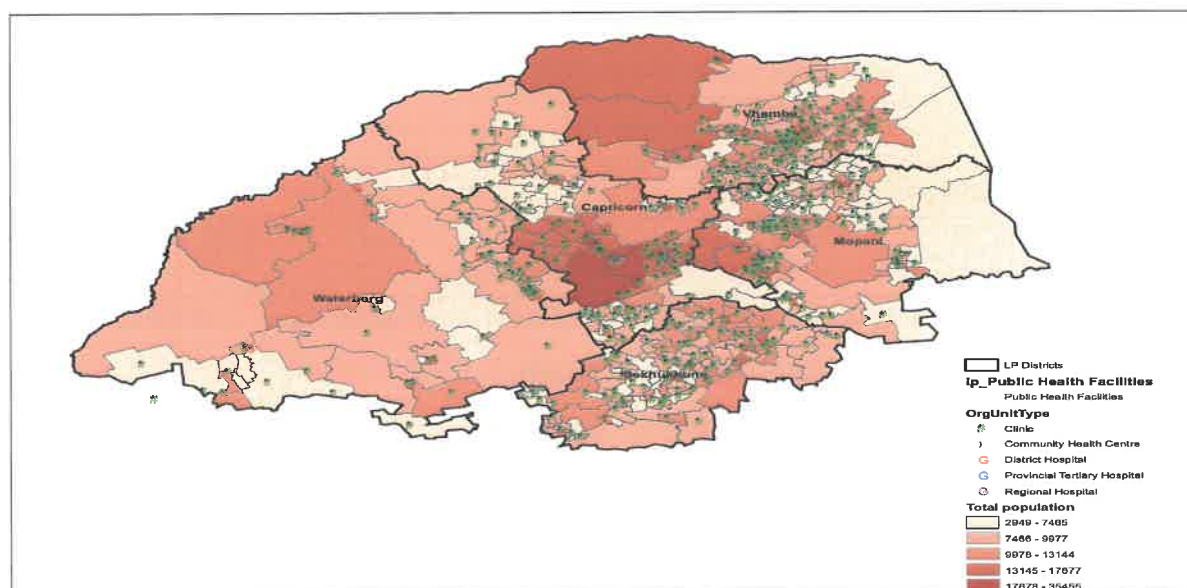


Figure 10: Geographical distributions of Limpopo health facilities

Table 6. District distribution of health facilities

	Capricorn District Municipality	Mopani District Municipality	Sekhukhune District Municipality	Vhembe District Municipality	Waterberg District Municipality	Grand Total
Clinic	97	97	86	115	61	456
Community Health Centre	4	8	3	8	3	26
District Hospital	6	6	5	6	7	30
EMS Station	12	10	13	10	12	57
Provincial Tertiary Hospital	2	0	0	0	0	2
Regional Hospital	0	1	2	1	1	5
Specialised Hospital	1	1	0	1	1	4
Grand Total	123	123	109	141	84	580

Narrative:

Capricorn district is the only district in the province that hosts two tertiary hospitals and has no regional hospital (see Figure 10 and Table 6). District hospitals within Capricorn district refer directly to the tertiary hospitals. The two tertiary hospitals further receive referrals from hospitals in the four other districts. Concomitantly, that leaves the tertiary hospitals overburdened which is clear in Capricorn being the highest in maternal mortality nationally.

Central to the overburdening of tertiary hospitals is the regional and district hospitals not providing health services optimally according to their service packages. The department is finalising plans for the implementation of the geographic service area model and the development of a central hospital to stabilise the service delivery platform.

In terms of primary healthcare facilities Sekhukhune, Waterberg and Capricorn have the lowest number of community healthcare centres. For an example, the number of CHCs in Capricorn is against the population size of the district considering the district being the second largest in the province. The department is building primary healthcare facilities including CHCs while refurbishing, maintaining and repurposing the old ones in compliance with ideal clinic status.

8.3.2 Universal Health Coverage (Population and Service Coverage)

The department in aligning with the SDGs, NDP, and LDP is on a path to contributing to the realisation of the National Health Insurance (NHI). Improving access to health services and quality of care are vital for realisation of the NHI. Therefore, a public health system that is efficient and effective is central towards an equitable care for all.

8.3.2.1 Hospital Care

Expenditure per Patient Day Equivalent (PDE)

Expenditure per patient day equivalent (PDE) is a composite process indicator that connects financial data with service-related data from the hospital admissions and outpatients' records. The indicator measures how the resources available to the hospital are being spent and is a marker of efficiency.

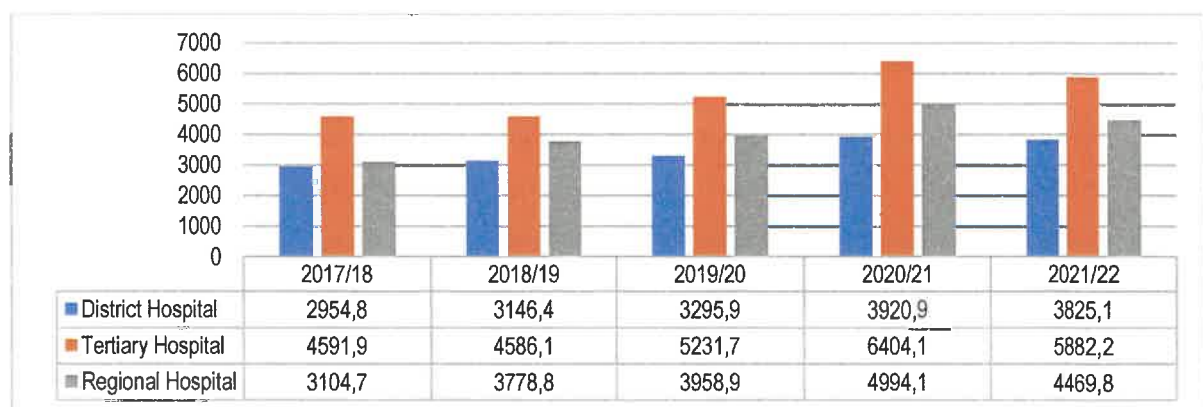


Figure 11. Limpopo per PDE

Source: DHIS

As depicted in Figure 11, expenditure per PDE for all hospital categories has shown a steady rise from 2017/18 to 2020/21, with an average increase of 14%, 23% and 16% for the district, regional and tertiary hospitals respectively. However, in 2021/22 financial year, expenditure

per PDE for all hospital categories decreased substantially by an amount of R96, R524 and R522 in rand value from 2020/21 baseline expenditure per PDE. This is most likely due to the impact of COVID-19 pandemic and not as a result of deliberate actions to improve expenditure on cost items. A high expenditure per PDE indicates an inability to use resources efficiently.

Average Length of Stay

Average length of stay (ALOS) indicates how much time a patient spends in the hospital. It is an outcome indicator and measures a component of quality.

Table 7. Average length of stay and IBUR

Limpopo Province	Average Length of Stay				Inpatient Bed Utilisation Rate			
	2018/19	2019/20	2020/21	2021/22	2018/19	2019/20	2020/21	2021/22
District Hospital	4,3	4,2	4	4	73,1	72,9	60,9	62,6
Regional Hospital	4,4	4,3	4,1	4,6	71,9	69,8	57,9	62,6
Tertiary Hospital	7,5	7,5	7,7	8,3	82,3	83,4	72,6	83,8

Source: DHIS

As illustrated in Table 7, ALOS has remained within the target of 7 (seven) for both district and regional hospital for 2018/19 – 2021/22 financial years. For tertiary hospitals, there was a slight increase above the target between 2020/21 and 2021/22 of about 0.6. This is attributed to prolonged hospitalisations of severe covid-19 patients given that the two tertiary hospitals were providing critical intensive care services during the pandemic.

Inpatient Bed Utilisation Rate

Inpatient Bed Utilisation rate (IBUR) measures how busy the hospital is and what proportion of beds are being used. As per Table 7 above in the period 2019/2020 to 2020/21, IBUR for all levels of care/hospitals showed a significant decline of 12% on average. The decline thus observed especially during 2020/21 was due to covid-19 pandemic lockdown restrictions. However, all hospitals managed to improve their utilisation rates in 2021/2022 by an average of 5,8% with tertiary hospitals showing better improvement at 83,8% IBUR from 2020/21 baseline of 72,6%. The improvement in utilisation rates during 2021/22 for all hospital categories was because of easing of lockdown restrictions following milder covid-19 resurgence peaks.

OPD Client not Referred

In light of the National Health Insurance Policy, a PHC level is the first point of contact with the health system and therefore key to ensuring health system sustainability. If it works well and the referral system is seamless, it is associated with fewer visits to specialists and to emergency rooms. OPD new client not referred rate which monitors the utilisation trends of clients who bypass PHC facilities, is a good measure of functionality of the health system referral networks.

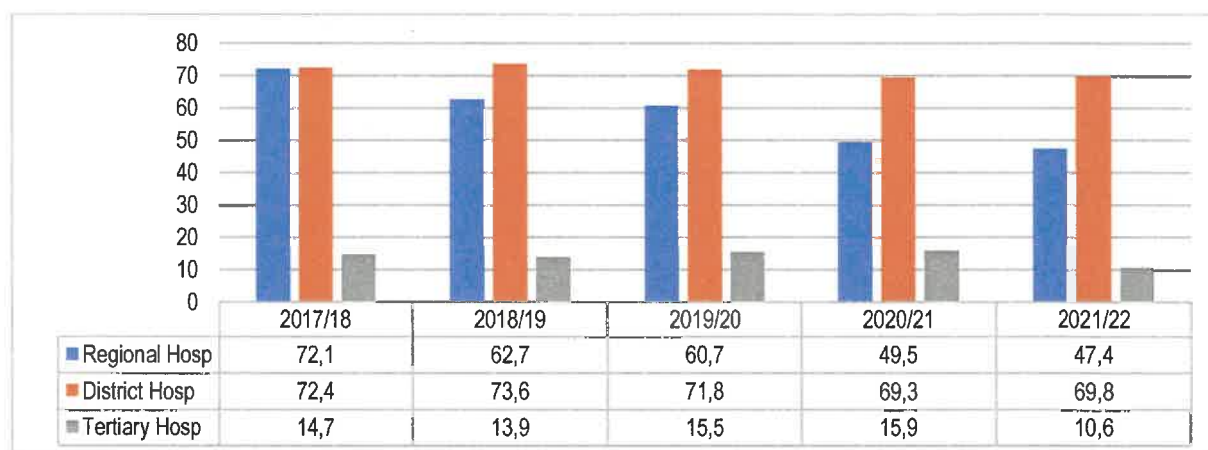


Figure 12. OPD client not referred rate

Source: DHIS

As shown in Figure 12 above, OPD new client not referred rate for regional hospitals has been on a downward trend with an average of 8% - 10% decline on an annual basis since 2017/18. Tertiary hospitals on the other hand, showed a fluctuating and unsteady trend between 2019/20 and 2020/21 financial years recording an OPD new clients not referred rate of 15.5% and 15.9% respectively. However, in 2021/22, a decrease of 5.3% was noted for tertiary hospitals which was an improvement from the 2020/21 baseline. OPD new client referred rate for district hospitals showed a decline (69.3%) in 2020/21 from a high of 71.8% in the previous year only to regress in 2021/22 and achieved 69.8%.

Covid-19 lockdown restrictions most likely played a role in reducing OPD new client not referred rate for both tertiary and regional hospitals. A high OPD new client not referred rate in all hospital categories especially for district hospitals could be as a result of lack of effective referral systems and patient dissatisfaction with the quality of PHC services.

8.3.2.2 Primary health care

PHC utilisation

PHC utilisation rate measures the rate at which PHC services are utilised by clients in the catchment population. Initiatives such Ward Based Outreach Teams (WBOT) and ideal clinic realisation framework are meant to strengthen the PHC platform so that clinics provide quality

services to the target population thereby reducing the need for clients to “self-refer” to hospitals.

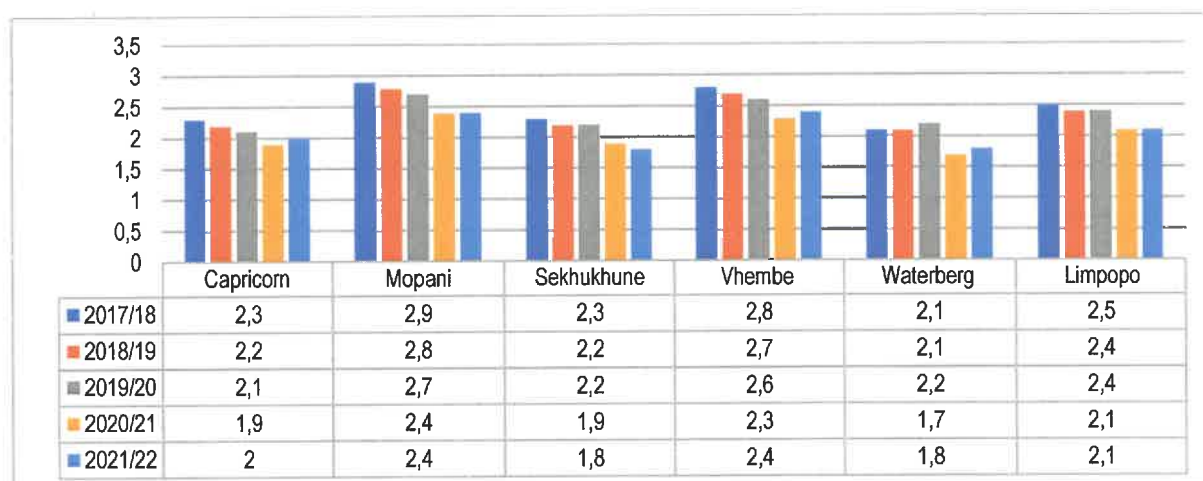


Figure 13. PHC utilisation rate

Source: DHIS

Despite PHC re-engineering efforts, PHC utilisation has been on a decline due to many reasons, including the implementation of the Centralised Chronic Medicine Dispensing and Distribution programme and improved health services leading to less need for health services. However, by-passing of the PHC clinics and the COVID-19 pandemic also contributed negatively to PHC utilisation rate. As at the end of 2021/22 Financial Year, provincial PHC Utilisation rate has remained at 2,1% (See Figure 13 above) which is way below the national target of 3.2%. Districts have also followed the provincial trend with Capricorn, Vhembe and Waterberg showing a 0.1% slight improvement in 2021/22. The significant decline in utilisation saw for 2020/21 is due to the effects of covid-19 pandemic. Lack of medical equipment, medicines, poor staff attitudes etc., contributes to patient dissatisfaction with PHC facilities thus low utilisation.

8.3.2.3 Ideal Clinic Status

An Ideal Clinic is a clinic that provides good clinical care to the patients it serves, and it also gives the patients a good experience of care. It has good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and adequate bulk supplies. Operation Phakisa launched in 2014 sought to ensure that PHC facilities in the country are turned into ideal facilities in preparation for National Health Insurance. Unfortunately, LDOH has had some success in ensuring that facilities become ideal, however, majority of facilities couldn't maintain their ideal status. Between 2018/19 and 2019/20, the department showed a sustained trend of ideal clinic status obtained annually with 2018/19 financial year being the year with the highest performance achieved thus far with 214 clinics having obtained ideal

status. During the covid-19 pandemic years, the trend declined as expected, having attained 46 and 32 ideal clinic status for 2019/20 and 2020/21 respectively (refer to Figure 14 below). With the slowing of the pandemic, the department is regaining the lost ground, given that for 2021/22, the department managed to report 167 clinics having achieved ideal status.

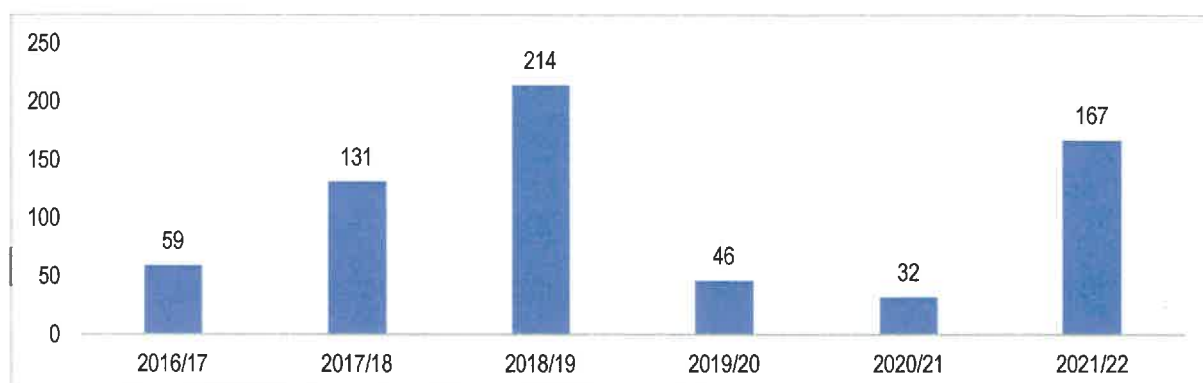


Figure 14. Number of ideal clinics in the province (2016/17 – 2021/22)

Source: Ideal clinic software

Further, districts performance on ideal clinic status obtained, resembles the provincial performance, with a sustained upward trajectory between 2016/17 and 2018/19 (see Figure 15). Capricorn district, however seemed to have made better strides compared to other districts, given that its performance peaked at 66 clinics having achieved ideal status in 2018/19 with Waterberg achieving the lowest (20) number of ideal clinics in the same year. Between 2019/20 and 2020/21 all districts saw their performance deteriorate with only Vhembe maintaining the same performance in the two financial years (11) whereas other districts saw a drop in the total number of ideal clinics status obtained.

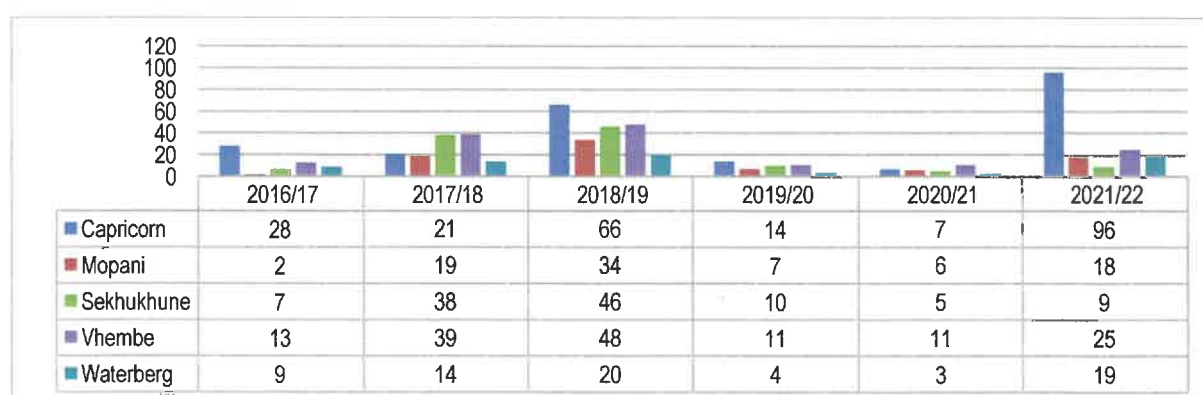


Figure 15. Number of ideal clinics per district (2016/17 – 2021/22)

Source: Ideal clinic software

Factors contributing to poor maintenance on ideal clinic status by facilities include amongst others; shortage of equipment for emergency trolley especially for complying to non-negotiable vitals. To improve all components of ideal clinic realisation framework, will require

a holistic approach to quality assurance. Continuous standards inspection without adequate root cause analysis and lack of follow-up on quality improvement plans will not change/improve the status quo. Development and implementation of quality improvement plans with adequate training of staff on quality improvement methodologies is required to ensure long lasting quality improvement.

8.3.2.4 Quality of care

South Africa's health system is undergoing major healthcare reforms in order to achieve UHC by 2030. Central to overhauling the health system, is improving the quality of healthcare thereby ensuring that patients are satisfied with the care they receive, clinical errors are avoided at all costs, healthcare professionals are competent in their work and care is provided in an environment that is patient-centric based on the principles of Batho Pele.

Following the findings of Lancet Commission (2018), NDOH launched several guidelines to improve the quality of care, namely:

- Complaints management
- Patient safety Incidence management
- Patient Experience of Care satisfaction

The following gives an overview of how LDOH performed in improving the quality of healthcare in readiness for NHI.

Complaints Management

Patient complaint is a sign of patient dissatisfaction or discontent about a specific health service being given and or care being provided. It is a proxy measure of healthcare quality. Key aims of complaint management in a health system are to resolve complaints/problems closest to the point of origin as possible to satisfy the concerns of a patient or their families, learn from the complaints to prevent recurrence and avoid litigations. Lodging a complaint from a patient perspective is to seek an apology or explanation from the health service, which if handled and addressed speedily to the satisfaction of a patient could prevent escalation of complaints to litigations.

For the period 2016/2017 – 2021/22, the department recorded a decline of 15% in overall complaints received which could be due to the impact of COVID-19 pandemic (Table 8). However, the department had an improvement in complaints resolution rate of 9% between 2016/17 and 2021/22 (Figure 16). Despite this notably improvement in complaints resolution rate across districts, Vhembe showed a marked decline of about 5% in resolution rate between 2020/21 and 2021/22. This may probably signify the escalating contingent liability that the district is currently facing.

Table 8. Number of complaints received, resolved, and complaints resolution rate (CRR), per district (2017 – 2022)

	2017/2018			2018/2019			2019/2020			2020/2021			2021/2022		
	Received	Resolved	CRR	Received	Resolved	CRR	Received	Resolved	CRR	Received	Resolved	CRR	Received	Resolved	CRR
Capricorn	1689	1145	68%	1104	881	80%	737	669	91%	417	391	94%	386	347	90%
Mopani	988	913	92%	793	723	91%	625	558	89%	377	356	94%	313	296	95%
Sekhukhune	821	726	88%	739	652	88%	458	387	84%	232	200	86%	257	246	96%
Vhembe	543	455	84%	438	348	79%	394	338	86%	257	224	87%	238	194	82%
Waterberg	736	663	90%	593	545	92%	486	421	87%	198	192	97%	220	206	94%
Limpopo	4777	3902	82%	3667	3149	86%	2700	2373	88%	1481	1363	92%	1414	1289	91%

Source: DHIS

The department has seen a steady increase of 2 - 3% of complaints resolved within 25 working days (Figure 16) from 2016 /17 to 2021/22 financial years, with all districts showing similar trends except for Vhembe district which continued to perform dismally at 75%. This, however, still falls short of the overall expected target of 100% resolution rate of all complaints within 25 working days. Resolving complaints within 25 days is critical in ensuring that the health system is seen to be responsive to patients needs and concerns.

Majority of complaints occur as result of patient care related factors followed by complaints emanating from factors related to physical access, waiting times and staff attitudes. Improving complaints management will require addressing a myriad of activities from ensuring that facilities have appropriate and functional complaints governance committees, strengthen Batho Pele principles and staff to learn from the complaints received to prevent recurrence.

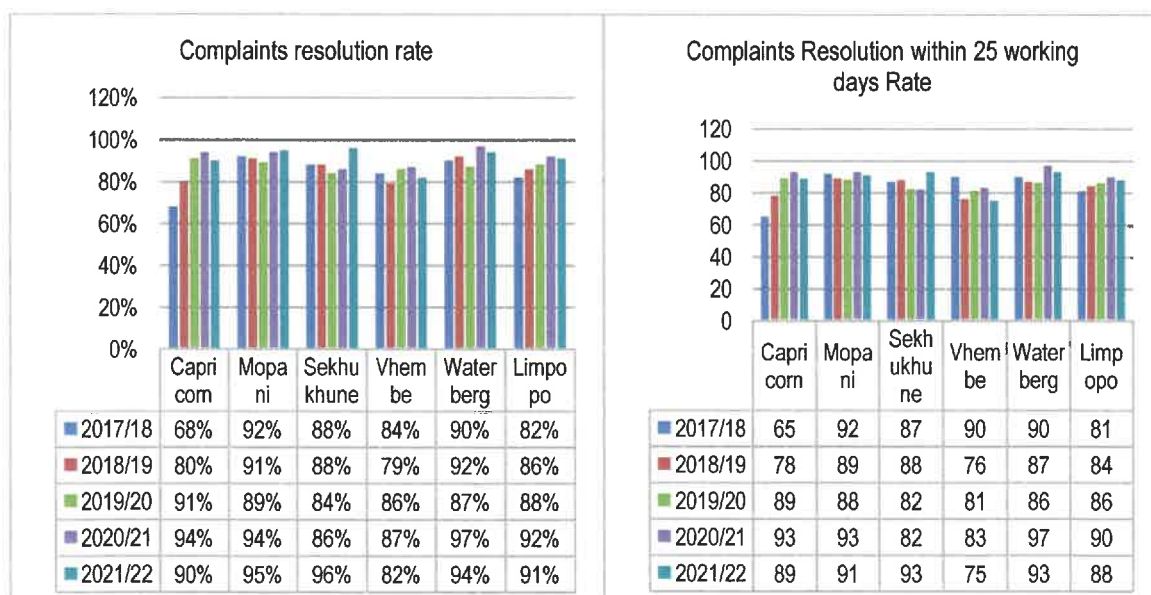


Figure 16. Complaints resolution rate and number of complaints resolved within 25 working days

Source: DHIS

Patient Safety Incidence (PSI)

A PSI is an event or circumstance that could have resulted or did result in harm to a patient as a result of the healthcare services provided, and not due to the underlying health condition. These are considered incidents. An incident can be a near miss, no harm incident or harmful incident (adverse event). Key objectives of the health system's focus on managing Patient Safety incidences are to prevent and or reduce harm to patients whilst undergoing medical care and learn from these PSIs that occurred in order to continuously improve quality of care through the identification of all missed opportunities in ensuring optimal patient outcomes.

Since the launch of the National Guideline for Patient Safety Incident Reporting and Learning in 2018, the department has recorded two-thousand four hundred and ten (2410) PSIs overall on the national online PSI reporting system (refer to Table 9 below). This is low compared to other provinces such as Gauteng, Western Cape, Kwazulu-Natal etc. who reported in excess of two thousand (2000) incidents annually (as depicted in Figure 17 below) for the period 2018 - 2021. Underreporting of patient incidents could be due to a lack of culture of reporting clinical errors from staff partly as a result of fear of victimisation.

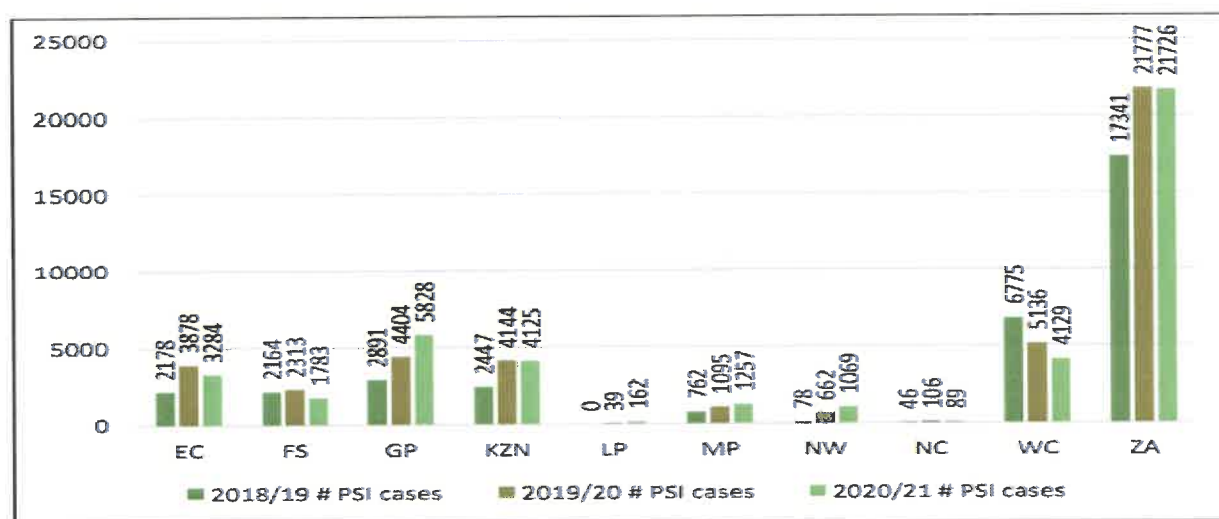


Figure 17. Number of PSI cases captured (2018/19 – 2020/21)

Source: National Patient Safety Incidents web-based system

Patient safety incidents are characterised in terms of type, severity, and contributory factors. Twenty-nine percentage (29%) of all PSIs reported between 2018 – 2021 were harmful in nature/type with 47% being near misses and 24% having caused no harm to patients. Vhembe district of all the districts had 62% of its incidents categorised as harmful followed by Waterberg and Sekhukhune districts at 41% and 23% respectively.

PSI are also categorised in terms of severity assessment code (SAC), with SAC 1 being a PSI with a potential to cause serious harm or death; SAC 2 causing moderate harm and SAC 3

minor harm. Twenty-two (22%) of all PSI were SAC 1 with SAC 2 & 3 being 32% and 46% respectively. Vhembe district had 58% of its PSIs categorised as SAC 1. The higher the code (SAC 1) the higher likelihood of having escalating medico-legal cases.

Several agents are known to play a role in the causation of PSIs. Seventy-eight percent (78%) of all PSI were associated with patient related factors with 15% and 7% of PSIs occurring because of staff and work/environmental factors respectively. Sekhukhune district had the highest proportion of its PSIs (82%) related to patient factors.

Table 9. Number, type, severity, and outcome of patient safety incidents per district (2019/20 – 2021/22)

	Categories	Vhembe	Capricorn	Sekhukhune	Waterberg	Mopani	Limpopo
SAC type	1	153	23	151	130	54	511
	2	64	122	430	53	93	762
	3	48	548	269	198	37	1100
Contributory factors	patient factors/behaviours	33	349	652	234	86	1354
	staff factors	5	62	110	62	29	268
	work/environment factors		40	33	29	10	112
Type of PSI	harmful	166	113	202	155	6	642
	near miss	66	543	401	42	1	1053
	no harm	37	37	269	185	3	531
Patient outcome	death		9	191	120	1	321
	severe		4	234	10		248
Total PSI		265	693	872	383	197	2410

Source: National Patient Safety Incidents web-based system

Outcomes of patient safety incidents maybe mild, moderate, and severe. However, on the balance of probabilities, death can also occur following an incident or brought forward in the short term as a result of the incident. Five-hundred and twenty-one, 521 (29%) of all PSI from 2018 – 2021 resulted in death outcome, with 16% (283) and 34% (431) resulting in moderate and severe outcomes respectively. Sekhukhune district registered 191 PSI incident with death as an outcome (Table 9 above). Reporting of patient safety incidents allows for monitoring of patient safety system through the following indicators; viz, PSI case closure rate, SAC1 incident reported within 24 hours and PSI case closure within 60 working days rate.

According to Figure 18 below, although there was a marked improvement of 99% on provincial patient safety incidence closure rate 2021/22 as compared to 81.7% in 2020/21, the target of 100% was not achieved. Waterberg district achieved the highest closure rate of 99% with Capricorn district closing 64.8% as the lowest. In 2021/22, Waterberg district improved their closure rate by 0.8%, from 99% to 99.8%. Capricorn district had a vast improvement of 32.6% (64, 8% to 97.4%). Out of all five districts, Sekhukhune achieved 100% closure rate in the financial year 2021/22.

The province had an improvement of 3.3% on patient safety closure rate within 60 working days 2021/22. There was a slight increase from 91,7% in 2020/21 to 95% in 2021/22. Capricorn District Patient safety closure within 60 working days improved from 69.3% in 2020/21 to 93.9% in 2021/22.

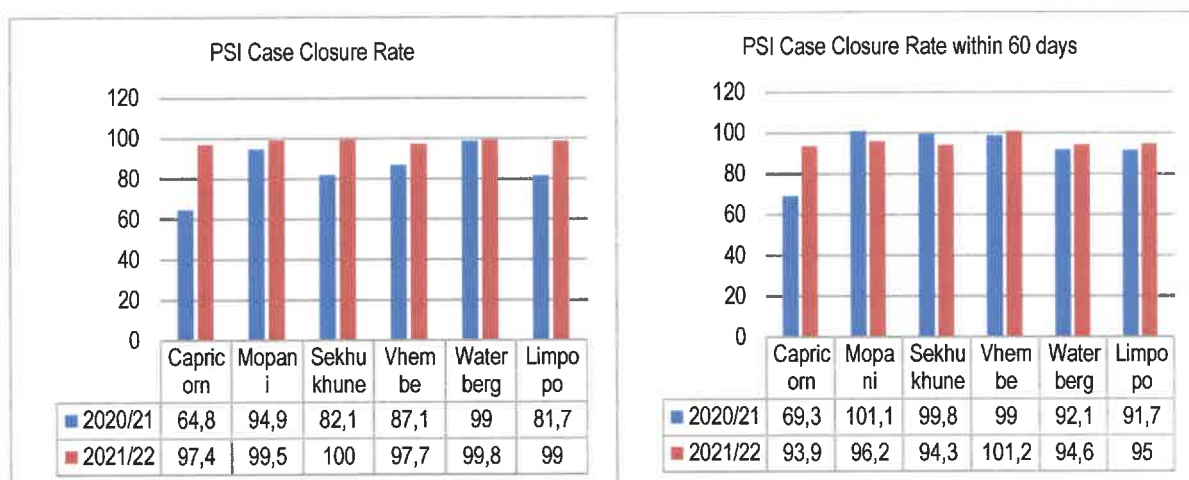


Figure 18. PSI case closure rates per district (2020/21 – 2021/22)

Source: DHIS

Most district failed to achieve the target of 100% which probably results in these cases not resolved. In 2020/21 achieved the patient safety incidence closure within 60 working days of 101.1% which is above the target. This resulted due to an overlap from the previous financial year. In the Vhembe district, there was an overlap of 1.2% from the 2020/21 to 2021/22. Probably cases which were not resolved might resulted in litigation that are confronting the province.

Patient Experience of Care

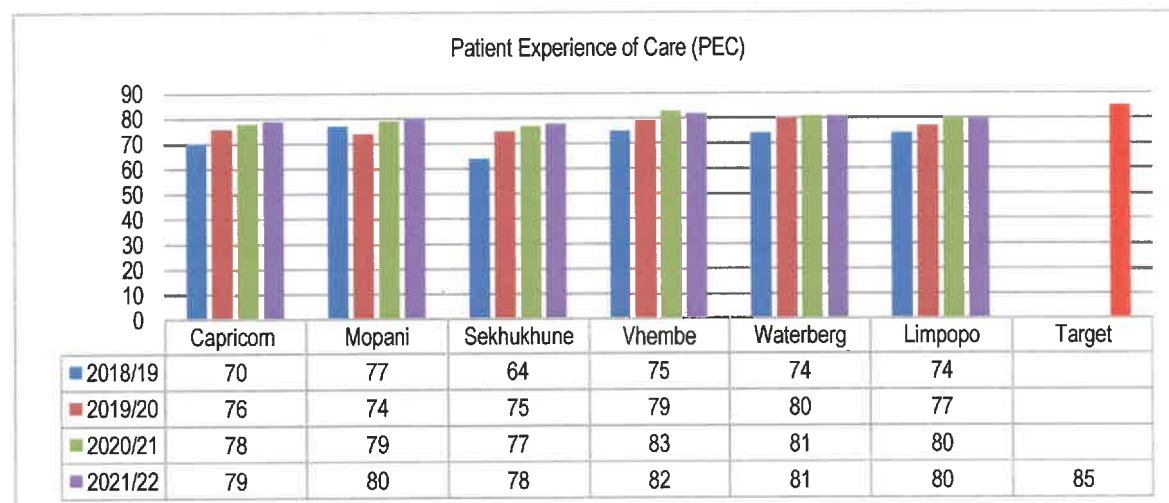


Figure 19. Patient experience of care (2018/19 – 2021/22)

Source: DHIS

As demonstrated in Figure 19, in year 2020/21 and 2021/22, the province managed to achieve the target of 80% in Patient Experience of Care Satisfaction Rate (PEC). All the five districts managed to improve from the year 2018/19 to 2021/22. Vhembe district managed to achieve

the highest performance of 82% with Sekhukhune district achieving the lowest at 78% in the year 2021/22.

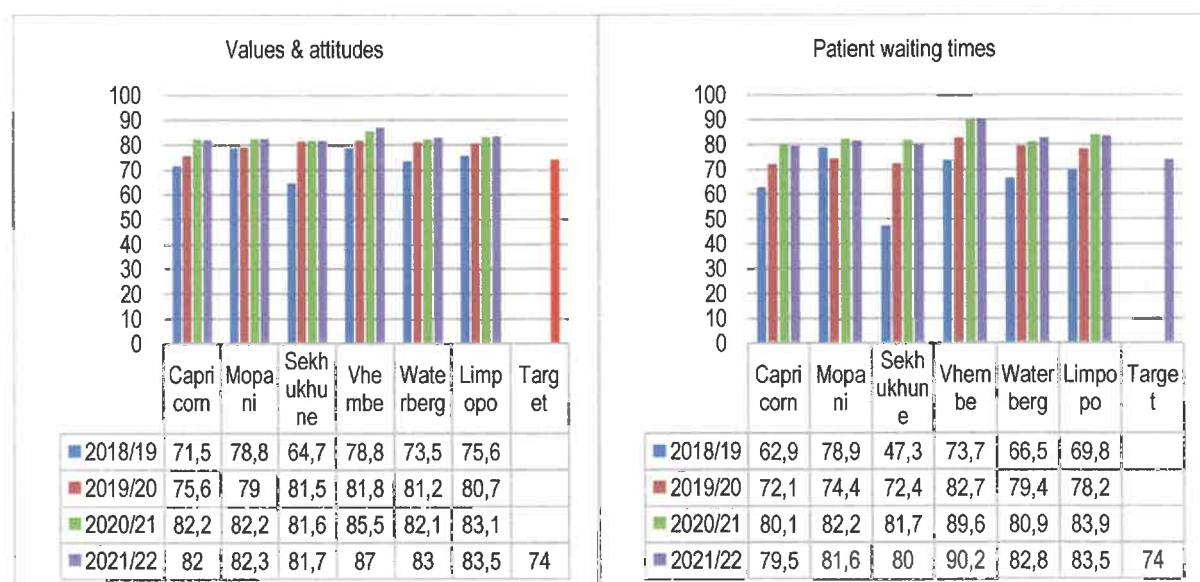


Figure 20. Values & Attitudes and Patient waiting times

Source: DHIS

Values & attitudes

In 2018/19, Sekhukhune district and Waterberg district achieved 64.7% and 73.5% respectively which is below the target of 74% for values and attitudes (refer to Figure 20). Provincially, there has been a drastic improvement from 75.6% to 83.5% with regard to values and attitude. All the districts achieved above 80% in the year 2021/22.

Patient waiting times

Further regarding Figure 20, the province managed to achieve 83.5% which is above the patient waiting time target of 74%. Vhembe district is leading with 90.2% in 2021/22 f/y. Overall all the districts managed to perform above the provincial target of 74% in 2021/22 f/y.

Access to Care

For 2018/19 to 2021/22, the province achieved below the target of 100% with regard to access to care (as shown in Figure 21 below). In 2019/20 access to care improved by 12% from 77.8% to 79.8% and in 2020/21 increased by 1.9%. In 2021/22 there was a decline by 6.2%. The COVID-19 pandemic led to an erratic attendance at our facilities which gave an impression of decreased access. However with normalisation of services, access is expected to improve..

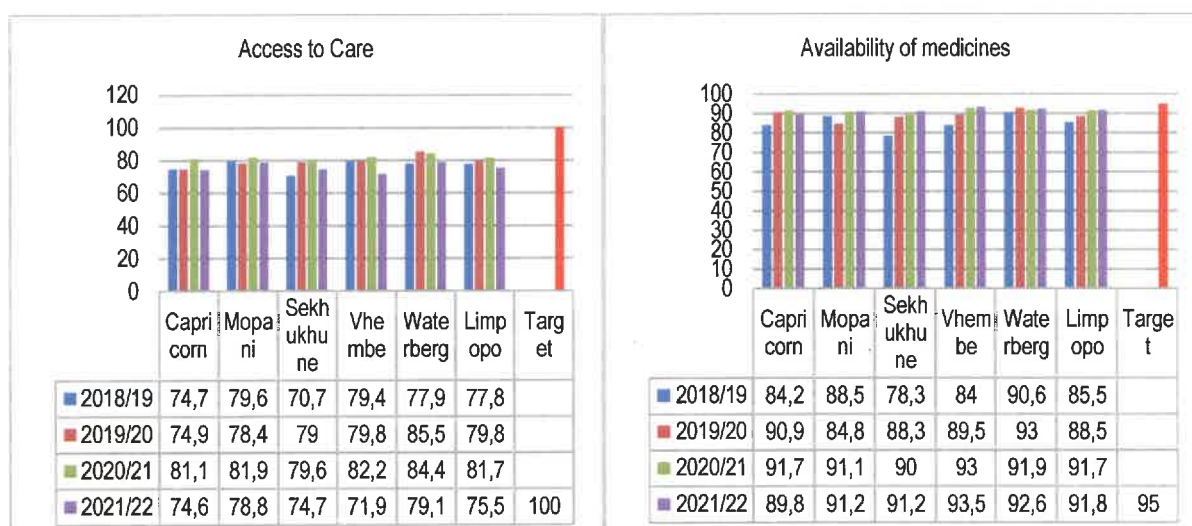


Figure 21. Access to care and availability of medicines

Source: DHIS

Availability of medicines

Availability of medicine remains the challenge with all the districts not achieving the target of 95%. According to Figure 21, in 2018/19 Sekhukhune district achieved below 80% with Waterberg achieving the highest score of 90.6%. There is a marked improvement of availability of medicine in all the district from 2019/20 to 2020/21. Capricorn district availability of medicine declined from 91.7% to 89.8% with the other four districts increasing their score. The challenge is due to an increase in the number of section 21 items such as Medroxy-progesterone, all items not awarded on new national contracts (30 items) e.g., Clonazepam, Lorazepam etc., including shortage of Active Pharmaceutical Ingredients (API) on fast moving items like paracetamol and Simvastatin.

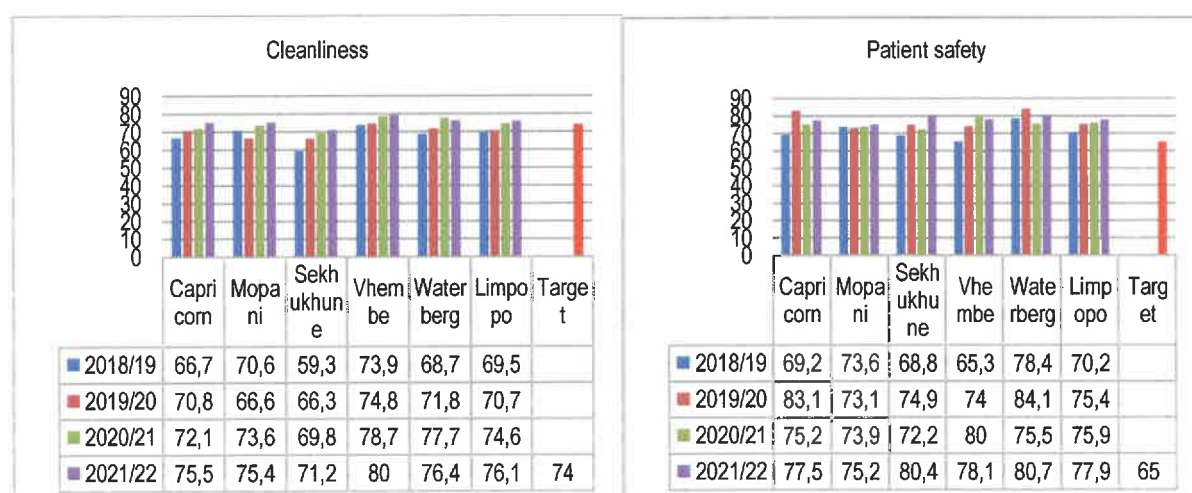


Figure 22. Cleanliness and patient safety

Source: DHIS

Cleanliness

According to Figure 22 above, the province managed to achieve 76.1% which is above the target of 74% on cleanliness in 2021/22. There has been a marked improvement from 69.5% in 2018/19 to 76.1% in 2021/22. All districts managed to improve yearly in the past five years. Vhembe district achieved the highest performance of 80% as compared to Sekhukhune district with a performance of 71.2%.

Patient Safety

Figure 22 further shows the province managed to achieve 77.9% which is above the target of 65% on patient safety. There was an increase of 7% from 2018/19 to 2021/22. However, a decline on patient safety in Capricorn, Sekhukhune and Waterberg districts was observed during 2019/20 to 2020/21.

8.3.2.5 Medico-legal litigations

Health systems across the world exist to reduce mortality and morbidity amongst the populations they serve but more importantly, they exist to render high quality services so as to satisfy their clientele. For care to be of high quality, can be judged by feedback received post-care e.g., positive responses from patient experience of care surveys, compliments submitted to quality officers etc. However, when care is not satisfactory, clients' perceptions of care will be manifested in the number of complaints and litigations lodged.

Medico-legal litigations in the country because of dissatisfaction with healthcare rendered has reached alarming proportions and the attending liabilities have the potential of bankrupting and draining the provincial health budgets. For the period between 2014/15 – 2021/22, LDOH registered 1773 cases, incurring liabilities to the tune of 8 billion rands with 338 million rands paid so far. On average, around 200 cases are litigated annually.

Vhembe district as shown in the Table 10 below, has the highest number of litigations at 594 cases followed by Capricorn, Sekhukhune, and Mopani districts at 445, 358 and 322 cases respectively. Waterberg has the lowest number of litigations at 97 cases. Vhembe district is also the district with highest medico-legal liabilities standing at 5 billion rands and Waterberg district with the lowest liabilities at 321 719 000 million as reflected in Table 10.

Table 10. Number of medico-legal cases and amount claimed per district (2014/15 – 2021/22)

District	Number of cases	Claim amount assessed
Capricorn	445	1 451 070 600,00
Mopani	279	1 259 094 747,00
Sekhukhune	358	1 807 146 300,00
Vhembe	594	3 553 522 000,00

Waterberg	97	371 719 000,00
Grand Total	1773	8 442 552 647,00

Source: Medico-legal register

Factors giving rising to cases of medico-legal litigations amongst others are, medical malpractice and poor-quality healthcare and or escalation of clinical errors/patient safety incidents during patient care. The public health sector in South Africa is fraught with reports of cases signifying poor quality care, e.g., Esidemeni tragedy in Gauteng Province where mental health patients died. Since the medico-legal health summit held in 2015, there has been an astronomical increase in medico-legal liabilities across all provinces.

Departmental strategies to prevent or reduce litigations will need to focus on the root causes. Interventions such as mediations and state attorneys are secondary/tertiary measures are aimed at eliminating the root causes. Strengthening clinical governance and ensuring continuous quality improvement initiatives may have an impact on reducing the scale and quantum of litigations.

8.3.3 Women and Maternal Health

Women's Health Trends

Couple year protection

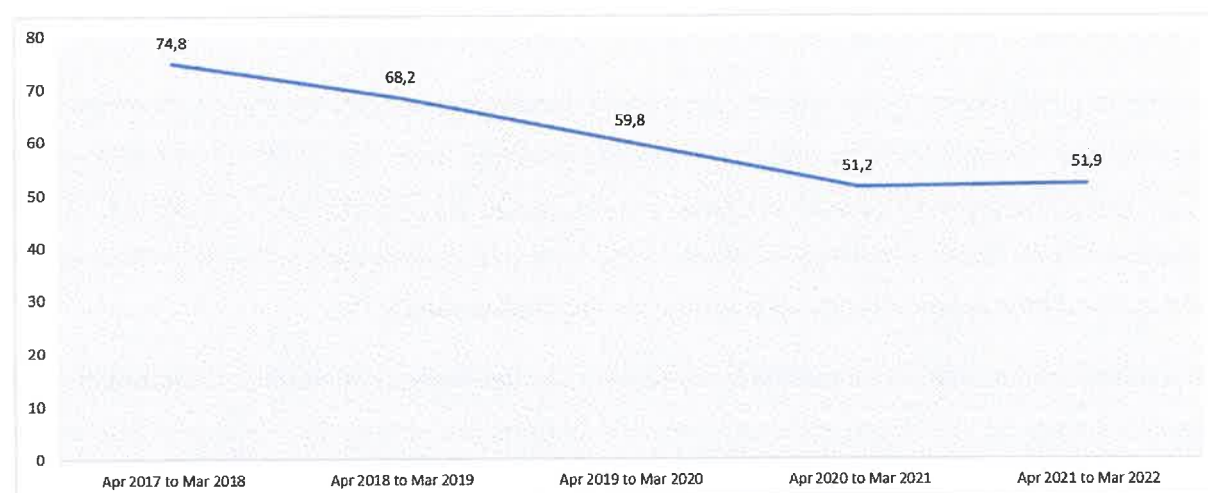


Figure 23. Couple year protection

Source: DHIS

According to Figure 23, couple-year protection has shown a steady decrease over the years. The financial year 2020/2020 and 2021/2022 had the lowest rate at around 51%. Although it still performed below the target of 55%, it is worth noting that in the previous years that performance was above 60%. The decline in the performance of the indicator could be because of challenges with the availability and distribution of some contraceptives including

both male and female condoms. This can be dealt with by lobbying NDoH to include all Contraceptive items on the SVS reporting tool as well as developing a strategy to market the uptake of available methods of contraceptive. The condom procurement system will need to be improved through effective management of suppliers on the National Contract to supply the relevant quantities of stock on time. The health facilities will continue to offer a wide range of contraceptive options (oral and injectable contraceptives, sub-dermal implants, IUCD, surgical procedures such as bilateral tubal ligation and vasectomies)

Antenatal 1st visit before 20 weeks rate

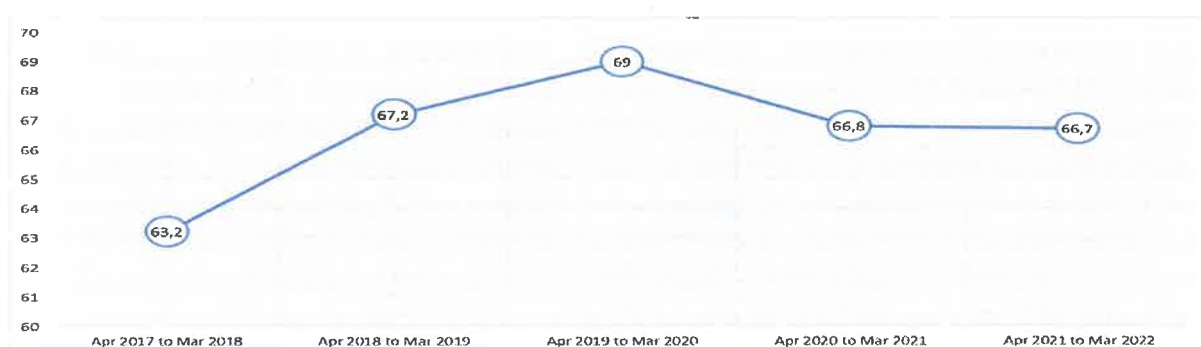


Figure 24. Antenatal 1st visit before 20 weeks rate (2017-2022)

Source: DHIS

According to Figure 24, indicator on antenatal first visit before 20 weeks rate has been performing below the 70% target in all years assessed. There was a steady increase from the financial year 2017/2017 with a peak in the financial year 2019/2020 almost reaching the target at 69%. However, the performance decreased (66%) in the subsequent financial years. The low performance is related to both health system (e.g., accessibility of the service, staff attitude, etc.) and patient factors (such as cultural beliefs, knowledge about the importance of early ANC visit bookings, etc.), and the department will conduct a survey to better understand the factors leading to late booking which is associated with negative pregnancy outcomes.

Delivery 10 to 19 years in facility

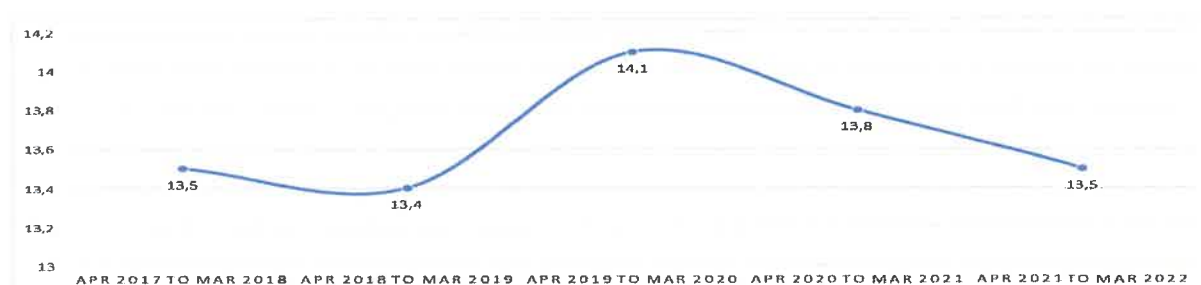


Figure 25. Delivery 10-19 years in facility

Source: DHIS

Narrative:

The delivery rate in the 10-19 years age group in facility rate as in Figure 25 has remained constant over the years ranging (from 13.4-13.8 rate), with a slight increase (14.1% rate) in the financial year 2019/2020 against the target of 14%. The constant achievement is attributed to health awareness and education to empower girls and young women in pregnancy prevention. Intersectoral collaboration with other social cluster departments are crucial to effectively deal with this societal issue of teenage pregnancy. It is encouraging however to see adolescent and youth accessing our facilities for purposes of delivery rather than deliver at home.

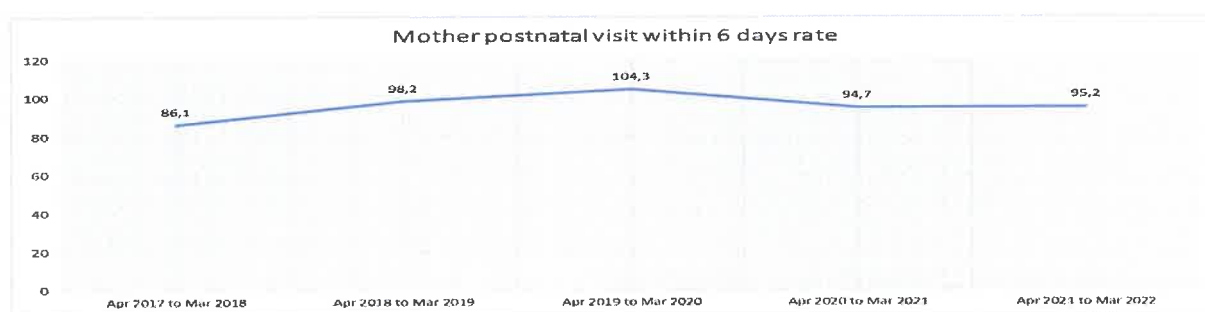
Mother postnatal visit

Figure 26. Mother postnatal visit within 6 weeks

Source: DHIS

Narrative:

In relation to Figure 26, mother postnatal visit within 6 days rate has been performing above the target of 95%. The financial year 2019/2020 had the highest number of visits by mothers for postnatal assessment within 6 days rate at almost 105%. This is related to pregnant women who gave birth in other provinces attending their within 6 days postnatal visits in the province. There was a noticeable decline in the financial years 2020/2021 and 2021/2022 which is attributed to the effects of COVID-19 restrictions.

Maternal Health

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

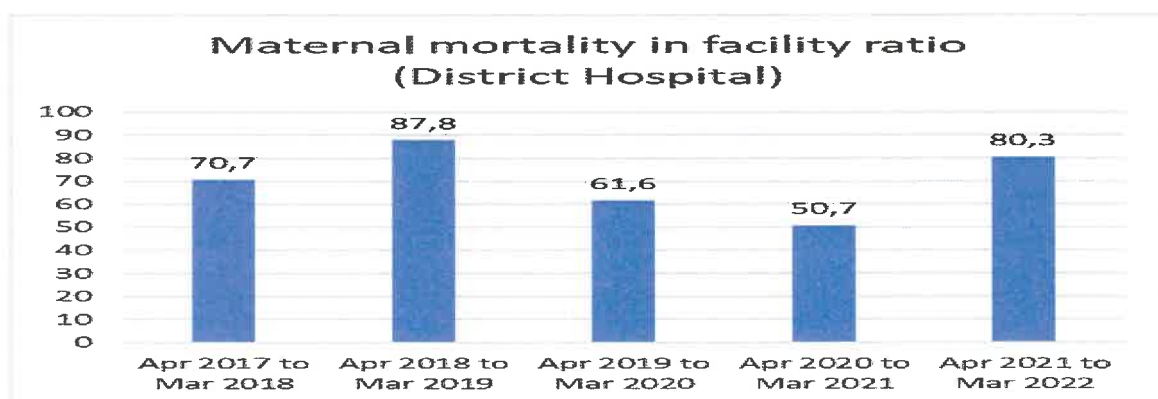


Figure 27. Maternal mortality (District hospitals)

Source: DHIS

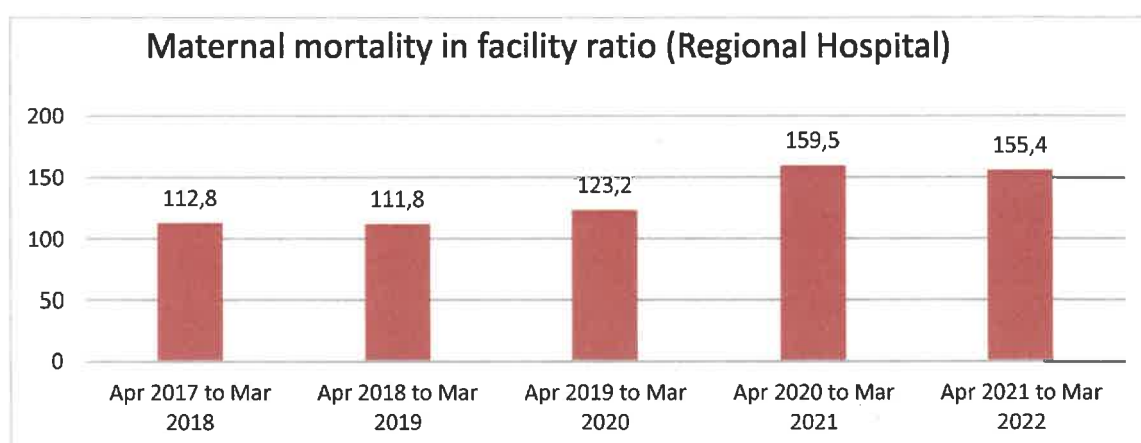


Figure 28. Maternal Mortality (Regional hospitals)

Source: DHIS

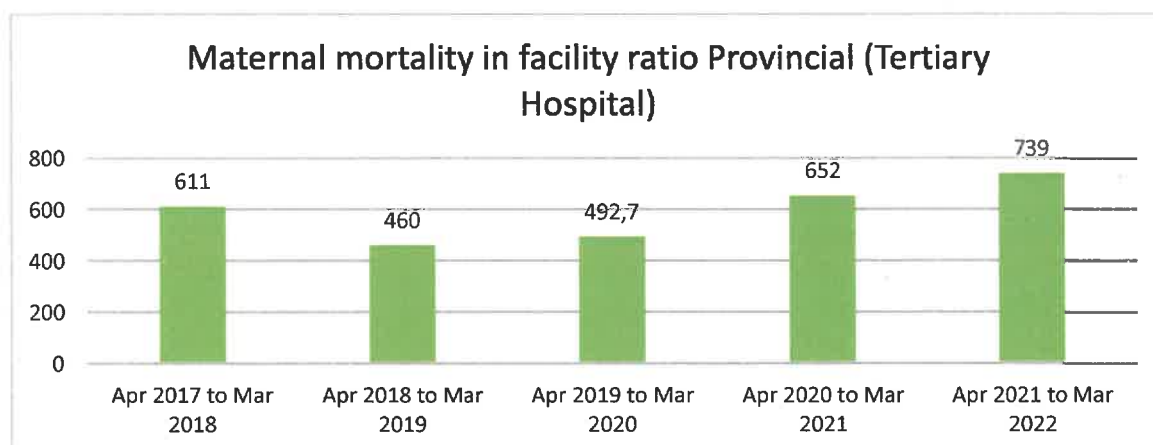


Figure 29. Maternal mortality (Tertiary hospitals)

Source: DHIS

Narrative:

The maternal mortality in facility ratio for district hospitals (see Figure 27) remained below the target of 100 per 100 000 live births. The performance was due to the implementation of the

quality improvement plans from 72-hour Maternal Mortality reviews and monthly Perinatal Mortality reviews. While the maternal mortality in facility ratio for Regional Hospitals (refer to Figure 28) exceeded the target of 111 per 100 000 live births. This is because of the delay in seeking healthcare and also the delay in referral from the district hospitals. These challenges will be addressed through conducting awareness for all pregnant women to present themselves in health facilities early. The department will also monitor the implementation of the referral policy.

The maternal mortality in facility ratio for tertiary hospitals (as shown in Figure 29) exceeded the target of 455 /100 000 live births due to delays in seeking healthcare and non-adherence to treatment. Also, the delay in referring patients to tertiary services by the regional hospitals contributed. These challenges will be addressed through conducting awareness for all pregnant women to present themselves in health facilities early. The department will further monitor the implementation of the developed referral policy.

8.3.4 Child Health

Live birth under 2500g

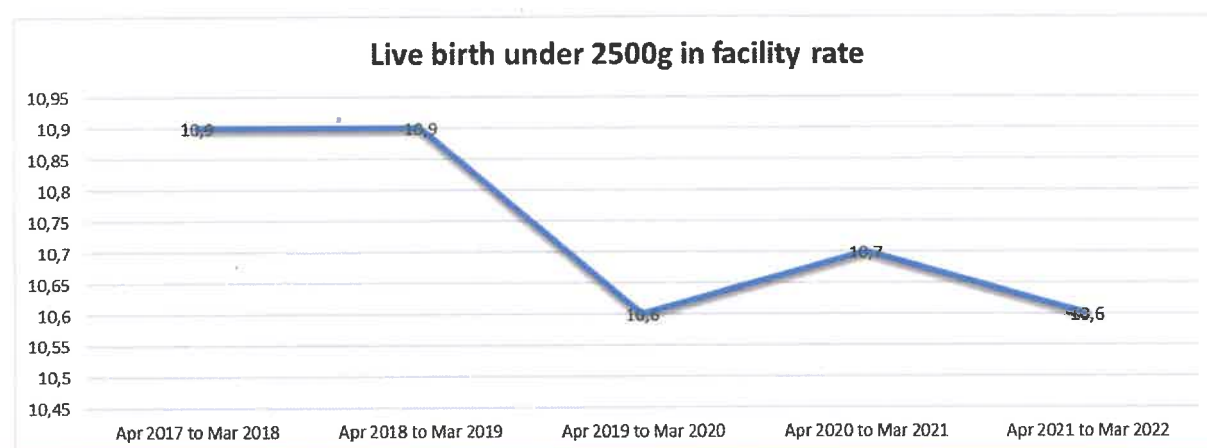


Figure 30. Live birth under 2500g in facility (2017 – 2022)

Source: DHIS

Narrative:

According to Figure 30, the live birth under 2500 g in facility rate has decreased from 2018 (10.9 per 1000 live births) to (10.6 per 1000 live birth) against the target of 12 per 1000 live birth. The sustained performance is due to the continued implementation of Basic Antenatal Care.

Neonatal (<28 days) death

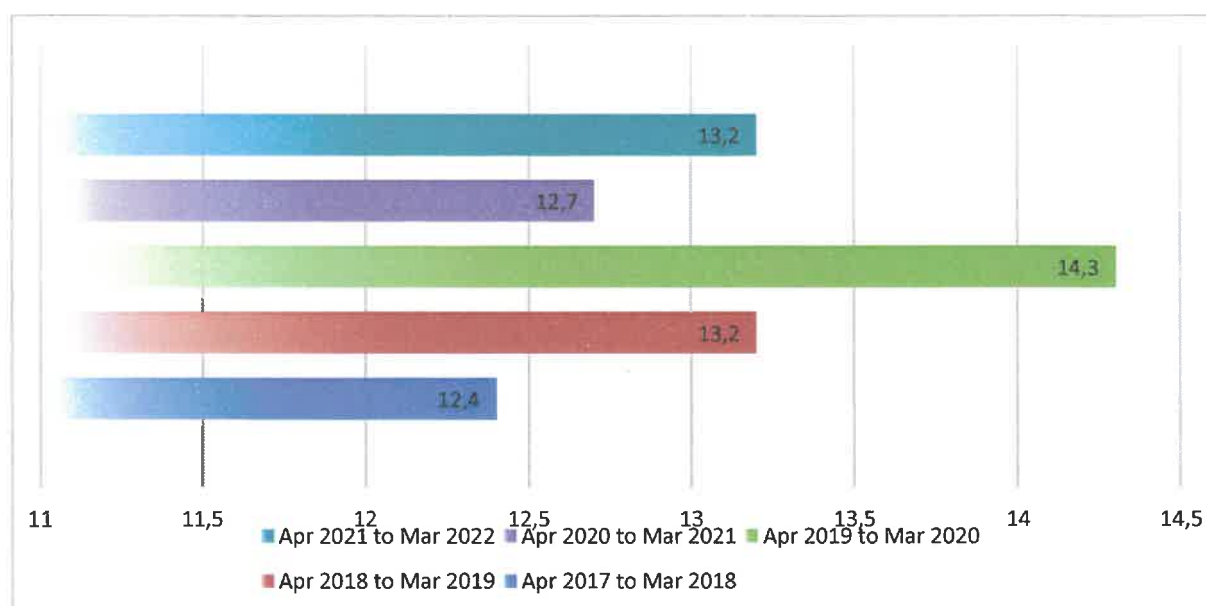


Figure 31. Under five years pneumonia case fatality rate

Source: DHIS

Narrative:

The department is not achieving the set target of 12 per 1000 live births. As depicted in Figure 31, the death among neonates is higher in the financial year 2019/2020 at 14.3 per 1000 live birth. The years 2021/2022 and 2018/2019 both had 13 per 1000 live birth. This performance is attributed to the high number of neonates born with extremely low birth weight and congenital abnormalities. The department will monitor implementation of the FAST tool to monitor the quality of newborn care at hospitals to reduce case fatality.

Child under 5 years diarrhoea fatality

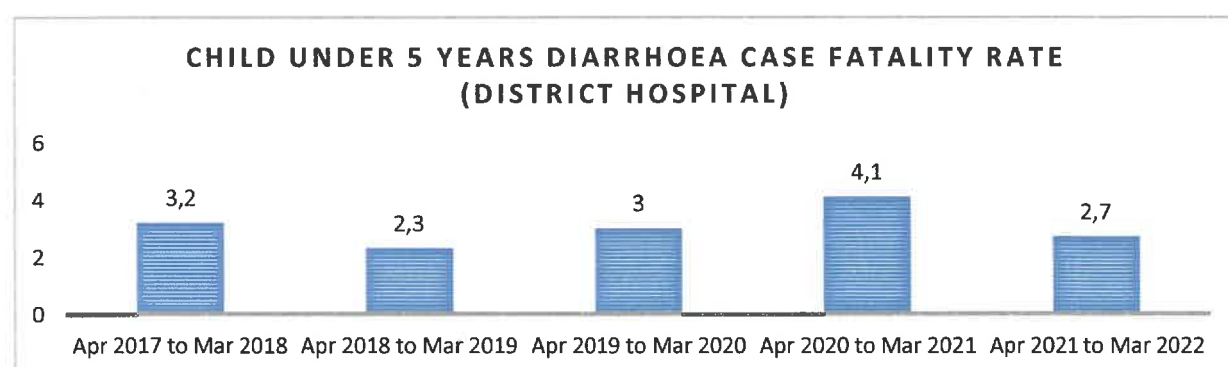


Figure 32. Child under 5 years diarrhoea case fatality – District hospitals (2017 – 2022)

Source: DHIS

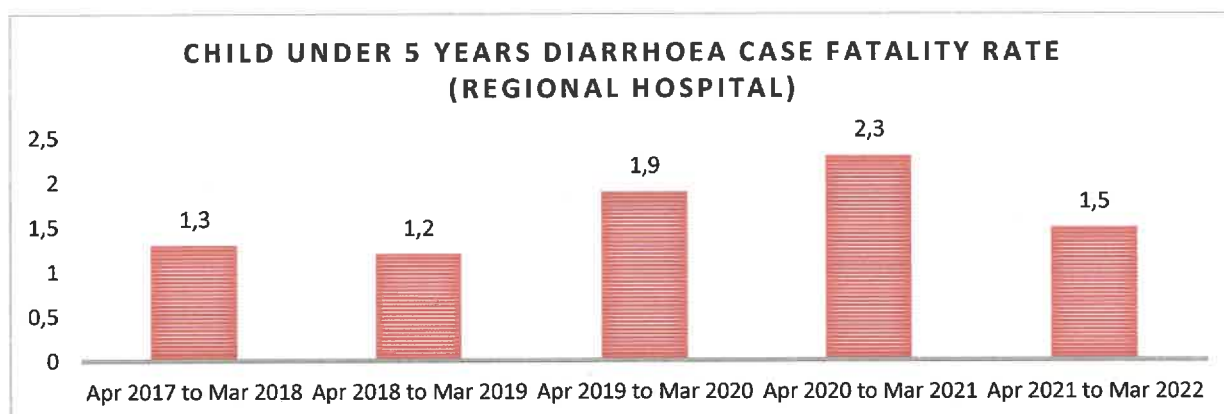


Figure 33. Child under 5 years fatality rate - Regional hospitals (2017 - 2022)

Source: DHIS

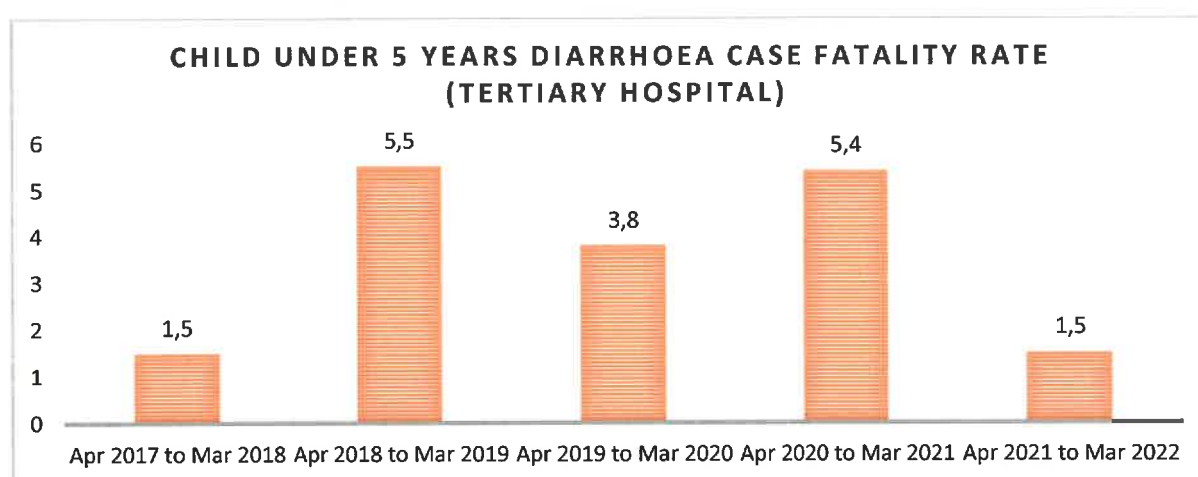


Figure 34. Child under 5 years diarrhoea case fatality - Tertiary hospitals (2017 - 2022)

Source: DHIS

Narrative:

The CFR of Children under 5 years of diarrhoea was mostly observed in the financial year 2019/2020 and 2020/2021. Most deaths because of diarrhoea were generally high in tertiary hospitals (see Figure 34), followed by district hospitals (Figure 32), and regional hospitals (Figure 33) had the lowest. Districts and tertiary hospitals achieved their targets of 5.5% and 5.4% respectively, while regional hospitals struggled to achieve their set target of 1.2%. The good performance in district hospitals is attributed to capacity building of medical officers by specialists from regional /tertiary hospitals through outreach visits, while low performance from regional hospitals is linked to delayed presentation to facilities and poor implementation of clinical guidelines which can be addressed through strengthening community awareness on the importance of seeking medical care early as well as continuous in-service training on clinical guidelines and protocols.

Child under 5 years pneumonia fatality

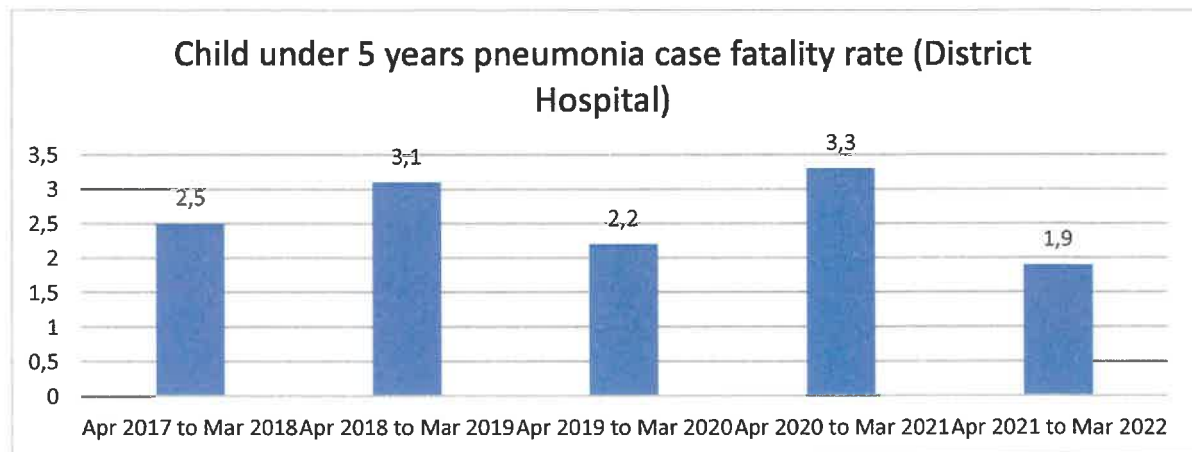


Figure 35. Child under 5 years pneumonia case fatality – District hospitals (2017 – 2022)

Source: DHIS

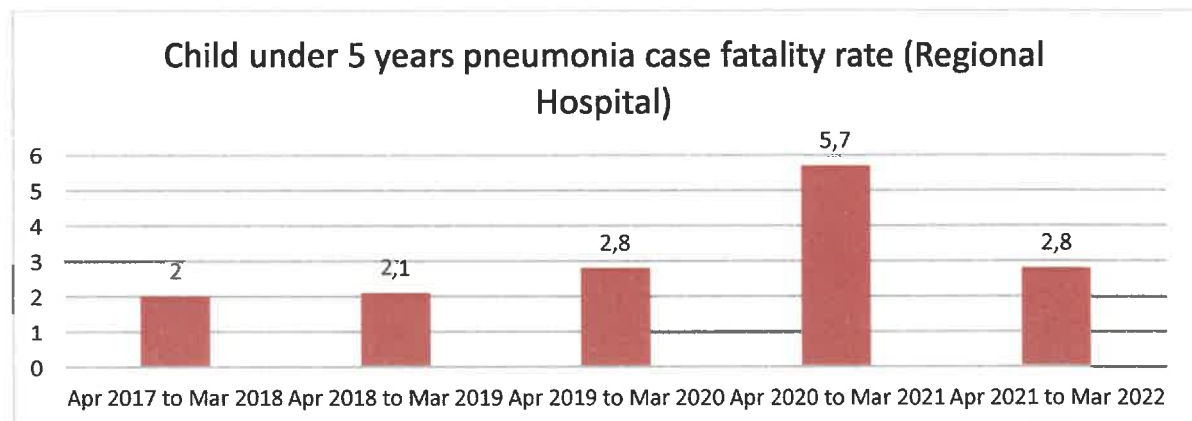


Figure 36. Child under years case fatality - Regional hospitals (2017 - 2022)

Source: DHIS

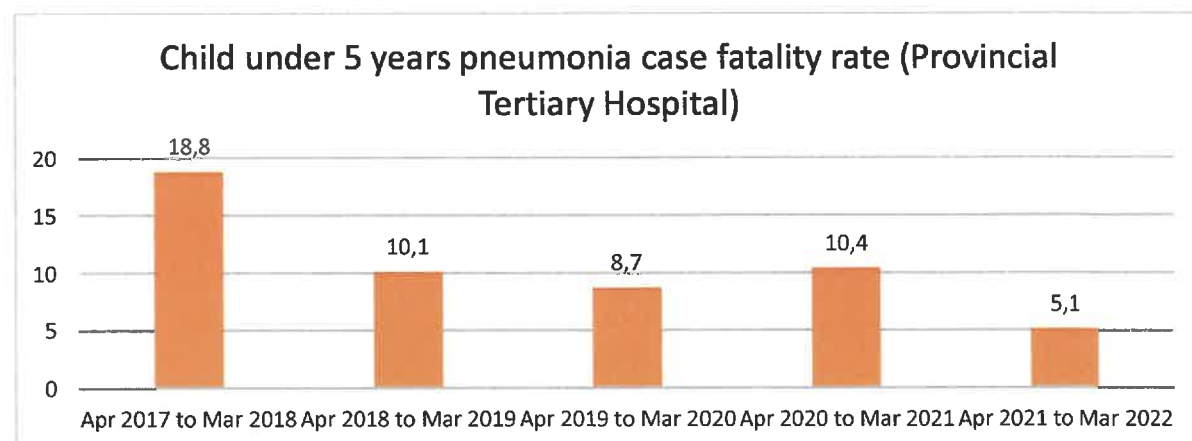


Figure 37. Child under years pneumonia case fatality - Tertiary hospitals (2017 - 2022)

Source: DHIS

Narrative:

Child under 5 years pneumonia case fatality rate (CFR) was the highest for provincial hospitals in 2017/18, followed by 2018/19 and 2020/21 and improved performance was realised in the 2021/22 financial year (as illustrated in Figure 37). Regional hospitals performance has (as in Figure 36) been high except in the financial year 2017/18 and 2018/19. The high performance is due to delayed presentation to facilities and poor implementation of clinical guidelines which will be addressed through strengthening community awareness on the importance of seeking medical care early and continuous in-service training on clinical guidelines and protocols. According to Figure 35, in district hospitals, the child under 5 pneumonia CFR indicator performed below the target of 3.5% in the last 5 financial years and was lowest (1.9%) in 2021/22 due to capacity building of medical officers by specialists from regional /tertiary hospitals through outreach visits.

Child under 5 years severe malnutrition fatality

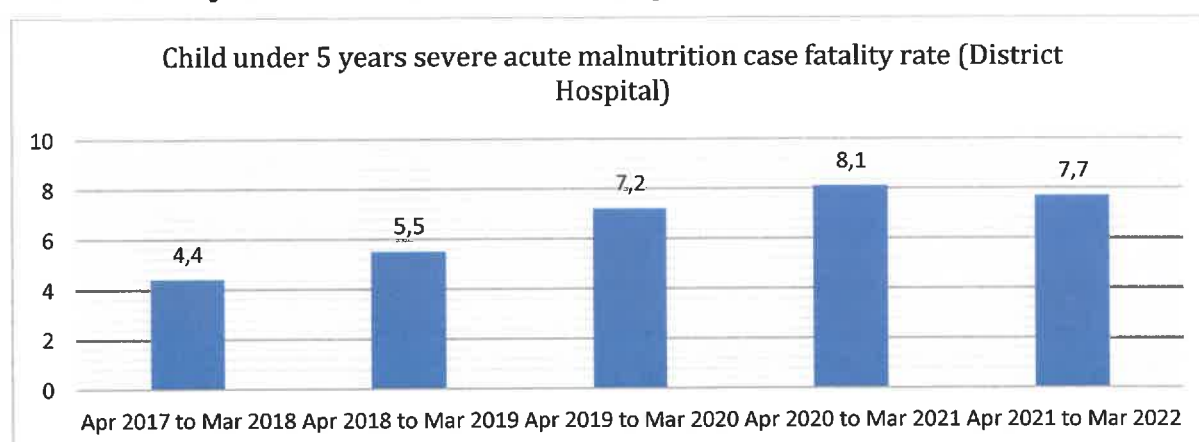


Figure 38. Child under 5 years severe malnutrition case fatality – District hospitals (2017 – 2022)

Source: DHIS

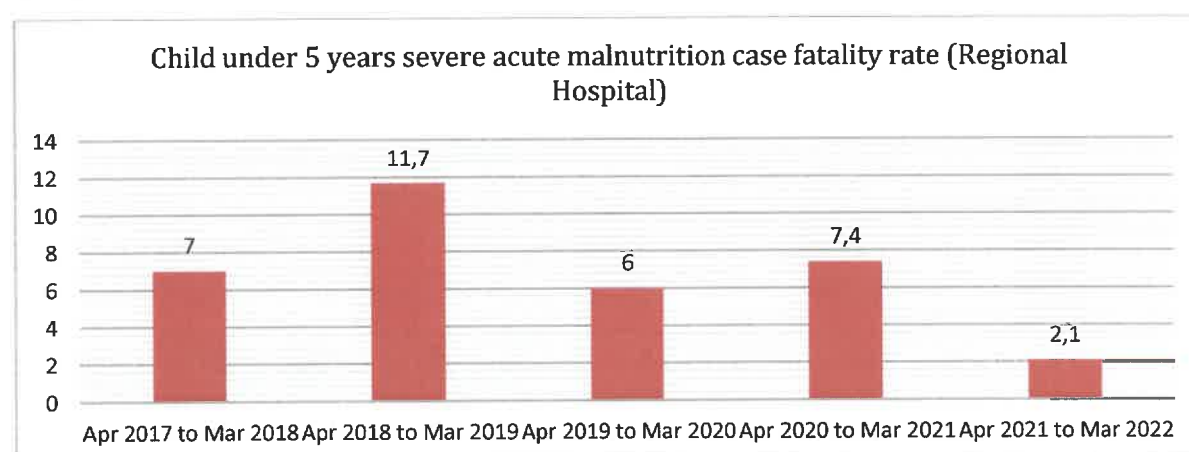


Figure 39. Child under 5 years severe acute malnutrition case fatality - Regional hospitals (2017 - 2022)

Source: DHIS

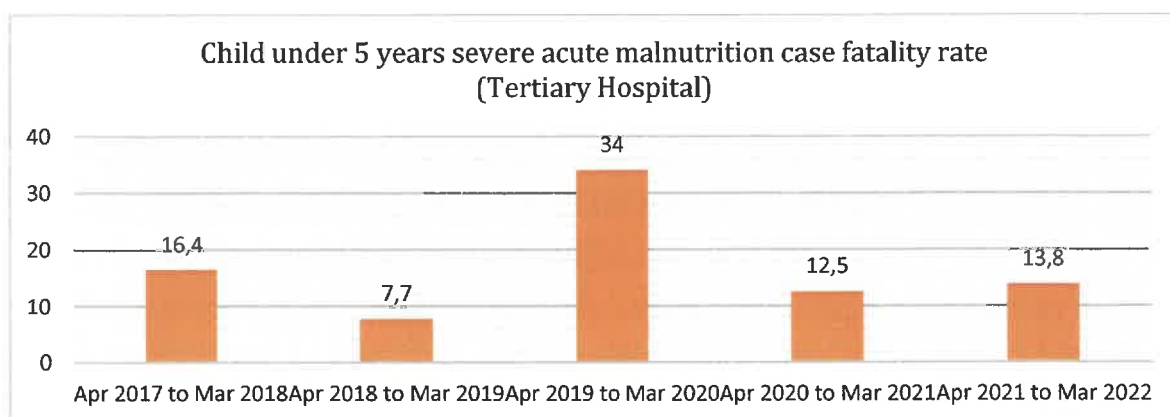


Figure 40. Child under 5 years severe acute malnutrition case fatality - Tertiary hospitals (2017 - 2022)

Source: DHIS

Narrative:

The indicator child under 5 years SAM case fatality rate in tertiary hospitals (as shown in Figure 40) has been high in the five financial years and peaked at 34% in 2019/20. There is also a gradual increase in SAM case fatality rate for district hospitals (as illustrated in Figure 38) which is attributed to delays in seeking healthcare and can be addressed through community awareness about malnutrition and the importance of seeking medical care early. Further, Figure 39 shows that there has been a decrease in the SAM case fatality rate in regional hospitals which was at its lowest level during 2021/22 against the target of 2.1%. This performance is linked to the multi-disciplinary team approach and compliance with protocols and guidelines.

Death under 5 years

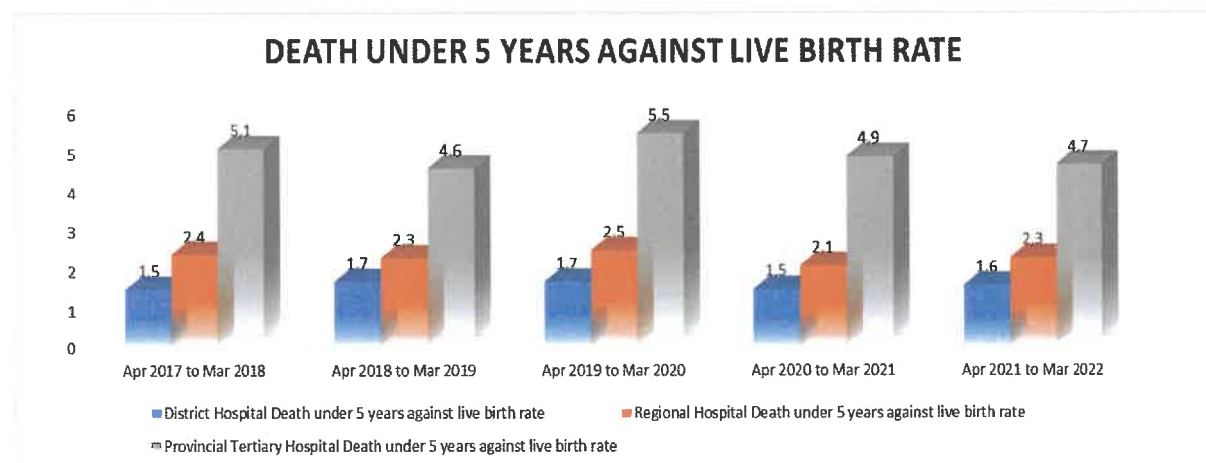


Figure 41. Death under years against live birth (2017 – 2022)

Source: DHIS

Narrative:

As depicted in Figure 41, the death rate under 5 years against live birth is higher in tertiary hospitals, followed by regional hospitals. Tertiary hospitals recorded the highest (5.5 per 1000 live birth) rate of death in the financial year 2019/2020 wherein in 2017/2018 performance was at 5.1 per 1000 live births due to extreme prematurity and congenital abnormalities. The regional hospitals had a slightly lower death rate when compared to the provincial tertiary hospitals. Regional hospitals performance hovered between 2.1 and 2.5 per 1000 live births. The district hospitals death rate of under 5 against live birth was the lowest and generally below the 1.7 per 1000 live births. However, in the financial year 2018/2019 and 2019/2020 recorded performance was at 1.7 per 1000 live births and in the latter years it decreased to 1.5 and 1.6 per 1000 live births. This performance is attributed to the capacity building among medical officers by specialists from regional /tertiary hospitals through outreach visits.

Infant PCR test positive

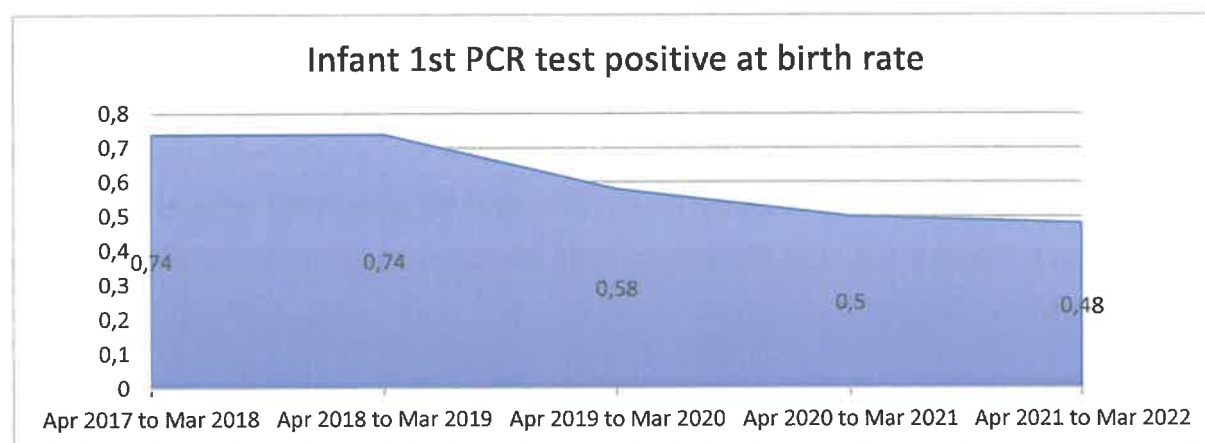


Figure 42. Infant PCR test positive at birth rate (2017 – 2022)

Source: DHIS

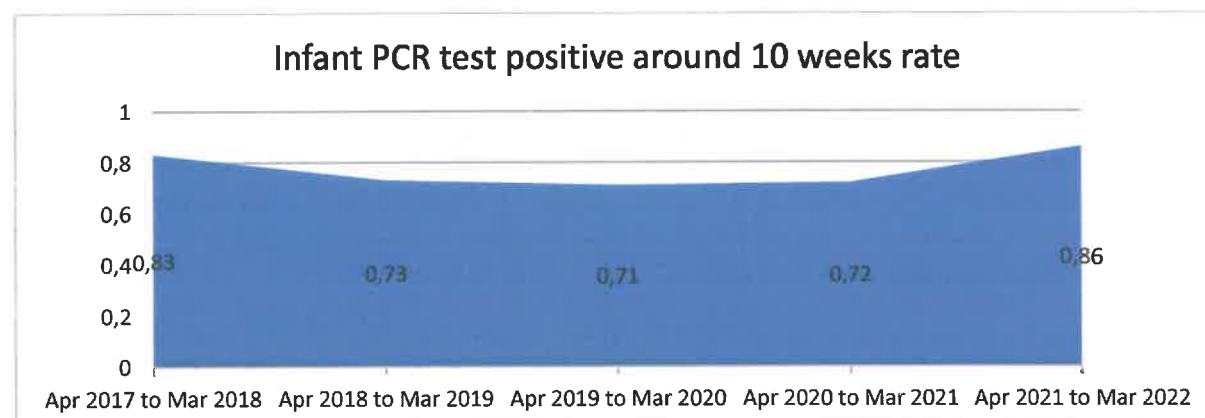


Figure 43. Infant PCR test positive around 10 weeks (2017 -2022)

Source: DHIS

Narrative:

As illustrated in both Figure 42 and 43, the infant PCR test positive at birth around 10 weeks rate has been steadily decreasing from 0.74% in the financial year 2017/2018 to below 0.48% in the financial year 2021/2022 due to routine ART initiation to HIV positive pregnant women in the province. The PCR test positive rate at 10 weeks has been above the target since 2017 to date due to ART treatment interruption by breastfeeding mothers during the postnatal period. This will be addressed through strengthening ART adherence and infant feeding support to breastfeeding mothers post-delivery.

Immunisation under 1-year coverage, Measles 2nd dose coverage, and Vitamin A 12-59 months coverage

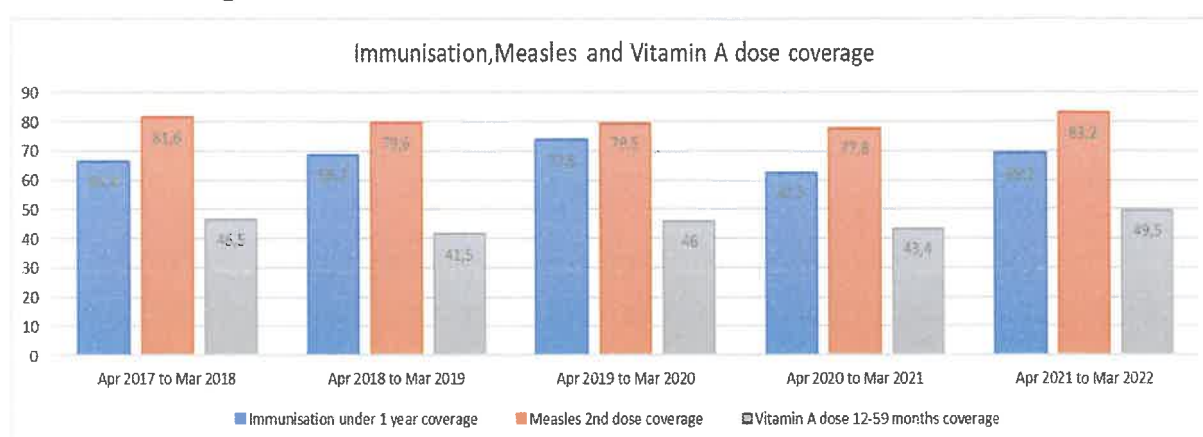


Figure 44. Immunisation, measles 2nd dose & Vitamin A 12 - 59 months (2017 - 2022)

Source: DHIS

Narrative:

According to Figure 44, the target for immunisation under 1-year coverage of 75% has not been achieved since 2017/18 due to a shortage of either BCG syringes or vaccines and will be addressed through vaccination catch-up drives when consumables are available and creating a buffer stock of consumables to overcome the supply challenges. Further, the department also achieved the target for measles 2nd dose coverage during 2017/2018 and 2021/2022 due to the availability of vaccines. In all the years reviewed, the target for vitamin A 12-59 months coverage was achieved due to the offering of Vitamin A at early childhood development centres.

8.3.5 HIV and AIDS

HIV positive 15-24 years (excl. ANC) rate

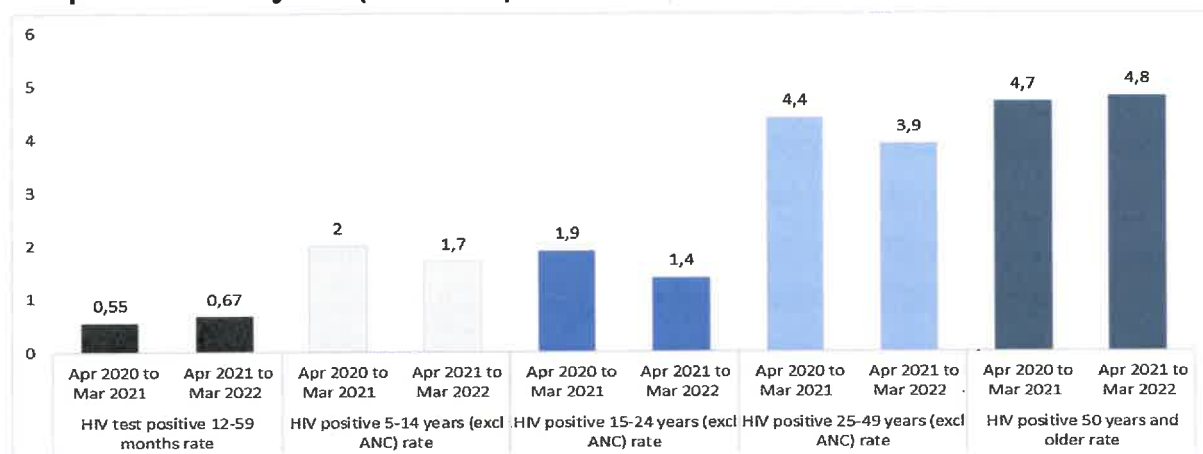


Figure 45. HIV positive 15-24 years (excl. ANC) rate

Source: DHIS

Narrative

The HIV test positive rate have been monitored since the financial year 2020/2021 at a target of 8%. As demonstrated in Figure 45, the rate of HIV test positives is higher for the 25-49 and the 50+ years at around 4% and 5% respectively for both financial years assessed. The 5-14- and 15-24-years old age group had an HIV test positive rate of around 2% for both the 2020/2021 and 2021/2022 financial years. This low rate of HIV incidence amongst the 15-24 years old age group is attributed to activities done by development partners to target and empower clients of this age group with HIV prevention interventions in non-health facilities. The HIV tested positive rate for children aged 12-59 months had the lowest (less than 1%) HIV test positive. The focus on adolescent and youth with interventions to curb HIV positivity has yielded results but Fig 45 reveals a gap among the older age-groups which show a higher positivity. Relevant interventions will be implemented to manage the older population.

HIV 90-90-90

Provincial Perspective

Narrative

There is an increase in the number of people living with HIV who knew their status as demonstrated in Figure 46. The 90% target of people living with HIV known status was reached in the last 3 financial years, achieving 90.2% respectively. The increase in people living with HIV who know their status was due to an increase in HIV testing which was

conducted through lay counsellors that have been placed in all our facilities and collaborations with developmental partners in upscaling HIV testing services.

In the last three financial years (2019/20 - 2021/22), there has been a gradual decrease in people living with HIV who are on antiretroviral therapy (ART). Although the target was achieved in the financial year 2017/18 and 2018/19, there was a decrease in people living with HIV on ART cascade by 36.6% between the financial year 2018/19 and 2021/22 largely due to the fear that gripped communities during the COVID-19 pandemic which affected access to services. The 90% target was not met in the last three financial years. The decrease in ART initiation was also due to poor data capturing in some facilities and will be addressed through regular data validations.

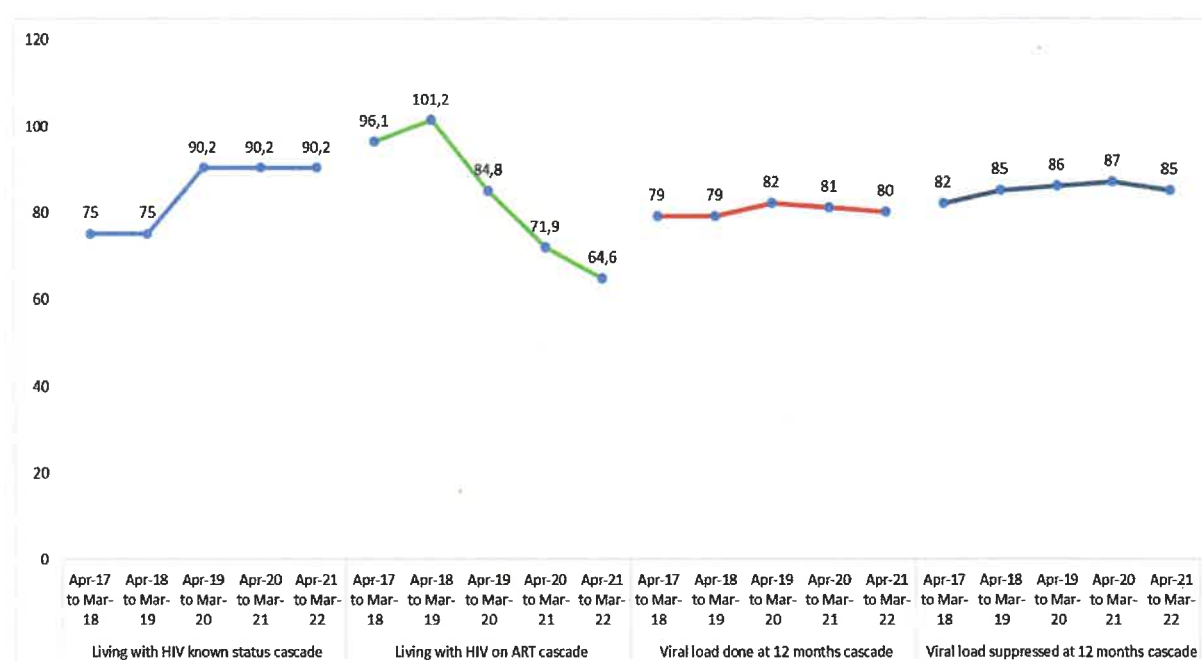


Figure 46. HIV 90-90-90 performance trends

Source: DHIS

Viral load done at 12 months cascade remained steady, ranging from 79% - 82% in the last 5 financial years. The 90% target was not met in all the financial years. This may be attributed to clinicians not adhering to clinical guidelines or poor recording and capturing of viral load. Out of those patients who did viral loads, the rate of virally suppressed remains constant, ranging between 82% and 87%, below the 90% target. The financial year 2020/2021 had the highest rate of HIV virally suppressed at 87%, followed by the financial year 2019/2020 at 86%. The financial year 2018/2019 and 2021/2022 recorded the same rate at 85%. The performance may be as a result of treatment interruption and poor adherence to treatment. This can be addressed through conducting step-up adherence on non-suppressors, tracking and tracing defaulters, and monitoring viral load closely.

ART outcome

Figure 47 below compares the outcome of antiretroviral therapy in adults (15+ years) and children (<15 years) population. In the last four financial years, ART adult remains in care rate was slightly lower than ART child remains in care rate in all the financial years. ART adults remained care rate was constant ranging from 61.2% - 62.6%. ART child remains in care rate has shown a gradual increase in the last three financial years (2018/19 - 2020/21), reaching a 71.5% rate in 2019/20 compared to 68.1% in the previous financial year (2019/20).

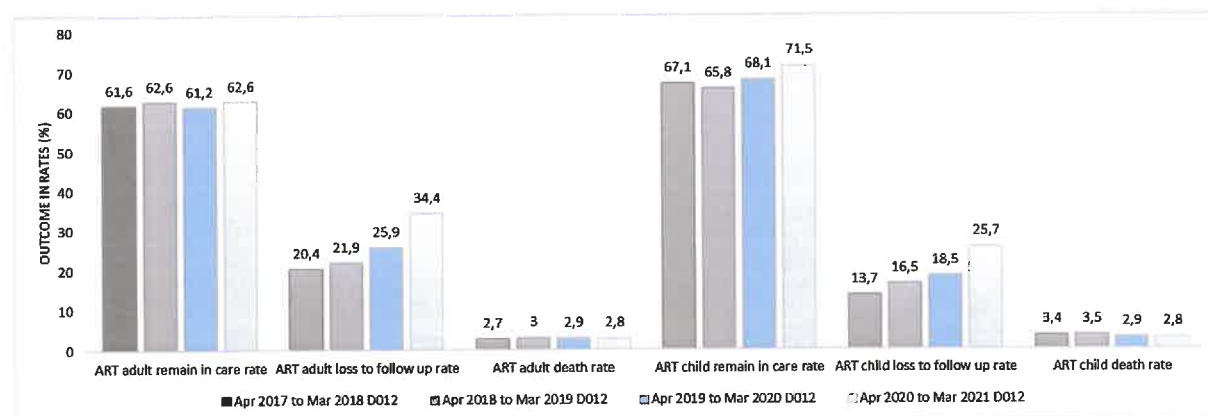


Figure 47. ART outcome performance trends, 2017 – 2021

Source: DHIS

Both ART adult and Child remain in care rate did not meet the 90% target in the financial year 2017/18 to 2020/21. The poor retention in care is inversely proportional to the loss to follow-up rate and can be addressed by monitoring the implementation of the 10- point plan through monthly reports by district and provincial CCMT program managers. The death rate of HIV patients on ART for both adults and children is below 4%. Children have a slightly higher death rate at an average of 3.1% as compared to adults at an average of 2.3%.

8.3.6 Tuberculosis

TB (90-90-90) Outcomes

DS-TB symptoms 5 years and older screened in facility rate has had a gradual increase, reaching a target of 90 in the financial year 2018/19 and 2019/20 however, there was a decline in 20/21 (see Figure 48). The decline during 2020/21 is attributed to the impact of COVID-19 pandemic lockdown levels. The DS-TB program integrated DS-TB screening into COVID-19 screening which increased the screening rate for the financial year 2021/22. DS-TB investigation done 5 years and older rate target were reached in the last 3 financial years. The achievement is related to the sustained implementation of the GX-pert and other TB diagnostic mediums such as X-Rays and U-LAM. The poor performance for the financial year 2017/18 and 2018/19 is attributed to the clinical stationery challenges resolved in 2019/2020.

The DS-TB treatment start rate has been surpassing the 90% target in the last 4 years 2018-2022. The program was performing at almost 99% for the financial years 2018/2019 and 2019/2020. There was a slight decrease (96.2%) in the financial year 2020/2021 of around 2%, however the following financial year it increased to 97.2%. This achievement is attributed to the active linkage of diagnosed TB patients to care and actioning of the line list from NHLS.

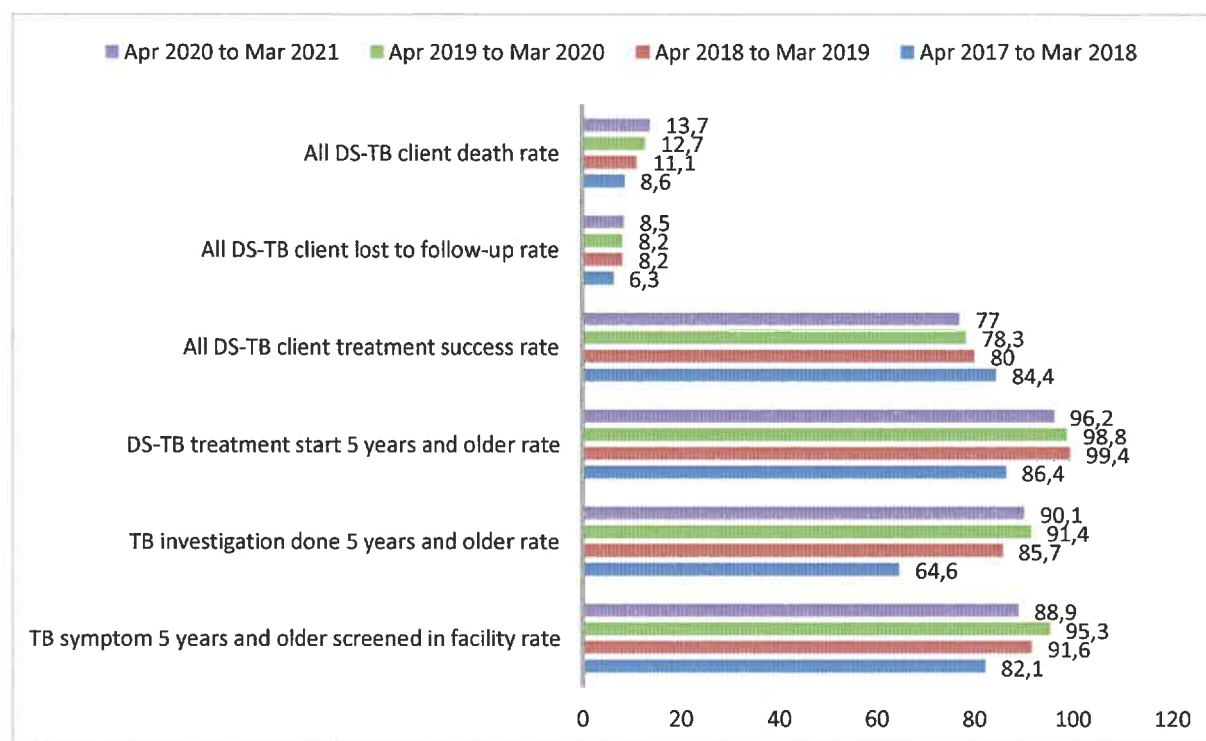


Figure 48. TB outcomes

Source:

The program has been struggling to successfully treat TB patients against the target of 90%. The TB success rate is on a downwards trend from 2017/18 (84.4%) to 2020/21 (77%) due to an increase in the loss to follow-up rate and death rates respectively. Therefore, implementing the strategies to reduce the loss to follow-up and death rates will increase the success rates.

The target for the DS-TB Loss to follow-up is at 8%, All the assessed years have been slightly above 8%. The poor achievement in the prior years was associated with treatment interruptions amongst patients who started treatment during the cohort. This can be addressed by monitoring TB patients' attachment to Directly Observed Treatment (DOT).

All DS-TB clients' death rates were last below the 10% target in the financial year 2017/2018 when the rate of death was 8.6%. In subsequent years, the DS-TB death rate has been performing above the target ranging from 11-13.5%. These high TB death rates are attributed to late presentation and late diagnosis of TB, especially in TB/HIV co-infected patients who

are very ill and will be addressed through monitoring the implementation of Urine TB diagnostic test (U-LAM) in all facilities for early TB diagnosis from HIV positive patients with advanced disease.

8.3.7 Audit control

In the audit year 2021/22, the department obtained a qualified audit opinion. The basis for the opinion was among others movable assets, contingent liability, performance information, and compliance with legislation. Key on assets management was the incorrect classification and valuation of assets as minor assets, resulting in major assets not being completely recognised. Further, sufficient appropriate supporting audit evidence could not be provided as fair valuation was not done using comparable base assets and the conditional assessment ratings used were not verifiable. In terms of contingent liability, the audit report showed that the department recorded litigations and claims by means of letters of demands and did not perform an assessment to determine the best estimate as at year end. Additionally, there were differences between the amount disclosed by the department and external confirmations.

On performance information, the audit report pointed that the achievements reported in the annual performance report materially differed from the supporting evidence provided in different indicators. In addition, limitation on evidence to support the reason for the variance between the planned target and the achievements reported was noted in the annual performance report for different indicators. In compliance with the legislation, it is noted that the financial statements that were submitted for auditing were not prepared in accordance with the prescribed financial reporting framework and/or supported by full and proper records. Among others raised on compliance is that no effective and appropriate steps were taken to prevent irregular expenditure and collect all money due, and no reasonable steps were taken to recover debts before writing them off.

In improving the audit outcome in the next audit year, the department will embark on several interventions that include the regular performance and budget reviews to address the above audit issues. In improving assets management, the department will *inter alia* ensure that there is preparation of an asset register outside the system where the description of the assets will be updated to provide more detail on the characteristics of the asset; valuation of assets is brought back into the register during the physical verification process; and reconcile current expenditure bi-weekly (after every payment run) and process journals to correct misclassifications. For contingent liabilities, the department is reviewing the medico-legal contingent liabilities procedure manual. Further the department is in contact with other provinces that were not qualified on contingent liabilities to help with benchmarking the processes and improving the disclosure note.

Furthermore, AOPO audit outcome will be improved by ensuring that from facility level data reconciliation and verification is conducted monthly and submitted up to the district. At the district level, a review of the reconciliations from the facilities will be conducted to confirm the accuracy of the reconciliations. Thereafter, all reviewed reconciliations by the districts will send to the provincial office team (information and M&E) for further analysis. The provincial office team will prepare an analysis/summary of the issues identified (if any) with the recommendations to correct the issues and communicate those issues in the monthly meeting. A training/workshop to emphasize on the awareness and importance of the role of each official in the final reporting in the annual performance report will be conducted. Management will also communicate the Audit report and the management report annexures to all officials to ensure awareness of their role in the audit outcomes. This will be followed by a development of an Standard Operating Procedure (SOP) detailing the activities of the audit and the consequence management for officials that are not fulfilling responsibilities assigned to them.

8.3.8 Overview of the 2022/23 budget and MTEF estimates

The Department has been allocated an amount of R23.8 billion in the 2023/24 financial year to deliver the healthcare services in Limpopo Province. The overall health budget increased from R22.7 billion in the 2022/23 financial year to R23.8 billion in 2023/24. This indicates an overall increase of 4.6%.

The budget has grown from R23.8 billion in 2023/24 to R25.3 billion in the year ending 2025/26. This represents a cumulative increase of 3.6% against the cumulative Consumer Price Index projection of 4.8%. The funding 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: -

- Funding of the maintenance of facilities and equipment;
- Medicines including vaccines;
- Blood and laboratory services;
- Security services; and
- Health technology equipment.

8.3.8.1 Equitable share

The equitable share analysis (on the allocation letter for 2023 MTEF) reflects that R2.3 billion has been reduced from the 2023/24 financial year. This trend is carried forward from the 2022 MTEF. The Department won't be able to introduce new projects in the current MTEF until the baseline is recovered. The nominal growth rate is reflected as 7.1% and 1.9% in 2023/24 and 2024/25 respectively whereas the cumulative growth of 4.5% from 2022/23 to 2025/26 is realised. The provided guide for CPI is set at 5.1%; 4.6% and 4.6% in 2023/24; 2024/25 and 2025/26 respectively. This situation means the Department is expected to continue rendering the services with tight fiscal resources.

8.3.8.2 Conditional grants

The total conditional grants allocation decreases by 6.4% , a growth of 0.9% and 4.5% in the 2023/24 , 2024/25 and 2025/26 financial years respectively. The reduction is mainly due to the absence of allocation on COVID-19 subcomponent throughout the 2023 MTEF. The allocation of conditional grants will assist the department in augmenting the equitable share budget in terms of building, refurbishment and maintenance of health facilities in the Department. The department

will ensure that services that are fundable under conditional grants are so allocated to reduce pressure from equitable share.

8.3.8.3 Expenditure estimates

Table 11. Expenditure estimates

	Programme R'000	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimate		
		2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
1.	Administration	298 186	275 706	283 486	294 218	295 865	312 158	298 951	303 990	317 697
2.	District Health Services	13 801 825	14 117 219	14 488 316	14 864 241	15 367 693	15 351 400	15 462 483	16 058 461	16 703 868
3.	Emergency Medical Services	817 796	855 667	903 533	906 066	994 571	994 571	1 303 667	1 088 841	1 121 774
4.	Provincial Hospital Services	2 636 859	2 664 559	2 771 320	2 775 384	2 801 286	2 801 286	2 913 703	2 976 605	3 089 959
5.	Central Hospital Services	2 018 364	1 998 220	2 108 496	1 938 421	2 091 901	2 091 901	2 105 014	2 155 384	2 249 790
6.	Health Sciences and Training	486 064	544 615	498 873	810 717	713 654	713 654	683 946	662 447	707 967
7.	Health Care Support Services	142 498	586 189	569 226	374 599	228 222	228 222	150 786	157 057	164 095
8.	Health Facilities Management	807 705	986 224	1 284 533	759 965	1 098 367	1 098 367	851 637	789 757	850 684
	Sub-total									
	Direct charges against the National Revenue Fund	1 978	1 978	1 978	1 978	2 037	2 037	2 037	2 037	2 037
	Total									

	Change to 2010/11 budget estimate	21 011 275	22 030 377	22 909 761	22 725 589	23 593 596	23 593 596	23 772 224	24 194 579	25 207 871
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Table 12. Summary of provincial expenditure estimates by economic classification

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
Current payments	20 215 880	20 960 648	21 957 356	21 554 107	22 509 875	22 549 861	22 590 022	23 319 097	24 271 012
Compensation of employees	15 048 215	14 966 409	15 406 490	16 718 977	16 602 161	16 602 161	16 447 701	16 712 537	17 092 312
Goods and services	5 167 665	5 994 239	6 550 866	4 835 130	5 907 714	5 947 700	6 142 321	6 606 560	7 178 700
Communication	68 731	76 632	88 099	87 480	88 731	90 236	88 573	96 931	119 774
Computer Services	124 243	139 887	118 018	143 396	148 396	91 099	172 453	179 771	202 825
Consultants Contractors and special services	50 408	102 747	64 531	90 823	152 380	155 149	96 650	95 217	109 335
Inventory	2 324 082	3 060 192	2 825 906	2 413 767	2 506 059	2 589 260	2 646 199	2 928 466	3 068 544
Operating leases	12 896	11 628	13 101	11 415	12 517	12 732	15 793	15 456	16 298
Travel and subsistence	51 445	21 359	55 808	55 504	41 369	71 678	50 734	63 564	45 175
Maintenance repair and running costs	161 251	149 892	168 443	121 272	138 072	152 587	171 750	177 903	189 873
Specify other	2 374 609	2 431 902	3 216 960	1 911 473	2820190	2784959	2900169	3049252	3426876
Transfers and subsidies to	307 421	342 760	335 844	299 967	264 016	268 295	253 251	219 607	229 354
Provinces and municipalities	1 848	1 509	1 940	1 688	1 688	1 792	2 049	2 167	2 263
Departmental agencies and accounts	83 572	79 233	106 306	18 486	--	42 890	20 000	25 000	26 120
Universities and technikons									
Households	222 001	262 018	227 598	279 793	262 328	223 613	231 202	192 440	200 971

Payments for capital assets	483 745	726 277	615 291	871 515	819 705	775 440	928 951	655 875	707 505
Buildings and other fixed structures	257 995	353 729	217 143	543 528	371 230	371 230	307 182	306 858	320 605
Machinery and Equipment	225 750	372 548	398 148	327 987	448 475	404 210	621 769	349 017	386 900
Payment of Financial asset	4 229	692	1 270	-	-	-	-	-	-
Total economic classification	21 011 275	22 030 377	22 909 761	22 725 589	23 593 596	23 593 596	23 772 224	24 194 579	25 207 871

Relating expenditure trends to specific goals

Table 13. Trends in provincial public health expenditure (R'000)

Expenditure	Audited/actual			Main Appropriation	MTEF projection		
	2019/20	2020/21	2021/22		2023/24	2024/25	2025/26
Current prices ¹							
Total ²	21 011	22 030	22 910	22 726	23 772	24 194	25 208
Total per person	3,97	4,24	4,50	4,47	4,67	4,75	4,95
Total per uninsured person	3,74	3,92	4,08	4,05	4,23	4,31	4,49
Constant (2008/09) prices ³							
Total ²	23 322	24 233	21 765	20 453	20 444	20 807	21 679
Total per person	4,3	4,5	4,0	3,8	3,8	3,9	4,0
Total per uninsured person	21 550	22 391	20 110	18 899	18 890	19 226	20 031
% Of Total spent personon:							
DHS	15,7%	19,1%	20,8%	22,5%	23,1%	23,8%	22,9%
PHS	4,2%	4,4%	4,6%	4,5%	4,6%	4,7%	4,6%
CHS	2,7%	3,1%	3,5%	4,0%	4,1%	4,2%	4,0%
All personnel	17,3%	19,5%	20,8%	22,3%	21,3%	21,0%	20,1%
Capital	3,3%	4,9%	4,3%	5,7%	5,4%	5,3%	5,1%
Health as a % of total public expenditure	45,4%	43,5%	41,9%	40,5%	41,6%	42,0%	43,1%

Part C: Measuring Our Performance Institutional Programme Performance Information

Programme 1: Administration 1.1 Purpose

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

Table 14. Administration outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets				
			2019/20	2020/21	2021/22		2023/24 Quarterly Targets				2025/26
							Q1	Q2	Q3	Q4	
1. Improve financial management	Audit outcome for regulatory audit expressed by AGSA for 2022/2023 financial year	1.1 Audit opinion of Provincial DoH	Unqualified audit opinion	Qualified audit opinion	Qualified audit opinion	Unqualified audit opinion	Unqualified audit opinion	-	-	Unqualified audit opinion	Unqualified audit opinion
		Numerator:	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-
	Compliance to payment of suppliers within 30 days	1.2 Percentage compliance to payment of suppliers within 30 days	85%	96%	96%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-
Credible asset registers		Denominator:	-	-	-	-	-	-	-	-	-
		1.3 Percentage completeness of asset register	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26	
								Q1	Q2	Q3	Q4			
		Denominator:	-	-	-	-	-	-	-	-	-	-	-	
Total revenue collected		1.4 Revenue collected	R 207.8million	R162.2m	R180.9m	R201.6m	R210.3m	R51.0m	R39.0m	R44.8m	R75.5m	R220.6m	R231.6m	
		Numerator:	-	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-	-

Explanation of Planned Performance over the Medium-Term Period:

- The achievement of the outputs will contribute towards an improved audit outcome.
- The output indicators in programme 1 provide an appropriate measure for monitoring as well as improving the departmental audit outcomes. An audit action plan is developed each year to address the audit findings raised by AGSA.

1.2 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 15. Administration - Expenditure estimates

Sub-programme	Expenditure outcome		Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21				2023/24	2024/25	2025/26
R' thousand								
MEC's Office	1 978	1 978	1 978	2 037	2 037	2 037	2 037	2 037
Management	298 186	275 706	283 486	295 865	312 158	298 951	303 990	317 697
Corporate Services								
Property Management								
TOTAL	300 164	277 684	285 464	297 902	314 195	300 988	306 027	319 734

Table 16. Administration - Summary of provincial expenditure estimates by economic classification

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
Current payments	288 823	275 208	280 406	294 143	296 149	312 442	299 087	304 050	317 669
Compensation of employees	250 040	240 293	237 808	261 138	253 167	253 167	258 197	261 197	266 898
Goods and services	38 783	34 915	42 598	33 005	42 982	59 275	40 890	42 853	50 771
Communication	6 425	6 505	10 457	7 445	7 445	11 909	10 754	9 698	12 132
Computer Services	-	-	102	-	-	726	-	-	-
Consultants Contractors and special services	510	47	518	-	-	44	-	-	-
Inventory	438	41	100	45	30	30	0	0	0
Operating leases	2 128	4 012	3 854	2 618	2 918	3 352	3 788	2 994	3 128
Travel and subsistence	6 350	3 925	6 288	2 900	2 900	21 394	-	-	-
Maintenance repair and running costs	-	77	-	134	134	134	244	256	267
Specify other	22 932	20 308	21 279	19 863	29 555	21 686	26 104	29 905	35 244
Transfers and subsidies to	6 093	1 170	2 387	1 590	1 590	1 590	1 601	1 677	1 752
Provinces and municipalities	57	33	77	35	35	35	30	31	32
Departmental agencies and accounts	-								
Universities and technicians									
Households	6 036	1 137	2 310	1 555	1 555	1 555	1 571	1 646	1 720
Payments for capital assets	1 019	614	1 401	463	163	163	300	300	313
Buildings and other fixed structures									
Machinery and Equipment	1 019	614	1 401	463	163	163	300	300	313

Payment of Financial asset	4 229	692	1 270	-	-	-	-	-	-
Total economic classification	300 164	277 684	285 464	296 196	297 902	314 195	300 988	306 027	319 734

1.3 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 R863.3 million from 2019/20 to 2021/22 while the 2021/22 budget amounts to R296.2 million. The proposed MTEF from 2023/24 to 2025/26 projected at R926.7 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.

1.4 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Improve financial management	Ineffective procurement processes	• Implementation of procurement plan • Revisiting of th • e processing of procuring emergency goods and services
	Unwanted expenditures (Irregular and unauthorised expenditures)	• Request adequate funding • Conduct training on financial management • Apply corrective measures for non-compliance
	Inadequate asset management	• Take action for non-compliance

		• Monitoring the effective implementation of BAUD system • Provide awareness on assets management procedure manuals
	Abuse of overtime	• Enforce compliance to departmental policies • Improve supervisory mechanism • Apply corrective measures for non-compliance

Programme 2: District Health Services

2.1 Purpose

The main objectives of the programme are the planning, managing and administering district health services; and rendering primary health care services; hospital services at district level; MCWH and nutrition programme; prevention and disease control programme; and a comprehensive HIV and AIDS, STI and TB programme.

2.2 Sub-programme: Primary Healthcare Services

2.2.1 Purpose

Strengthening provisioning of PHC services through coordination and integration of existing municipal ward-based outreach teams in the districts.

Table 17. PHC Outcome, outputs, output indicators and Targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Patient experience of care in public health facilities Improved	Patient experience of care survey satisfied responses	1.1 Patient experience of care satisfaction rate (PHC)	New indicator	80.6%	81%	65%	82%	-	82%	-	-	83%	84%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
Management of patient safety incidents improved to reduce new medico-legal cases	Severity assessment code (SAC) 1 incident reported within 24 hours	2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
	Patient safety incident (PSI) case closed	2.2 Patient safety incidents (PSI) case closure rate	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	100%	100%	100%	100%
Numerator:		-	-	-	-	-	-	-	-	-	-	-	
		Denominator:	-	-	-	-	-	-	-	-	-	-	-

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Health facilities ready for NHI accreditation	Fixed health facilities that have obtained ideal clinic status (silver, gold, platinum)	1.2 Ideal clinic status obtained rate	14.7%	18.1%	21.9%	15%	20%	-	-	-	20%	30%	40%
		Numerator:	61	72	105	71	96	-	-	-	96	145	193
		Denominator:	413	480	480	482	482	-	-	-	482	482	482

Explanation of Planned Performance over the Medium-Term Period:

- The outputs contribute towards improving the quality of health care services offered to patients and preparing PHC facilities for the NHI roll-out.
- The selected output indicators allow for monitoring of the quality of healthcare received by the patients and progress made to realise the ideal clinic status rate for NHI implementation.
- The department will strengthen efforts towards having more clinics become ideal and ascertain that those that are ideal maintain their status.

2.3 Sub-programme: District Hospitals

2.3.1 Purpose

To provide level 1 hospital services and support the PHC facilities within the catchment area.

Table 18. District hospitals outcomes, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				
								Q1	Q2	Q3	Q4	
1a. Patient experience of care in public health facilities improved	Patient experience survey satisfied responses	1.1 Patient experience of care satisfaction rate	New indicator	80.1%	79%	80%	80%	-	80%	-	81%	82%
		Numerator:	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-
2. Management of patient safety incidents improved to reduce new medico-legal cases	Severity assessment code (SAC) 1 incident reported within 24 hours	2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	New indicator	94.6%	91.8%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-
	Patient safety incident (PSI) case closed	2.2 Patient safety incidents (PSI) case closure rate	New Indicator	97.2%	99.8%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-

Explanation of Planned Performance over the Medium-Term Period:

- The outputs contribute towards improving the quality of healthcare service offerings in district hospitals as well as strengthening efforts towards the reduction of child and maternal mortalities.
- The selected output indicators will help monitor the quality of care offered to patients at the level of a district hospital in order to reduce incidents of adverse events and monitor trends towards reduced child and maternal mortalities.
- The department will develop and implement the quality improvement plan to address matters of quality of care raised by patients and other stakeholders in each health facility.

2.4 Sub-programme: HIV and AIDS, STI Control (HAST) -

2.4.1 Purpose:

To strive for the combat of HIV and AIDS and decreasing the burden of diseases from TB and other communicable diseases.

Table 19. HAST outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. AIDS related deaths reduced by implementing the 90-90-90 strategy	HIV positive 15-24 years (excl. ANC)	1.1 HIV positive 15-24 years (excl. ANC) rate	New indicator	1.9%	1.4%	4.39%	2%	2%	2%	2%	1.8%	1.6%	
		Numerator:	-	-	-	9958	7530	-	-	-	7107	6633	
		Denominator:	-	-	-	226800	376040	-	-	-	394842	414584	
		1.2 ART adult remain in care rate (12 months)	New indicator	60.3%	61.7%	90%	90%	90%	90%	90%	90%	90%	
	ART adult remain in care – total	Numerator:	-	25126	20304	32 008	25349	-	-	-	26730	26784	
		Denominator:	-	41638	32901	35 564	28166	-	-	-	29700	29760	
		1.3 ART child remain in care rate (12 months)	New indicator	67.3%	67.3%	90%	90%	90%	90%	90%	90%	90%	
		Numerator:	-	855	526	1 058	756	-	-	-	771	812	
	ART adult viral load under 50	Denominator:	-	1270	781	1 176	840	-	-	-	857	902	
		1.4 ART Adult viral load suppressed rate (12 months)	New indicator	87.4%	86.7%	90%	90%	90%	90%	90%	90%	90%	
Numerator:		-	17660		25 926	20533	-	-	-	21651	21695		
Denominator:		-	20201		28 807	22815	-	-	-	24057	24106		
ART child viral load under 50	1.5 ART child - viral load suppressed rate (12 months)	New indicator	55.6%	66.5%	90%	90%	90%	90%	90%	90%	90%		
	Numerator:		317	216	857	612	-	-	-	625	658		

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance				Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
									Q1	Q2	Q3	Q4		
TB mortality reduced by 75%		Denominator:		570	350	953	680	-	-	-	-	694	731	
	All DS-TB client loss to follow-up	1.6 All DS-TB client LTF rate	8.4%	9.8%	8.5%	8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.5%	7%	
		Numerator:	972	1036	695	843	945	-	-	-	-	892	848	
		Denominator:	11574	10532	8186	10532	11764	-	-	-	-	11881	12118	
		1.7 All DS-TB client treatment success rate	78.5%	76.9%	77%	78%	78.5%	78.5%	78.5%	78.5%	78.5%	79%	79.5%	
	TB Rifampicin resistant/Multidrug – resistant success	Numerator:	9085	8104	6304	8215	9235	-	-	-	-	9386	9634	
		Denominator:	11574	10532	8186	10532	11764	-	-	-	-	11881	12118	
		1.8 TB Rifampicin resistant/Multidrug – Resistant treatment success rate	New indicator	New indicator	New indicator	New indicator	65.2%	65.2%	65.2%	65.2%	65.2%	66%	66.8%	
		Numerator:	-	-	-	-	188	-	-	-	-	172	167	
	Denominator:	-	-	-	-	288	-	-	-	-	260	250		
TB Rifampicin resistant/Multidrug – Resistant lost to follow-up	1.9 TB Rifampicin resistant/Multidrug – Resistant lost to follow-up rate	New indicator	New indicator	New indicator	New indicator	8%	8%	8%	8%	8%	7.8%	7.6%		
	Numerator:	-	-	-	-	23	-	-	-	-	20	19		
	Denominator:	-	-	-	-	288	-	-	-	-	260	250		
	1.10 TB Pre-XDR treatment success rate	New indicator	New indicator	New indicator	New indicator	60%	60%	60%	60%	60%	61%	62.5%		
		Numerator:	-	-	-	-	12	-	-	-	11	10		

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
							Q1	Q2	Q3	Q4			
		Denominator:	-	-	-	-	20	-	-	-	-	18	16
	TB Pre-XDR loss to follow up	1.11 TB Pre-XDR loss to follow up rate	New indicator	New indicator	New indicator	New indicator	12%	12%	12%	12%	12%	10%	6.3%
		Numerator:	-	-	-	3	-	-	-	-	-	2	1
		Denominator:	-	-	-	25	-	-	-	-	-	20	16

Explanation of Planned Performance over the Medium-Term Period:

- The outputs aim to achieve an empowered and healthy population by improving the health outcomes of clients affected by HIV and TB.
- The output indicators track key performance in reducing morbidity and mortality because of TB and HIV. The assumption is that medicine availability will be sustained at the required levels.
- In achieving the set performance, the department will among others intensify patient tracing through community health workers (CHW) and stakeholders as well as the implementation of the Finding Missing TB Patients strategy. The department will as well strengthen the implementation of the Direct Observed Treatment (DOT) strategy for all TB patients. In addition, the department will ascertain the effective roll-out of U-LAM at Primary Healthcare facilities. Retention of patients on treatment will be closely observed in achieving the last two 90-90 of the 90-90-90 strategy based on historical performance as demonstrated in Part B of the plan.

2.5 Sub-programme: Mother, Child, Women Health and Nutrition (MCWH&N)

2.5.1 Purpose

To steer interventions for the reduction of maternal and child morbidity and mortality.

Table 20. MCWH&N outcome, outputs, output indicators and targets

Outcome (as per Sp 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. Maternal, Neonatal, and Child Mortality reduced	Couple year protection	1.1 Couple year protection rate	55%	46.8%	51.9%	50%	55%	55%	55%	55%	60%	65%	
		Numerator:	931328.1	1160859	810094.8	847365	858977	-	-	-	-	937066	1015154
	Denominator:	1678459.5	1694730	1561776	1694730	1561776	-	-	-	-	1561776	1561776	
	Delivery 10-19 years in facility	1.2 Delivery 10 to 19 years in facility rate	14.1%	13.8%	13.5%	14%	13.5%	13.5%	13.5%	13.5%	13%	12%	
		Numerator:	18810	19405	18070	19653	18086	-	-	-	-	17416	16077
	Denominator:	133455	140384	133971	140384	133971	-	-	-	-	133971	133971	
Antenatal 1 st visit before 20 weeks	1.3 Antenatal 1st visit before 20 weeks rate	69%	66.8%	66.7%	67%	68%	68%	68%	68%	70%	72%		
		Numerator:	93967	94604	84368	94868	86029	-	-	-	-	88559	91089
	Denominator:	136160	141594	126513	141594	126513	-	-	-	-	126513	126513	
	Mother postnatal visit within 6 days	1.4 Mother postnatal visit within 6 days rate	104.2%	94.7%	95.2%	96%	97%	97%	97%	97%	98%	98%	
Numerator:		139084	133564	127534	134769	129952	-	-	-	-	131292	131292	
Denominator:	133455	140384	133971	140384	133971	-	-	-	-	133971	133971		
Maternal, Neonatal, Infant and Child Mortality reduced	Maternal death in facility	1.5 Maternal Mortality in facility ratio	97.8/100000	New Indicator	New Indicator	New Indicator	115/100000 live births	-	-	115/100 000 live births	112/ 100 000 live births	110/100 000 live births	

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance				Estimated Performance	MTEF Targets							
			2020/21		2021/22	2022/23		2023/24	2023/24 Quarterly Targets				2024/25	2025/26	
									Q1	Q2	Q3	Q4			
		Numerator:	-	-	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-	-	-
	Neonatal deaths in facility	1.6 Neonatal death in facility rate	14.3 per 1000 live births	12.7 per 1000 live births	13.2 per 1000 live births	12 per 1000 live births	12 per 1000 live births	12 per 1000 live births	12 per 1000 live births	12 per 1000 live births	12 per 1000 live births	11.8 per 1000 live births	11.5 per 1000 live births		
		Numerator:	-	-	-	-	-	-	-	-	-	-	-	-	
	Diarrhoea death under 5 years	1.7 Child under 5 years diarrhoea case fatality rate	2.8%	New Indicator	New Indicator	New Indicator	2.3%	2.3%	2.3%	2.3%	2.3%	2.1%	1.9%		
		Numerator:	134	-	-	-	-	75	-	-	-	69	62		
	Pneumonia death under 5 years	1.8 Child under 5 years pneumonia case fatality rate	4846	-	-	-	-	3281	-	-	-	3281	3281		
		Numerator:	154	-	-	-	-	72	-	-	-	66	58		
	Severe acute (SAM) death under 5 years	1.9 Child under 5 years severe acute malnutrition case fatality rate	5637	-	-	-	-	2883	-	-	-	2883	2883		
		Numerator:	124	-	-	-	-	70	-	-	-	67	64		
Death in facility under 5 years	1.10 Death under 5 years against live birth rate	New indicator	New indicator	New indicator	New indicator	1.5	1.5%	1.5%	1.5%	1.5%	1.4	1.3			
	Numerator:	-	-	-	-	-	1996	-	-	-	1864	1750			

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
		Denominator:	-	-	-	-	133099	-	-	-	-	133099	133099
	Live birth under 2500g in facility	1.11 Live birth under 2500g in facility rate	New indicator	10.7 per 1000 live births	10.6 per 1000 live births	12%	12%	12%	12%	12%	11.5%	11%	
		Numerator:	-	-	-	-	10140	-	-	-	-	9295	
		Denominator:	-	-	-	-	84502	-	-	-	-	84502	
	Infant PCR test positive under 5 years	1.12 Infant PCR test positive around 6 months rate	New indicator	New indicator	New indicator	New indicator	0.8%	0.8%	0.8%	0.8%	0.7%	0.6%	
		Numerator:	-	-	-	-	174	-	-	-	-	130	
		Denominator:	-	-	-	-	21657	-	-	-	-	21657	
	HIV test positive under 5 years	1.13 HIV test positive around 18 months rate	New indicator	New indicator	New indicator	New indicator	0.8%	0.8%	0.8%	0.8%	0.7%	0.6%	
		Numerator:	-	-	-	-	192	-	-	-	-	144	
		Denominator:	-	-	-	-	23891	-	-	-	-	23891	
Immunised fully under 1 year	1.14 Immunisation under 1 year coverage	73.8%	60.6%	69.2%	75%	75%	75%	75%	75%	76%	77%		
	Numerator:	96 010	79390	86468	93909	91000	-	-	-	-	96817		
	Denominator:	129 669.75	131028	124972	125213	125709	-	-	-	-	127391		
Measles 2 nd dose	1.15 Measles 2nd dose 1 year coverage	79%	76.4%	83.2%	80%	87%	87%	87%	87%	90%	95%		
	Numerator:	104430	100459	105881	99995	109367	-	-	-	-	113769	121021	

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
		Denominator:	131634.75	131557	127327	124994	125709	-	-	-	-	126410	127391
Stunting among children reduced	Vitamin A dose 12-59 months	1.16 Vitamin A dose 12-59 months coverage	46.5%	43.6%	49.5%	45%	60%	60%	60%	60%	60%	62%	64%
		Numerator:	496909	409577	520672	23849	631082	-	-	-	-	652118	67154
		Denominator:	1066533	529986	1051804	529986	1051804	-	-	-	-	1051804	1051804

Explanation of Planned Performance over the Medium-Term Period:

- The health of mothers and children remains a priority for the health sector in the attainment of life expectancy. The outputs are key in measuring the women and child health trends. These trends are used to strengthen efforts to reduce both child and maternal mortalities.
- Prevention and promotion of women's and children's health through family planning, early ANC visits and children's vaccination are essential in improving morbidity and reducing mortality among the target groups. Measuring institutional mortalities will aid in the disaggregation of maternal and child mortalities to facilities in order to attach the accountability of mortalities to referring institutions rather than pointing accountability only to the Tertiary Hospitals.
- The department intends to achieve the targets through among others increasing access to reproductive health services wherein youth are a target population. Approaches such as the Youth Friendly Services (YFS) and SHE Conquers campaigns will be used to reach out to the target population. In terms of neonates' care, the department is implementing the Maternal and Child Centre of Excellence (MCCE) to improve infrastructure for neonatal health services. In addition, the department will conduct awareness campaigns on the prevention of unplanned and unwanted pregnancies including the use of family planning methods. Furthermore, the department will increase awareness in communities on the management of childhood illnesses through among others the ward-based outreach teams.

2.6 Sub-programme: Disease Prevention and Control

2.6.1 Purpose

To ensure prevention and control of the non-communicable disease.

Table 21. DPC outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26	
								Q1	Q2	Q3	Q4			
1. Malaria eliminated by 2023	Malaria deaths reported	1.1 Malaria case fatality rate	0.63%	0.55%	0.43%	<1%	<1%	<1%	<1%	<1%	<1%	<1%		
		Numerator:	190	19	16	35	15	-	-	-	15			
		Denominator:	3686	3461	1978	3461	1978	-	-	-	1978			

Explanation of Planned Performance over the Medium-Term Period:

- The output contributes towards striving for a reduced prevalence of diabetes and malaria incidences among the community in the province.
- The output is selected to monitor trends in key NCDs and treatment effectiveness.
- The department will continue conducting community awareness campaigns on early health-seeking behaviour.

2.2 2.7 Reconciling Performance Targets with Expenditure Trends

Table 22. DHS – Expenditure estimates

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
R' thousand	2019/20	2020/21	2021/22	2022/23			2023/24	2024/25	2025/26
District Management	564 684	557 639	540 190	533 726	524 782	524 782	551 699	577 853	603 740

Clinics	3 274 189	3 382 262	3 367 914	3 439 094	3 484 432	3 484 432	3 623 914	3 611 432	3 773 225
Community Health Centres	657 064	601 357	594 824	683 576	674 100	680 669	658 868	680 494	710 979
Community-based Services	172 378	144 776	327 139	783 189	875 054	875 054	781 138	840 975	900 363
Other Community Services	101 578	112 138	175 435	373 135	345 427	530 705	170 102	141 589	141 589
HIV and AIDS	1 970 452	2 306 557	2 441 196	1 935 362	2 026 013	2 026 013	1 924 794	2 011 235	2 101 338
Nutrition	3 331	25 687	27 769	14 191	14 191	14 191	18 387	19 269	20 132
District Hospitals	7 058 149	6 986 803	7 013 849	7 101 968	7 423 694	7 215 554	7 733 581	8 175 614	8 452 502
TOTAL	13 801 825	14 117 219	14 488 316	14 864 241	15 367 693	15 351 400	15 462 483	16 058 461	16 703 868

Table 23. DHS - Summary of provincial expenditure estimates by economic classification

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
Current payments	13 560 448	13 674 258	13 924 905	14 455 554	15 000 186	14 976 791	15 187 371	15 784 714	16 420 152
Compensation of employees	9 918 877	9 722 830	9 989 569	11 108 393	10 990 163	10 990 163	10 848 113	10 994 074	11 240 329
Goods and services	3 641 571	3 951 428	3 935 336	3 347 161	4 010 023	3 986 628	4 339 258	4 790 640	5 179 823
Communication	42 131	52 201	59 255	60 098	61 349	58 302	57 144	65 596	75 535
Computer Services	122 224	137 568	115 619	143 396	143 396	85 373	172 453	179 771	202 825
Consultants Contractors and special services	6 419	34 872	8 281	7 736	7 673	10 398	7 070	7 409	7 741
Inventory	1 771 353	2 067 332	1 857 212	1 758 729	1 758 729	2 296 736	1 951 873	2 069 948	2 243 680
Operating leases	4 607	3 463	5 638	5 174	5 174	5 258	5 402	5 708	5 964

Travel and subsistence	32 122	13 234	44 381	37 658	34 223	42 921	48 853	61 712	43 239
Maintenance repair and running costs	130 235	105 079	93 634	76 063	92 863	65 320	106 940	111 373	120 363
Specify other	1 532 480	1 537 679	1 751 316	1 258 307	1906616	1422320	1989523	2289123	2480476
Financial transactions in assets and liabilities	-	-	-	-	-	-	-	-	-
Transfers and subsidies to	150 438	190 376	212 656	103 485	116 285	120 550	122 720	98 380	102 697
Provinces and municipalities	950	992	1 030	910	910	962	1 043	1 102	1 151
Departmental agencies and accounts	83 572	79 233	106 306	18 486	-	-	-	-	-
Non-profit institutions	-	-	-	-	-	-	-	-	-
Households	65 916	110 151	105 320	84 089	115 375	119 588	121 677	97 278	101 546
Payments for capital assets	90 939	252 585	350 755	305 202	251 222	254 059	152 392	175 367	181 019
Buildings and other fixed structures	16 232	16 703	21 611	114 400	38 774	38 774	-	-	-
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Machinery and equipment	74 707	235 882	329 144	190 802	212 448	215 285	152 392	175 367	181 019
Total economic classification	13 801 825	14 117 219	14 488 316	14 864 241	15 367 693	15 351 400	15 462 483	16 058 461	16 703 868

2.8 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 immunization 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 whilst 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 R42.4 billion from 2019/20 to 2021/22 while the 2022/23 budget amounts to R14.9 billion. The proposed MTEF from 2023/24 to 2025/26 projected at R48.2 billion will be used to maintain and improve the current services.

2.9 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Patient experience of care in public health facilities improved	Failure to manage key health priorities (e.g. long queues, medicine stock-outs, governance and leadership, staff attitudes, cleanliness)	Encourage proactive management than reactive management
Management of patient safety incidents improved to reduce new medico-legal cases	Increased litigations due to medical negligence	• Mortality and morbidity reviews and training • Provisioning of training for clinical managers and medical doctors on ethics and general management

		• Reduction of medico-legal expenditure through alternate dispute resolution (ADR) • Reduction of medico-legal expenditure through defence • Make representation to the Ministerial Task Team (MTT) to reduce the quantum of cases lost
AIDS related deaths reduced by implementing the 90-90-90 strategy	Ineffective communicable diseases management	Intensify implementation of the universal test and treat intervention
	Diseases Outbreak (e.g. Malaria and Collera)	• Strengthen interdepartmental meetings with COGSTA, Water and Sanitation and Department of Agriculture • Provincial Public Health to participate in the development of early warning system for infectious diseases (IDEWS) with National Institute of Communicable disease Control (NICC) • Intensify fumigation

Maternal, Neonatal, and Child Mortality reduced	Lack of capacity to manage women and child health (e.g. medical equipment, infrastructure not fit for purpose, inadequate skills mix)	• Procure the necessary medical equipment • Skills capacity building among health professionals • Accelerate deliverance of the centre of excellence
Morbidity and Premature mortality due to Non-Communicable diseases reduced by 10%	Risky lifestyle among community members	• Conduct community awareness campaigns

3.1 Purpose

The purpose of this programme is to render emergency medical services including ambulance service, special operations, communications and air ambulance service; and render efficient Planned Patient Transport. Therefore, provide for pre-hospital Emergency Medical Services including Inter-hospital transfers.

Table 24. EMS outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. Co-ordinating of health services across the care continuum, re-orienting the health system towards primary health	EMS P1 urban response under 30 minutes	New indicator		49.6%	52.5%	65%	65%	65%	65%	65%	70%	70%	
		Numerator:	-	265	237		293	-	-		315	315	
		Denominator:	-	534	451		451	-	-		451	451	
	EMS P1 rural response under 60 minutes	New indicator		69.5%	45.5%	70%	70%	70%	70%	70%	75%	75%	
		Numerator:	-	2349	1778		2734	-	-		2929	2929	
		Denominator:	-	3379	3905		3905	-	-		3905	3905	

Explanation of Planned Performance over the Medium-Term Period:

- a) Improved response time and availability of EMS vehicles to attend to incidents are critical in increasing access to emergency medical services.
- b) Measuring response times in urban and rural areas helps in monitoring accessibility to EMS by the communities.

- c) The department will implement a Computerised Assisted Call Tracking & Dispatch system to ensure that ambulances' response to the scene of calls is improved. In improving personnel capacity, the department will continue to attract and recruit Advanced Life Support Paramedics, in improving capacity to respond to priority (critical) calls.

3.2 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 25. EMS - Expenditure estimates

Sub-programme	Audited outcome		Main appropriation	Adjusted appropriation 2022/23	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21				2023/24	2024/25	2025/26
R' thousand								
Emergency Transport	817 796	855 667	906 066	994 571	994 571	1 303 667	1 088 841	1 121 774
Planned Patient Transport								
TOTAL	817 796	855 667	906 066	994 571	994 571	1 303 667	1 088 841	1 121 774

Table 26. EMS - Summary of provincial expenditure by economic classification

	Audited Outcomes		Main appropriation	Adjusted appropriation 2022/23	Revised estimate	Medium-term estimate		
	2019/20	2020/21				2023/24	2024/25	2025/26
Current payments	796 791	806 772	870 425	898 982	946 113	967 756	1 001 440	1 030 394
Compensation of employees	715 598	722 423	763 478	784 415	784 415	803 131	845 241	863 008
Goods and services	81 193	84 349	106 947	114 567	161 698	164 625	156 199	167 386
Communication	7 226	6 503	6 930	6 930	6 930	6 935	7 268	9 594
Consultants Contractors and special services	4 869	4 589	20 000	16 620	16 620	20 860	21 799	28 776
Inventory	9 147	6 396	4 731	4 731	4 731	867	909	950
Operating leases	-	6	196	196	196	205	215	225
Travel and subsistence	284	459	-	-	275	-	-	-

Maintenance repair and running costs	30 836	44 731	74 778	44 095	44 095	86 153	64 483	66 190	69 155
Specify other	28 831	21 665	28 751	30 995	41 995	46 793	7 1275	59818	58686
Transfers and subsidies to	2 016	939	2 338	758	2 258	2 258	911	959	1 002
Provinces and municipalities	578	250	580	465	465	507	605	638	667
Departmental agencies and accounts									
Non-profit institutions									
Households	1 438	689	1 758	293	1 793	1 751	306	321	335
Payments for capital assets	18 989	47 956	28 018	34 883	93 331	46 200	335 000	86 442	90 378
Machinery and equipment	18 989	47 956	28 018	34 883	93 331	46 200	335 000	86 442	90 378
Total economic classification	817 796	855 667	903 533	906 066	994 571	994 571	1 303 667	1 088 841	1 121 774

3.3 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 purchasing of ambulances and communication equipment.
- Strengthen Obstetric Ambulances services.

The department has spent a total of R2.6 billion in 2019/20 to 2021/22 while the 2022/23 budget amounts to R906.1 million. The MTEF from 2023/24 to 2025/26 is projected at R3.5 billion. This amount will be used to maintain and improve the current services.

3.4 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Co-ordinating of health services across the care continuum, re-orienting the health system towards primary health	Ineffective emergency medical service	• Migration from Analogue to Digital system • Attract and retain appropriately qualified EMS staff • In-service training of EMS personnel

Programme 4: Provincial Hospitals Services

4.1 Purpose

The purpose of the programme is the delivery hospital services, which are accessible, appropriate, and effective and to provide general specialist services, including specialised drug-resistant TB and rehabilitation services, as well as a platform for training health professionals and research. Programme purpose include the rendering of hospital services at a general specialist level, providing specialist psychiatric hospital services for people with mental illness and intellectual disability, providing in-patient care for complicated drug-resistant tuberculosis and providing a platform for training of health workers and research.

4.2 Sub-programme: Regional Hospitals

4.2.1 Purpose

Provide specialized rehabilitation services as well as a platform for training health professionals.

Table 27. Regional hospitals outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. Patient experience of care in public health facilities improved	Patient experience survey satisfied responses	1.1 Patient experience of care satisfaction rate	New indicator	78.3%	79%	80%	80%	-	80%	-	-	81%	82%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
2. Management of patient safety incidents	Severity assessment code (SAC) 1 incident	2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	New indicator	76.1%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets					
							2023/24 Quarterly Targets				2023/24	2024/25
			2019/20	2020/21	2021/22	2022/23	Q1	Q2	Q3	Q4		
improved to reduce new medico-legal cases	reported within 24 hours	Denominator:	-	-	-	-	-	-	-	-	-	-
		2.2 Patient safety incidents (PSI) case closure rate	New Indicator	59.2%	99.7%	100%	100%	100%	100%	100%	100%	100%
	Patient safety incident (PSI) case closed	Numerator:	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-

Explanation of Planned Performance over the Medium-Term Period:

- The outputs contribute towards improving the healthcare service offering at regional hospitals.
- The selected indicators leverage for monitoring the quality of care offered to patients at the level of a regional hospital in order to reduce incidents of adverse events. Measuring institutional mortalities will aid in the disaggregation of maternal and child mortalities to facilities in order to attach the accountability of mortalities to referring institutions rather than pointing accountability only to the Tertiary Hospitals.
- The department will develop and implement the quality improvement plan to address matters of quality of care raised by patients and other stakeholders in each health facility. In terms of reducing maternal, neonatal, infant and child under five mortalities, the department will continue creating awareness among communities on the management of childhood illness and increase access to reproductive health services. Furthermore, the department will conduct awareness campaigns on the prevention of unplanned and unwanted pregnancies including the use of family planning methods. Among staff, the departments will continue implementing key interventions such as ESMOE and IMCI training.

4.3 Sub-programme: Specialised Hospitals

4.3.1 Purpose

To provide specialist psychiatric hospital services for people with mental illness and intellectual disability and provide a platform for the training of health workers and research and tuberculosis hospital services.

Table 28. Specialised hospitals outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. Patient experience of care in public health facilities improved	Patient experience of survey satisfied responses	1.1 Patient experience of care satisfaction rate (Specialised Hospital)	New indicator	75.6%	83%	80%	82%	-	82%	-	-	84%	86%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
		2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate (Specialised Hospitals)	New Indicator	100%	100%	100%	100%	100%	100%	100%	100%	100%	
2. Management of patient safety incidents improved to reduce new medico-legal cases	Severity assessment code (SAC) 1 incident reported within 24 hours	Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
		2.2 Patient safety incidents (PSI) case closure rate (Specialised Hospitals)	New Indicator	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-

Explanation of Planned Performance over the Medium-Term Period:

- a) Specialised psychiatric and drug-resistant TB hospitals need to achieve and maintain good offerings of quality services with proper governance structures (mental health review boards and hospital boards) in order to be responsive to the beneficiaries, including people with mental disabilities.
- b) The selected indicators will help in monitoring the quality of care offered to patients at the level of a specialised hospital in order to reduce incidents of adverse events.
- c) The department will develop and implement the quality improvement plan to address matters of quality of care raised by patients and other stakeholders in each health facility.

4.4 Reconciling Performance Targets with Expenditure Trends

Table 29. Provincial Hospitals - Expenditure estimates

Sub-programme	Audited outcome		Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21				2023/24	2024/25	2025/26
R' thousand								
General (regional) hospitals	2 069 324	2 061 211	2 149 379	2 140 617	2 140 617	2 242 623	2 286 788	2 369 236
Psychiatric hospitals	567 535	567 072	580 362	599 283	599 283	624 218	640 705	669 410
TB Hospitals	–	36 276	41 579	61 386	61 386	46 862	49 112	51 313
TOTAL	2 636 859	2 664 559	2 771 320	2 775 384	2 801 286	2 913 703	2 976 605	3 089 959

Table 30. Provincial Hospitals - Summary of provincial expenditure estimates by economic classification

	Audited Outcomes		Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate	
	2019/20	2020/21				2023/24	2025/26
				2022/23			

Current payments	2 614 274	2 645 029	2 750 123	2 757 216	2 783 118	2 783 118	2 893 738	2 955 912	3 068 338
Compensation of employees	2 240 861	2 290 451	2 350 565	2 415 162	2 388 723	2 388 723	2 453 433	2 511 055	2 561 236
Goods and services	373 413	354 578	399 558	342 054	394 395	394 395	440 305	444 857	507 102
Communication	7 051	6 275	6 850	6 614	6 614	6 614	7 419	7 775	12 124
Consultants Contractors and special services	5	234	-	-	-	-	-	-	-
Inventory	235 261	220 335	226 636	199 949	230 246	230 246	277 714	248 464	277 094
Operating leases	476	259	1 048	332	332	332	1 374	1 650	1 724
Travel and subsistence	1 646	1 886	1 208	-	-	-	-	-	-
Maintenance repair and running costs	131	5	-	65	65	65	-	-	-
Specify other	128 843	125 584	163 816	135 094	157 138	152 935	153 798	186 968	216 160
Transfers and subsidies to	14 985	14 149	19 999	14 534	14 534	14 548	14 801	15 521	16 216
Provinces and municipalities	82	80	88	115	115	116	146	162	169
Households	14 903	14 069	19 911	14 419	14 419	14 432	14 655	15 359	16 047
Payments for capital assets	7 600	5 381	1 198	3 634	3 634	3 620	5 164	5 172	5 405
Buildings and other fixed structures	1 000	495	-	-	-	-	-	-	-
Machinery and equipment	6 600	4 886	1 198	3 634	3 620	5 164	5 172	5 405	5 405
Software and other intangible assets	-	-	-	-	-	-	-	-	-
Total economic classification	2 636 859	2 664 559	2 771 320	2 775 384	2 801 286	2 801 286	2 913 703	2 976 605	3 089 959

4.5 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 specialized 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 R8.1 billion in 2019/20 to 2021/22 while the 2022/23 budget amounts to R2.8 billion. The MTEF from 2023/24 to 2025/26 is projected at R9 billion. This amount will be used to maintain and marginally improve other services.

4.6 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Quality of health services in public health facilities improved	Failure to manage key health priorities (e.g. long queues, medicine stock-outs, governance and leadership, staff attitudes, cleanliness)	Encourage proactive management than reactive management
Management of patient safety incidents improved to reduce new medico-legal cases	Increased litigations due to medical negligence	• Mortality and morbidity reviews and training • Provisioning of training for clinical managers and medical doctors on ethics and general management • Reduction of medico-legal expenditure through alternate dispute resolution (ADR) • Reduction of medico-legal expenditure through defence

		• Make representation to the Ministerial Task Team (MTT) to reduce the quantum of cases lost
Maternal, Neonatal, Infant and Child Mortality reduced	Lack of capacity to manage women and child health (e.g. medical equipment, infrastructure not fit for purpose, inadequate skills mix)	• Procure the necessary medical equipment • Skills capacity building among health professionals • Accelerate deliverance of the centre of excellence

Programme 5: Central & Tertiary Hospitals Services

5.1 Purpose

The purpose of this programme is to provide tertiary health services and creates a platform for the training of health workers. Programme purpose include rendering highly specialised health care services; provisioning a platform for the training of health workers; and serving as specialist referral centres for regional hospitals.

Table 31. Tertiary hospital outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets					
								Q1	Q2	Q3	Q4		
1a. Patient experience of care in public health facilities improved	Patient experience of survey satisfied responses	1.1 Patient experience of care satisfaction rate	New indicator	71%	70%	80%	82%	-	82%	-	-	84%	86%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
2. Management of patient safety incidents improved to reduce new medico-legal cases	Severity assessment code (SAC) 1 incident reported within 24 hours	2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	New Indicator	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-
Patient safety incident (PSI) case closed	Patient safety incident (PSI) case closure rate	2.2 Patient safety incidents (PSI) case closure rate	New Indicator	19.6%	95.4%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	-	-	-	-	-	-	-	-	-	-	-
		Denominator:	-	-	-	-	-	-	-	-	-	-	-

Explanation of Planned Performance over the Medium-Term Period:

- a) The outputs contribute towards improving the healthcare service offering at tertiary hospitals.
- b) The selected indicators help monitor the quality of care offered to patients at the level of a tertiary hospital in order to reduce incidents of adverse events. A measure of maternal mortalities attached to tertiary hospitals will aid in referral hospitals accounting for their own maternal mortalities which have been referred to the tertiary hospitals.
- c) The department will develop and implement the quality improvement plan to address matters of quality of care raised by patients and other stakeholders in each health facility. In terms of reducing maternal, neonatal, infant and child under five mortalities, the department will continue creating awareness among communities on the management of childhood illness and increase access to reproductive health services. Furthermore, the department will conduct awareness campaigns on the prevention of unplanned and unwanted pregnancies including the use of family planning methods. Among staff, the departments will continue implementing key interventions such as ESMOE and IMCI training.

5.2 Reconciling Performance Targets with Expenditure Trends and Budgets

Table 32. C&THS - Expenditure estimates

Sub-programme	Audited outcome		Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21				2023/24	2024/25	2025/26
Tertiary hospital	2 018 364	1 998 220	1 938 421	2 091 901	2 091 901	2 105 014	2 155 384	2 249 790
	-	-	-	-	-	-	-	-
TOTAL	2 018 364	1 998 220	1 938 421	2 091 901	2 091 901	2 105 014	2 155 384	2 249 790

Table 33. C&THS - Summary of provincial expenditure estimates by economic classification

	Audited Outcomes		Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate	
	2019/20	2020/21				2023/24	2024/25
				2022/23			

Current payments	1 981 817	1 948 402	2 062 879	1 851 981	1 958 267	1 958 267	1 987 731	2 085 222	2 152 098
Compensation of employees	1 479 204	1 481 333	1 559 945	1 461 396	1 501 187	1 501 187	1 426 848	1 450 137	1 479 103
Goods and services	502 613	467 069	502 934	390 585	457 080	457 080	560 883	635 085	672 995
Communication	4 835	4 108	4 390	4 920	4 920	4 920	5 220	5 471	8 716
Consultants Contractors and special services	-	-	709	-	-	-	-	-	-
Inventory	297 423	316 233	319 075	221 798	221 798	262 871	279 984	298 835	332 225
Operating leases	5 143	3 325	1 496	1 320	2 122	1 633	3 003	2 772	2 896
Travel and subsistence	827	474	1 056	126	126	2 436	157	118	123
Maintenance repair and running costs	-	-	31	915	915	915	83	84	88
Specify other	194 385	142 929	176 177	161 506	227 199	184 305	272 436	327 805	328 947
Transfers and subsidies to	7 747	8 992	14 493	923	7 423	7 423	1 014	1 076	1 124
Provinces and municipalities	57	27	37	33	33	42	90	93	97
Households	7 690	8 965	14 456	890	7 390	7 381	924	983	1 027
Payments for capital assets	28 800	40 826	31 124	85 517	126 211	126 211	116 269	69 086	96 568
Buildings and other fixed structures	-	-	-	-	-	-	-	-	-
Machinery and equipment	28 800	40 826	31 124	85 517	126 211	126 211	116 269	69 086	96 568
Total economic classification	2 018 364	1 998 220	2 108 496	1 938 421	2 091 901	2 091 901	2 105 014	2 155 384	2 249 790

5.3 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 for elective surgery or treatment due to the availability of speciality 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 R6.1 billion from 2019/20 to 2021/22 while the 2022/23 budget amounts to R1.9 billion. The MTEF from 2023/24 to 2025/26 is projected at R6.5 billion which will be used to maintain and improve the current service.

5.4 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Quality of health services in public health facilities improved	Failure to manage key health priorities (e.g. long queues, medicine stock-outs, governance and leadership, staff attitudes, cleanliness)	Encourage proactive management than reactive management
Management of patient safety incidents improved to reduce new medico-legal cases	Increased litigations due to medical negligence	• Mortality and morbidity reviews and training • Provisioning of training for clinical managers and medical doctors on ethics and general management • Reduction of medico-legal expenditure through alternate dispute resolution (ADR) • Reduction of medico-legal expenditure through defence

		• Make representation to the Ministerial Task Team (MTT) to reduce the quantum of cases lost
Maternal, Neonatal, Infant and Child Mortality reduced	Lack of capacity to manage women and child health (e.g. medical equipment, infrastructure not fit for purpose, inadequate skills mix)	• Procure the necessary medical equipment • Skills capacity building among health professionals • Accelerate deliverance of the centre of excellence

Programme 6: Health Sciences Training

6.1 Purpose

The purpose of the programme is to provide training and development opportunities for actual and potential employees of the Department of Health.

Table 34. HST outcome, outputs, output indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. Improved co- ordination of health services across the care continuum, re- orienting the health system towards primary health	Registered nurses in diploma in nursing: General	Number of new nursing students registered in diploma in nursing: General	New indicator	New indicator	New indicator	New indicator	150	-	-	-	150	150	
	Numerator:	-	-	-	-	-	-	-	-	-	-	-	
	Denominator:	-	-	-	-	-	-	-	-	-	-	-	

Explanation of Planned Performance over the Medium-Term Period:

- a) Skills development among health personnel in different specialities affords improved access to service delivery.
- b) Indicators on the training of additional health personnel in key specialities contribute towards the realisation of improved health outcomes.
- c) The department will continue with monitoring and ensuring support to medical students including the Cuban programme.

6.2 Reconciling Performance Targets with Expenditure Trends

Table 35. HST - Expenditure estimates

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
R' thousand									
Nurse training colleges	196 875	174 573	163 593	220 650	195 462	195 462	165 063	168 686	176 243
EMS training colleges	3 873	3 452	2 610	5 101	5 177	5 177	4 870	5 104	5 333
Bursaries	133 307	129 471	81 538	196 306	84 355	81 436	97 264	82 250	85 935
PHC training	-	-	-	-	-	-	-	-	-
Other training	152 009	237 119	251 132	388 660	428 660	431 579	416 749	406 407	440 456
TOTAL	486 064	544 615	498 873	810 717	713 654	713 654	683 946	662 447	707 967

Table 36. HST - Summary of provincial expenditure estimates by economic classification

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
Current payments	360 063	415 584	414 697	630 945	590 633	590 633	572 047	560 772	601 737
Compensation of employees	338 858	400 887	398 977	590 589	564 277	564 277	543 612	530 888	562 314
Goods and services	21 205	14 697	15 720	40 356	26 356	26 356	28 435	29 884	39 423
Communication	631	638	631	630	630	630	658	690	1 221
Computer Services	-	-	-	-	-	-	-	-	-
Consultants Contractors and special services	-	-	-	-	-	-	-	-	-
Inventory	7	552	18	584	584	845	296	310	324

Operating leases	128	52	319	854	1 603	1 213	838	878	917
Travel and subsistence	9 349	599	890	13 757	2 757	3 107	1 016	1 017	1 063
Maintenance repair and running costs	49	-	-	-	-	-	-	-	-
Specify other	11 041	12 856	13 862	24 531	20 782	20 561	25 627	26 989	35 898
Transfers and subsidies to	125 952	126 965	83 761	178 384	121 633	121 633	111 899	101 675	106 230
Provinces and municipalities	124	127	128	130	130	130	135	141	147
Departmental agencies and Accounts						42 890	20 000	25 000	26 120
Non-profit institutions									
Households	125 828	126 838	83 633	178 254	121 503	78 613	91 764	76 534	79 963
Payments for capital assets	49	2 066	415	1 388	1 388	1 388	-	-	-
Buildings and other fixed structures									
Machinery and equipment	49	2 066	415	1 388	1 388	1 388	-	-	-
Total economic classification	486 064	544 615	498 873	810 717	713 654	713 654	683 946	662 447	707 967

6.3 Performance and Expenditure Trends

The purpose is to render health care training and development of staff. The allocated budget has a direct impact on the achievements of targets in the following ways:

- Training of nursing, medical and allied professionals
- Training of EMS professionals
- Cater for the internship and community services of health professionals

The budget allocated over the MTEF is sufficient to fund the current students on Cuban Scholarship Programme.

Reduction in the shortage of EMS practitioners e.g. the department uses 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 R1.5 billion in 2019/20 to 2021/22 while the 2022/23 budget amounts to R810.7 million. The proposed MTEF from 2023/24 to 2025/26 is projected at R2.1 billion which will be used to maintain and improve the current services.

6.4 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Improved co-coordination of health services across the care continuum, re-orienting the health system towards primary health	Limited capacity in training and development Loss of accreditation	Enter into a memorandum of understanding with local institutions of higher learning for enhancement of staff development

Programme 7: Healthcare Support Services

7.1 Purpose

The purpose of the programme is to render support services as required by the Department to realise its aim and incorporate all aspects of rehabilitation.

Table 37. HCS outcome, outputs, performance indicators and targets

Outcome (as per SP 2020/21- 2024/25)	Output	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22		2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
1. Improved co- coordination of health services across the care continuum, re- orienting the health system towards primary health	Essential medicines available at all levels	1.1 Availability of essential medicines depot	62.2%	67.7 %	70%	70%	70%	70%	70%	70%	70%	70%	
		Numerator:	203	222	247	209	207	-	-	-	207	207	
		Denominator:	328	328	353	298	295	-	-	-	295	295	
		1.2 Availability of essential medicines in hospitals	81.02%	63%	63%	80%	80%	80%	80%	80%	80%	80%	
		Numerator:	239	189	231	292	290	-	-	-	290	290	
		Denominator:	295	295	367	365	362	-	-	-	362	362	
		1.3 Availability of essential medicines in PHC facilities	71.9%	77.6%	81%	80%	80%	80%	80%	80%	80%	80%	
		Numerator:	122	132	135	145	65	-	-	-	65	65	
Denominator:	170	170	166	181	81	-	-	-	81	81			

Explanation of Planned Performance over the Medium-Term Period:

- The outputs strive to ensure constant availability and visibility of medicine in health facilities for improved stock management.
- The indicators were chosen in order to monitor that medicine levels are at the required levels at all times in health facilities to avoid stock-outs.
- The department will continue investing in a new ICT system for monitoring stock visibility in order to avoid unnecessary stock outages.

7.2 Reconciling Performance Targets with Expenditure Trends

Table 38. HCS - Expenditure estimates

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
R' thousand	40 755	40 507	47 024	50 729	52 178	52 178	47 779	50 404	52 663
Forensic services									
Orthotic and prosthetic services	5 790	5 167	4 987	6 273	16 383	16 383	9 680	10 145	10 600
Medicines trading account	95 953	540 515	517 215	317 597	159 661	159 661	93 327	96 508	100 832
TOTAL	142 498	586 189	569 226	374 599	228 222	228 222	150 786	157 057	164 095

Table 39. HSC - Summary of provincial expenditure estimates by economic classification

	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
Current payments	141 780	585 864	568 359	373 206	226 829	226 829	150 359	156 610	163 628
Compensation of employees	96 625	100 671	101 259	100 821	104 334	104 334	95 367	99 945	99 424
Goods and services	45 155	485 193	467 100	272 385	122 495	122 495	54 992	56 665	64 204
Communication	432	402	405	843	843	843	443	433	452
Computer Services	2 019	2 319	2 297	—	—	—	—	—	—

Consultants Contractors and special services	25 977	27 453	30 684	28 222	28 222	28 222	29 883	31 172	35 569
Inventory	8 469	448 529	418 500	227 931	77 804	77 173	11 235	10 693	11 173
Operating leases	414	511	608	921	921	966	921	965	1 008
Travel and subsistence	483	540	962	373	373	434	178	187	196
Maintenance repair and running costs	-	-	-	-	-	-	-	-	-
Specify other	7 361	5 439	13 644	14 095	92 136	92030	23567	23808	26979
Financial transactions in assets and liabilities	0								
Transfers and subsidies to	190	169	210	293	293	293	305	319	333
Provinces and municipalities	-	-	-						
Households	190	169	210	293	293	293	305	319	333
Payments for capital assets	528	156	657	1 100	1 100	1 100	122	128	134
Machinery and equipment	528	156	657	1 100	1 100	1 100	122	128	134
Total economic classification	142 498	586 189	569 226	374 599	228 222	228 222	150 786	157 057	164 095

7.3 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:

- The allocated budget is used to facilitate the purchase and distribution of 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 R1.3 billion from 2019/20 to 2021/22 while the 2022/23 budget amounts to R374.6 million. The MTEF from 2023/24 to 2025/26 is projected at R471.9 million which will be used to maintain and improve the current services. The reduction in the 2023

MTEF is due to the removal of bulk PPEs procurement that was linked with the COVID-19 prevalence in 2020/21 and 2021/22. The Department intends to realize this programme's strategic objectives and targets through effective and economic utilization of the resources regular monitoring of the programme performance and stakeholders' participation.

7.4 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Improved co-ordination of health services across the care continuum, re-orienting the health system towards primary health	Poor connectivity in leveraging of full functionality of the stock monitoring system	Collaborate with SITA to ensure seamless connectivity in all health facilities to enhance functionality of the stock monitoring system

8.1 Purpose

Table 40. HFM outcome, outputs, performance indicators and targets

Explanation of Planned Performance over the Medium-Term Period:

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any unplanned maintenance. In being proactive in maintenance, the department shall ensure that all facilities develop, implement, and adhere to their maintenance plans.

8.2 Reconciling Performance Targets with Expenditure Trends

Table 41. HFM - Expenditure estimates

Sub-programme	Audited outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium term expenditure estimates		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
R' thousand									
Community Health facilities	699 211	869 374	1 052 029	624 860	952 717	952 717	799 653	751 306	810 510
District Hospital Services	61 423	48 874	11 042	74 673	70 673	70 673	-	-	-
Provincial Hospitals Services	25 138	21 722	5 109	43 540	22 540	22 540	-	-	-
Tertiary Hospitals Services	21 812	45 319	21 262	15 220	50 765	50 765	51 484	37 851	39 547
Other Facilities	121	935	195 091	1 672	1 672	1 672	500	600	627
Total	807 705	986 224	1 284 533	759 965	1 098 367	1 098 367	851 637	789 757	850 684

Table 42. HFM - Summary of provincial expenditure estimates by economic classification

	Audited Outcomes			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate		
	2019/20	2020/21	2021/22				2023/24	2024/25	2025/26
Current payments	471 884	609 531	1 082 810	320 637	755 711	755 668	531 933	470 377	516 996
Compensation of employees	8 152	7 521	10 948	18 000	15 895	15 895	19 000	20 000	20 000
Goods and services	463 732	602 010	1 071 862	302 637	739 816	739 773	512 933	450 377	496 996
Communication	-	-	-	-	-	88	-	-	-
Computer	-	-	-	-	5 000	5 000	-	-	-

Consultants Contractors and special services	12 628	35 552	22 459	34 865	99 865	99 865	38 837	34 837	37 249
Inventory	1 984	774	783	-	-	-	-	-	-
Operating leases	-	-	-	-	-	-	-	-	-
Travel and subsistence	384	242	503	690	990	990	530	530	554
Maintenance repair and running costs	-	-	-	-	-	-	-	-	-
Specify other	448 736	565 442	1 048 117	267 082	633 961	633 287	473 566	415 010	459 193
Transfers and subsidies to	-	-	-	-	-	-	-	-	-
Households	-	-	-	-	-	-	-	-	-
Payments for capital assets	335 821	376 693	201 723	439 328	342 656	342 699	319 704	319 380	333 688
Buildings Other fixed structures	240 763	336 531	195 532	429 128	332 456	332 456	307 182	306 858	320 605
Machinery and equipment	95 058	40 162	6 191	10 200	10 200	10 243	12 522	12 522	13 083
Total economic classification	807 705	986 224	1 284 533	759 955	1 098 367	1 098 367	851 637	789 757	850 684

8.3 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 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 R3.1 billion from 2019/20 to 2021/22 while the 2022/23 budget amounts to R759.9 million. The MTEF from 2023/24 to 2025/26 is projected at R2.5 billion. 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 stakeholder participation.

8.4 Updated Key Risks

Outcome	Key Risk	Risk Mitigation
Infrastructure maintained and back log reduced	Unsafe and dilapidated infrastructure	Building of new infrastructure

Public Entities

The department does not have public entities in existence.

Infrastructure Projects

Province	District Municipality	Project Name	Project Details / Scope	Project Estimated Start Date	Project Actual Start Date	Project Estimated End Date	Expenditure for the 2022/2023 year	Budget allocated for the 2023/2024 year
Limpopo (LP)	Capricorn (DC35)	Pietersburg hospital Upgrade MCCE (Phase B)	Upgrade Mother, Child, Centre of Excellence facilities (Phase B) Neonatal unit, Paediatric ICU & Antenatal Care	2017/11/06	2022/11/07	2026/03/31	-	20 000
Limpopo (LP)	Vhembe (DC34)	Thohoyandou Nursing Campus Projects	Nursing Student accommodation Repurpose Dining Hall and storm water management	2023/04/03		2026/03/31	-	6 000
Limpopo (LP)	Capricorn (DC35)	Pietersburg Hospital Mass water storage tanks	construction of a Mass water storage tanks	2022/10/03	2022/10/03	2024/03/29	-	8 260
Limpopo (LP)	Capricorn (DC35)	WF Knobel Hospital Project	Repairs and maintenance of House 01, 02, 04, 09, Laundry, Kitchen, Stores, X-ray and Male & Female Ward. Site sewer & water reticulation. HR building to be demolished. Storm water control, new guard house and walkway renewal	2020/10/01	2020/10/01	2024/02/02	-	27 000

Province	District Municipality	Project Name	Project Details / Scope	Project Estimated Start Date	Project Actual Start Date	Project Estimated End Date	Expenditure for the 2022/2023 year	Budget allocated for the 2023/2024 year
Limpopo (LP)	Waterberg (DC36)	Ellisras Hospital_Projects	1. Perimeter Fence 2. Mental Health CareUnit – Upgrade and repurpose the change room and laundry block 3. Refurbishment of Doctors and Nurses Quarters	2022/06/06	2022/06/06	2026/09/30	26 260	40 000
Limpopo (LP)	Capricorn (DC36)	Helene Franz Hospital_Projects	Maternity Complex Mental Healthcare Unit Male & Female Ward Main Gate entrance & ring road Tuckshop waiting area palisade OPD Pharmacy & Casualty X-ray & Reception	2023/04/03		2026/03/31	-	10 000
Limpopo (LP)	0 - All Districts	Upgrades of Helipads	1. Upgrades & Repairs of Helipads to South African Civil Aviation Authority standards.	2023/04/03		2026/03/31	-	6 000
Limpopo (LP)	0 - All Districts	Mental Health care units	Provision of Mental Health care units	2023/04/03		2026/03/31	-	30 000
Limpopo (LP)	0 - All Districts	Provision of Bulk Oxygen tanks & related auxiliary works (HFRG)	Provision of Bulk Oxygen tanks & related auxiliary works	2023/04/03		2026/03/31	-	5 000
Limpopo (LP)	0 - All Districts	EMS Stations	Development of new EMS Stations	2023/04/03		2026/03/31	-	15 000

Province	District Municipality	Project Name	Project Details / Scope	Project Estimated Start Date	Project Actual Start Date	Project Estimated End Date	Expenditure for the 2022/2023 year	Budget allocated for the 2023/2024 year
Limpopo (LP)	0 - All Districts	Upgrades Roads, Storm water, Fencing & walling	Upgrades of Roads, Storm water, Fencing & walling	2023/04/03		2024/03/29	-	24 180
Limpopo (LP)	Sekukhune (DC47)	Bosele EMS Station	Construction of an EMS station at Bosele	2006/05/26	2006/05/26	2023/09/30	14 302	14 824
Limpopo (LP)	Mopani (DC33)	Sekororo Hospital Projects	Maternity Complex OPD Mental Healthcare unit Medical Gas Plant Room	2023/04/03		2026/03/31	-	5 300
Limpopo (LP)	Waterberg (DC36)	Phagameng Clinic Replacement of the existing clinic on a new site	Replacement of the existing Phagameng clinic on a new site	2007/06/07	2007/06/07	2025/08/30	-	1 000
Limpopo (LP)	Waterberg (DC36)	Warmbad Hospital Projects	Address water challenges, Undertake corrective work on Maternity, EMS and the buildings within the facility	2023/04/03		2026/03/31	-	17 000

Province	District Municipality	Project Name	Project Details / Scope	Project Estimated Start Date	Project Actual Start Date	Project Estimated End Date	Expenditure for the 2022/2023 year	Budget allocated for the 2023/2024 year
Limpopo (LP)	Mopani (DC33)	Letaba Hospital A6 Replacement Female Medical Ward, upgrade waste store, etc	New Waste Management Facility, New 36 bed female general ward, fire compliance, repairs and upgrading of existing walkways for fire, rehabilitation /upgrading of fuel storage the calorifier at the old paediatric ward, etc	2016/05/29	2016/04/01	2024/03/29	16 034	200
Limpopo (LP)	Vhembe (DC34)	Tshilidzini Hospital: Upgrade Central Mini-Hub Laundry Building	Upgrade Central Mini-hub laundry building	2016/04/01	2016/04/04	2024/03/29	-	400
Limpopo (LP)	Capricorn (DC35)	Mankweng Hospital Upgrade Laundry Building	Upgrade of existing Laundry building	2016/04/01	2016/04/04	2024/03/29	-	2 000
Limpopo (LP)	Waterberg (DC36)	MDR_FH Odendaal Hospital: Electrical Upgrades	Upgrading Electrical capacity in the hospital	2022/01/17	2022/01/28	2024/03/29	5 064	3 000
Limpopo (LP)	Capricorn (DC35)	Pietersburg hospital_repurposing of ICU Ward & Ward F	Converting Ward F into ICU ward. The former ICU repurposed into other functional spaces. Storm water management	2020/11/17	2022/01/03	2026/03/31	-	7 000

Province	District Municipality	Project Name	Project Details / Scope	Project Estimated Start Date	Project Actual Start Date	Project Estimated End Date	Expenditure for the 2022/2023 year	Budget allocated for the 2023/2024 year
Limpopo (LP)	Capricorn (DC35)	Lebowakgomo EMS station_Upgrade EMS station	Upgrade EMS station	2016/08/30	2016/10/01	2023/12/30	4 684	16 057
Limpopo (LP)	Capricorn (DC35)	Sovenga Nursing College Campus_Student Nurses residential accommodation	Construction of student nurses residential accommodation	2023/04/03		2026/03/31	-	5 000
Limpopo (LP)	Waterberg (DC36)	Modimolle EMS Station: New EMS Station	Construction of new EMS station	2005/05/26	2007/06/06	2025/08/30	-	1 000
Limpopo (LP)	0 - All Districts	Provision of Relocatable Units & related works	Provision of Relocatables & related works for records storage and other use as per Facility needs requirements	2016/05/23	2016/05/23	2026/03/31	15 310	5 600

Public Private Partnerships

The department does not have public private partnerships in existence.

Part D: Technical Indicator Description (TID) for Annual Performance Plan

Programme 1: Administration

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Audit opinion of Provincial DoH	Audit opinion for Provincial Departments of Health for financial performance	Auditor General Report Management report	Audit outcome for regulatory audit expressed by AGSA for 2021/2022 financial year	Not applicable	Not applicable	Not applicable	Provincial office	Not Applicable	Annual	Unqualified opinion	Chief Financial Officer Director Internal Control
1.2 Percentage compliance to payment of suppliers within 30 days	Invoice paid within 30days	BAS	Numerator: No of valid invoices paid within 30days Denominator: Total number of valid invoices received	Schedule for payments showing the total invoices paid within 30 days and after 30 days on monthly basis	Financial systems are in place	All SMEs and suppliers	All districts	Non-cumulative	Quarterly	A 100% payment of suppliers within 30 days	Director Expenditure and Accounts
1.3 Percentage completeness of asset register	Asset register exist, all assets account for, fair valued, and all identified redundant and obsolete assets are disposed	Asset register	Numerator Asset register	Asset register	All assets are recorded and verified twice a year	N/A	Provincial office	Non-cumulative	Quarterly	A 100% completeness asset register	Chief Director SCM
1.4 Revenue Collected	Amount of revenue collected for the year	BAS	Amount collected against the set target	BAS report	Staff to manage revenue collection in facilities Implemented electronic data interchange for claiming from	N/A	All districts	Cumulative (year-to-date)	Quarterly	High	Director Revenue Management

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
					healthcare funders						

Programme 2: District Health Services

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
PHC											
1.1 Patient experience of care satisfaction rate	Total number of satisfied responses as a proportion of all responses from patient experience of care survey questionnaires	Patient surveys	Numerator: Patient experience of care survey satisfied responses Denominator: Patient experience of care survey total responses	Patient survey tools	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	All users of health care services	All districts	Cumulative (year-to-date)	Annual	High	Deputy Director Quality assurance (M&E)
2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC)1 incidents reported within 24 hours as a proportion of severity assessment code (SAC) 1 incident reported	Patient safety incident software	Numerator: Severity assessment code (SAC) 1 incident reported within 24 hours Denominator: Severity assessment code (SAC) 1 incident reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Low	Deputy Director Quality Assurance, Director Medico-Legal
2.2 Patient safety incidents (PSI) case closure rate	Patient safety incident (PSI) case closed in the reporting month as a proportion of patient safety incident (PSI) cases reported in	Patient safety incident software	Numerator: Patient Safety Incident (PSI) case closed Denominator: Patient Safety Incident (PSI) case reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct	N/A	All districts	Cumulative (year-to-date)	Quarterly	Increased percentage of reporting	Deputy Director Quality Assurance, Director Medico-Legal

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
3.1 Ideal clinic status obtained rate	the reporting month Fixed PHC health facilities that obtained Ideal Clinic status (silver, gold, platinum) as a proportion of fixed PHC clinics and CHCs and or CDCs	Ideal health facility software	Numerator: Fixed PHC health facilities have obtained Ideal Clinic status Denominator: Fixed PHC clinics or fixed CHCs and or CDCs	Ideal clinic checklists	patient surveys Teams (PPTICRM) and district coordinators for ICRM are available to conduct assessments and monitor implementation of quality improvement plans National support	N/A	All districts	Cumulative (year-to-date)	Annual	High	Deputy Director PHC
District Hospitals											
1.1 Patient experience of care satisfaction rate	Total number of satisfied responses as a proportion of all responses from patient experience of care survey questionnaires	Patient surveys	Numerator: Patient experience of care survey satisfied responses Denominator: Patient experience of care survey total responses	Patient survey	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	Not applicable	All districts	Cumulative (year-to-date)	Annual	High	Deputy Director Quality assurance (M&E)
2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of severity assessment code (SAC) 1 incident reported	Patient safety incident software	Numerator: Severity assessment code (SAC) 1 incident reported within 24 hours Denominator: Severity assessment code (SAC) 1 incident reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Low	Deputy Director Quality Assurance, Director Medico-Legal

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
2.2 Patient safety incidents (PSI) case closure rate	Patient safety incident (PSI) case closed in the reporting month as a proportion of patient safety incident (PSI) cases reported in the reporting month	Patient safety incident software	Numerator: Patient Safety Incident (PSI) case closed Denominator: Patient Safety Incident (PSI) case reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Increased percentage of reporting	Deputy Director Quality Assurance, Director Medico-Legal
HAST											
1.1 HIV positive 15-24 years (excl. ANC) rate	Adolescent and youth 15 to 24 years who tested positive as a proportion of those who were tested for HIV in this age group	HTS register (HIV testing services), TIER.Net, DHIS	Numerator: HIV positive 15-24 years (excl. ANC) Denominator: HIV test 15-24 years (excl. ANC)	HTS register (HIV testing services), TIER.Net, DHIS	All systems for monitoring HIV/TB epidemic are in place and functional	Youth	All districts	Cumulative (year-to-date)	Quarterly	Low	Chief Director Special Programmes Director HAST
1.2 ART adult remain in care rate (12 months)	ART adult remain in care – total as a proportion of ART adult start minus cumulative transfer out	ART paper register, TIER.Net, DHIS	Numerator: ART adult in remain in care – total Denominator: ART adult start minus cumulative transfer out	ART paper register, TIER.Net, DHIS	All systems for monitoring HIV/TB epidemic are in place and functional	All adults	All districts	Cumulative (year-to-date)	Quarterly	Higher total indicates a larger population on ART treatment	Chief Director Special Programmes Director HAST
1.3 ART child remain in care rate (12 months)	ART child remain in care – total as a proportion of ART child start minus cumulative transfer out	ART paper register, TIER.Net, DHIS	Numerator: ART child in remain in care – total Denominator: ART child start minus cumulative transfer out	ART paper register, TIER.Net, DHIS	All systems for monitoring HIV/TB epidemic are in place and functional	Children	All districts	Cumulative (year-to-date)	Quarterly	Higher total indicates a larger population on ART treatment	Chief Director Special Programmes Director HAST
1.4 ART Adult - viral load suppressed rate (12 months)	ART adult viral load under 50 as a proportion of ART adult viral	DHIS	Numerator: ART adult viral load under 50 (at 12 months)	DHIS report	All systems for monitoring HIV/TB epidemic are	Adults	All districts	Cumulative (year-to-date)	Quarterly	Higher total indicates a larger population on	Chief Director Special Programmes Director HAST

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
	load done at 12 months		Denominator: ART adult viral load done (at 12 months)		in place and functional					ART treatment are having their viral load suppressed	
1.5 ART Child - viral load suppressed rate (12 months)	ART child viral load under 50 as a proportion of ART child viral load done at 12 months	DHIS	Numerator: ART child viral load under 50 (at 12 months) Denominator: ART child viral load done (at 12 months)	DHIS report	All systems for monitoring HIV/TB epidemic are in place and functional	Children	All districts	Cumulative (year-to-date)	Quarterly	Higher total indicates a larger population on ART treatment are having their viral load suppressed	Chief Director Special Programmes Director HAST
1.6 All DS-TB client LTF rate	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who were subsequently lost to follow-up as a proportion of all those who started DS TB treatment	TIER.Net ; DHIS	Numerator: All DS-TB client lost to follow-up Denominator: All DS TB Treatment Start	DHIS report	All systems for monitoring TB epidemic are in place and functional	Children and adults	All districts	Cumulative (year-to-date)	Quarterly	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager
1.7 All DS-TB client treatment success rate	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and subsequently successfully completed treatment as a proportion of ALL those who started DS TB treatment	TIER.Net ; DHIS	Numerator: All DS-TB client successfully completed treatment Denominator: All DS TB Treatment Start	DHIS report	All systems for monitoring TB epidemic are in place and functional	Children and adults	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage suggests better treatment success rate.	TB Programme Manager
1.8 TB Rifampicin resistant Multidrug –	Rifampicin Resistant/Multidrug Resistant clients	EDRWeb , DHIS	Numerator: TB Rifampicin resistant/Multidrug	EDRWeb , DHIS	All systems for monitoring TB epidemic	Children and adults	All districts	Cumulative (year-to-date)	Quarterly	Higher success rate	TB Programme Manager

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
Resistant treatment success rate	successfully completed treatment as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment		Resistant successfully completed treatment Denominator: TB Rifampicin Resistant/Multidrug Resistant client started on treatment		are in place and functional						
1.9 TB Rifampicin resistant/Multidrug Resistant lost to follow-up rate	TB Rifampicin Resistant/Multidrug Resistant clients lost to follow-up as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment	EDRWeb , DHIS	Numerator: TB Rifampicin Resistant/Multidrug Resistant client loss to follow-up Denominator: TB Rifampicin Resistant/Multidrug Resistant client started on treatment	EDRWeb , DHIS	All systems for monitoring TB epidemic are in place and functional	Children and adults	All districts	Cumulative (year-to-date)	Quarterly	Lower lost to follow up rate	TB Programme Manager
1.10 TB Pre-XDR treatment success rate	TB Pre-XDR clients successfully completed treatment as a proportion of TB Pre-XDR clients started on treatment	EDRWeb , DHIS	Numerator: TB Pre-XDR client who successfully completed treatment Denominator: TB Pre-XDR client started on treatment	EDRWeb , DHIS	All systems for monitoring TB epidemic are in place and functional	Children and adults	All districts	Cumulative (year-to-date)	Quarterly	Higher success rate	TB Programme Manager
1.11 TB Pre-XDR loss to follow up rate	TB Pre-XDR clients who are lost to follow up as a proportion of TB Pre-XDR clients started on treatment	EDRWeb , DHIS	Numerator: TB Pre-XDR client who are lost to follow up Denominator: TB Pre-XDR client started on treatment	EDRWeb , DHIS	All systems for monitoring TB epidemic are in place and functional	Children and adults	All districts	Cumulative (year-to-date)	Quarterly	Lower lost to follow up rate	TB Programme Manager
MCWH&N											

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Couple year protection rate	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 condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10).	PHC Comprehensive Tick Register, DHIS, Denominator: StatsSA	Numerator Couple year protection Denominator: Population 15-49 years female	PHC Comprehensive Tick Register, DHIS, Denominator: StatsSA	Availability of all methods of contraception	Targeting youth and women of child bearing age	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage indicates higher usage of contraceptive methods.	Director MCWH&N
1.2 Delivery 10 to 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Health Facility Register, DHIS, Delivery register	Numerator: Delivery 10-19 years in facility Denominator: Delivery in facility total	Health Facility Register, DHIS, Delivery register	Family planning services are being offered	Females 10 -19 years	All districts	Cumulative (year-to-date)	Quarterly	Lower percentage indicates better family planning	Director MCWH&N

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.3 Antenatal 1st visit before 20 weeks rate	Women who have a first visit before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	PHC Comprehensive Tick Register, DHIS	Numerator: Antenatal 1st visit before 20 weeks Denominator: Antenatal 1st visit before 20 weeks	PHC Comprehensive Tick Register, DHIS	Basic antenatal care plus implemented in all primary healthcare facilities	Targeting women of child bearing age	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage indicates better uptake of ANC services	Director MCWH&N
1.4 Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion	PHC Comprehensive Tick Register	Numerator: Mother postnatal visit within 6 days after delivery Denominator: Delivery in facility total	PHC Comprehensive Tick Register	Postnatal care implemented at all levels of care	Targeting women	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage indicates better uptake of postnatal services	Director MCWH&N
1.5 Maternal Mortality in facility ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	Maternity register, delivery register	Numerator: Maternal death in facility Denominator: Live birth known to facility	Maternity register, delivery register	ESMOE training as a key to reduction of maternal mortalities is being conducted. Strengthened HIV/AIDS management	Females	All districts	Cumulative (year-to-date)	Annual	Lower	Director MCWH&N
1.6 Neonatal (<28 days) death in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility	Delivery register, Midnight report	Numerator: Neonatal deaths (0-28 days) in facility Denominator: Live birth in facility	Delivery register, Midnight report		Children	All districts	Cumulative (year-to-date)	Quarterly	Lower	Director MCWH&N

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.7 Child under 5 years diarrhoea case fatality rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	Ward register	Numerator: Diarrhoea death under 5 years Denominator: Diarrhoea separation under 5 years	Ward register	Implementing integrated management of childhood illness	Children	All districts	Cumulative (year-to-date)	Quarterly	Lower children mortality rate is desired	Director MCWH&N
1.8 Child under 5 years pneumonia case fatality rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Ward register	Numerator: Pneumonia death under 5 years Denominator: Pneumonia separation under 5 years	Ward register	Implementing integrated management of childhood illness	Children	All districts	Cumulative (year-to-date)	Quarterly	Lower children mortality rate is desired	Director MCWH&N
1.9 Child under 5 years severe acute malnutrition case fatality rate	Severe acute malnutrition death in children under 5 years as a proportion of SAM inpatients under 5 years	Ward register	Numerator: Severe acute malnutrition (SAM) death in facility under 5 years Denominator: SUM/(Severe Acute Malnutrition separation under 5 years	Ward register	Implementing integrated management of childhood illness	Children	All districts	Cumulative (year-to-date)	Quarterly	Lower children mortality rate is desired	Director MCWH&N
1.10 Death under 5 years against live birth rate	Children under 5 years who died during their stay in the facility	Midnight report	Numerator: Death in facility under 5 years total Denominator: Live birth in facility	Midnight report	Implementing integrated management of childhood illness	Children	All districts	Cumulative (year-to-date)	Quarterly	Lower children mortality rate is desired	Director MCWH&N
1.11 Live birth under 2500g in facility rate	Infants born alive weighing less than 2500g as proportion of total Infants born alive in health facilities (Low birth weight)	Delivery register, Midnight register	Numerator: Live birth under 2500g in facility Denominator: Live birth in facility	Delivery register, Midnight register	Implementing basic antenatal care	Targeting pregnant women	All districts	Cumulative (year-to-date)	Quarterly	Lower live birth under 2500g in facility is desired	Director MCWH&N

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.12 Infant PCR test positive around 6 months rate	Infant PCR test positivity around 6 months among infants born to HIV positive mothers	PHC Comprehensive Tick Register	Numerator: Infant PCR test positive around 6 months Denominator: Infant HIV PCR test around 6 months	PHC Comprehensive Tick Register	Universal test and treat strategy is been implemented in the department	Children	All districts	Cumulative (year-to-date)	Quarterly	Lower	Chief Director Special Programmes Director HAST
1.13 HIV test positive around 18 months rate	HIV test positive around 18 months (18-24 months) as a proportion of HIV tests done around 18 months	PHC Comprehensive Tick Register	Numerator: HIV test positive around 18 months Denominator: HIV tests done around 18 months	PHC Comprehensive Tick Register	Universal test and treat strategy is been implemented in the department	Children	All districts	Cumulative (year-to-date)	Quarterly	Lower	Chief Director Special Programmes Director HAST
1.14 Immunisation under 1 year coverage	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year.	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA	Numerator: Immunised fully under 1 year new Denominator: Population under 1 year	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA	Availability of vaccines	Children	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage indicate better immunisation coverage	Director EPI
1.15 Measles 2nd dose 1 year coverage	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population.	PHC Comprehensive Tick Register Denominator: StatsSA	Numerator: SUM([Measles 2nd dose]) Denominator: Population under 1 year	PHC Comprehensive Tick Register Denominator: StatsSA	Availability of vaccines	Children	All districts	Cumulative (year-to-date)	Quarterly	Higher coverage rate indicate greater protection against measles	Director EPI
1.16 Vitamin A 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.	PHC Comprehensive Tick Register	Numerator: Vitamin A dose 12-59 months Denominator: Target population 12-59 months * 2	PHC Comprehensive Tick Register	Availability of Vitamin A	Children	All districts	Cumulative (year-to-date)	Quarterly	Higher proportion of children 12-29 months who received Vit A will increase health	Director MCWH&N

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
Disease Prevention and Control											
1.1 Malaria case fatality rate	Malaria deaths in hospitals as a proportion of confirmed malaria cases for those admitted for malaria	Malaria Information System	Numerator: Malaria inpatient death Denominator: Malaria new cases reported	Malaria Information System	Strengthened indoor residual spraying and surveillance	Not applicable	All districts	Non-cumulative	Quarterly	Lower percentage indicates a decreasing burden of malaria	Chief Director Health Care Support

Programme 3: Emergency Medical Services

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 EMS P1 urban response under 30 minutes rate	Emergency P1 responses in urban locations with response times under 30 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	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	Numerator: EMS P1 urban response under 30 minutes Denominator: EMS P1 urban responses	DHIS, institutional EMS registers Patient and vehicle report.	Availability of operational ambulances and paramedics	Not applicable	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage indicate better response times in the urban areas	Chief Director Health Care Support Director EMS
1.2 EMS P1 rural response under 60 minutes rate	Emergency P1 responses in rural locations with response times under 60 minutes as a proportion of EMS P1 rural call	DHIS, institutional EMS registers Patient and vehicle report.	Numerator: EMS P1 rural response under 60 minutes Denominator: EMS P1 rural responses	DHIS, institutional EMS registers Patient and vehicle report.	Availability of operational ambulances and paramedics	Not applicable	All districts	Cumulative (year-to-date)	Quarterly	Higher percentage indicate better response times in the rural areas	Chief Director Health Care Support Director EMS

Programme 4: Regional and Specialised Hospital

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Patient experience of care satisfaction rate (Regional & Specialised Hospitals)	Total number of satisfied responses as a proportion of all responses from patient experience of care survey questionnaires	Patient surveys	Numerator: Patient experience of care survey satisfied responses Denominator: Patient experience of care survey total responses	Patient survey	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	Not applicable	All districts	Cumulative (year-to-date)	Annual	High	Deputy Director Quality assurance (M&E)
2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate (Regional & Specialised Hospitals)	Severity assessment code (SAC)1 incidents reported within 24 hours as a proportion of severity assessment code (SAC) 1 incident reported	Patient safety incident software	Numerator: Severity assessment code (SAC) 1 incident reported within 24 hours Denominator: Severity assessment code (SAC) 1 incident reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Low	Deputy Director Quality Assurance, Director Medico-Legal
2.2 Patient safety incidents (PSI) case closure rate (Regional & Specialised Hospitals)	Patient safety incident (PSI) case closed in the reporting month as a proportion of patient safety incident (PSI) cases reported in the reporting month	Patient safety incident software	Numerator: Patient Safety Incident (PSI) case closed Denominator: Patient Safety Incident (PSI) case reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Increased percentage of reporting	Deputy Director Quality Assurance, Director Medico-Legal

Programme 5: Tertiary Hospitals

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Patient experience of care satisfaction rate	Total number of satisfied responses as a proportion of all responses from patient experience of care survey questionnaires	Patient surveys	Numerator: Patient experience of care survey satisfied responses Denominator: Patient experience of care survey total responses	Patient survey	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	Not applicable	All districts	Cumulative (year-to-date)	Annual	High	Deputy Director Quality assurance (M&E)
2.1 Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC)1 incidents reported within 24 hours as a proportion of severity assessment code (SAC) 1 incident reported	Patient safety incident software	Numerator: Severity assessment code (SAC) 1 incident reported within 24 hours Denominator: Severity assessment code (SAC) 1 incident reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Low	Deputy Director Quality Assurance, Director Medico-Legal
2.2 Patient safety incidents (PSI) case closure rate	Patient safety incident (PSI) case closed in the reporting month as a proportion of patient safety incident (PSI) cases reported in the reporting month	Patient safety incident software	Numerator: Patient Safety Incident (PSI) case closed Denominator: Patient Safety Incident (PSI) case reported	Patient safety incident software	Institutions have appointed or delegated quality assurance officials to conduct patient surveys	N/A	All districts	Cumulative (year-to-date)	Quarterly	Increased percentage of reporting	Deputy Director Quality Assurance, Director Medico-Legal

Programme 6: Health Sciences Training

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Number of new nursing students registered in diploma in nursing: General	A total number of newly registered of nursing students into the nursing diploma	Student enrolment register	Numerical	enrolment register	Student competency to pass	N/A	N/A	Non-cumulative	Annual	High	Director nursing education and service

Programme 7: Health Care Support

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Availability of essential medicines (Depot)	Percentage of essential medicines and surgical sundries monitored at the depot	Quarterly reports	Numerator: Totals number of medicines available at depot, Hospitals and clinics. Denominator: Total number of medicines to be monitored.	Stock reports	The department has competent pharmaceutical personnel to manage medicine stock levels and rotation	Not applicable	All districts	Cumulative (year-to-date)	Quarterly	High percentage indicates the availability of ordered medicines and sundries from the suppliers	Chief Director Health Care Support Director Pharmaceutical Services
1.2 Availability of essential medicines (Hospitals)	Percentage of essential medicines and surgical sundries monitored at the hospitals	Quarterly reports	Numerator: Totals number of medicines available at depot, Hospitals and clinics. Denominator: Total number of medicines to be monitored.	Stock reports	The department has competent pharmaceutical personnel to manage medicine stock levels and rotation	Not applicable	All districts	Cumulative (year-to-date)	Quarterly	High percentage indicates the availability of ordered medicines and sundries from the suppliers	Chief Director Health Care Support Director Pharmaceutical Services
1.3 Availability of essential medicines (PHC)	Percentage of essential medicines and surgical sundries monitored at the clinics	Quarterly reports	Numerator: Totals number of medicines available at depot, Hospitals and clinics. Denominator: Total number of medicines to be monitored.	Stock reports	The department has competent pharmaceutical personnel	Not applicable	All districts	Cumulative (year-to-date)	Quarterly	High percentage indicates the availability of ordered medicines	Chief Director Health Care Support Director Pharmaceutical Services

				Total number of medicines to be monitored.		to manage medicine stock levels and rotation						and sundries from the suppliers	
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Programme 8: Health Facilities Management

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation type	Reporting Cycle	Desired performance	Indicator Responsibility
1.1 Percentage of health facilities with completed capital infrastructure projects	Number of health facilities with completed capital infrastructure projects (i.e., Practical Completion or equivalent achieved for projects categorised as New & Replacement, Upgrade & Additions or Rehabilitation, Renovations & Refurbishments) expressed as a percentage of the number of health facilities planned to have completed capital infrastructure projects.	Project Management Information System	Numerator: Total number of health facilities with completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) issued Denominator: Total number of health facilities planned to have completed capital infrastructure projects i.e., Practical Completion Certificate (or equivalent) planned to be issued	Project list (B5) and Practical Completion Certificates (or equivalent)	Project Management Information System is updated frequently and accurately	Not applicable	All districts	Cumulative (year-to-date)	Annual	Higher	Chief Director Infrastructure Director Infrastructure Planning

Annexure A: Amendments to Strategic Plan

Initial outcome (Strategic Plan 2020 - 2025)	Revised outcome (APP 2022/23)
Quality of health services in public health facilities improved	Patient experience of care in public health facilities improved
Quality of health services in public health facilities improved	Health facilities ready for NHI accreditation
Quality of health services in public health facilities improved	Management of patient safety incidents improved to reduce new medico-legal cases
Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	AIDS related deaths reduced by implementing the 90-90-90 strategy
Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	TB mortality reduced by 75%
Maternal, Neonatal, and Child Mortality reduced	Stunting among children reduced
Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	Malaria eliminated by 2023
Co-coordinating health services across the care continuum, re-orienting the health system towards primary health	Improved co-coordination of health services across the care continuum, re-orienting the health system towards primary health

Annexure B: Conditional Grants

Name of Grant	Purpose	Outputs	Current Annual Budget (R thousand)	Period of Grant
National tertiary Services Grant (NTSG)	-Ensure the provision of tertiary health services in South Africa -To compensate tertiary facilities for the additional costs associated with the provision of these services	• Number of inpatient separations • Number of day patient separations • Number of outpatient first attendances • Number of outpatient follow-up attendances • Number of in-patient days • Average length of stay by facility (tertiary) • Bed utilization rate by facility(all levels of care)	470 401	Annual
Statutory Human Resources Training and Development Grant	-To appoint statutory positions in the health sector for systematic realisation of the human resources for health strategy and the phase-in of National Health Insurance -Support provinces to fund service costs associated with clinical training and supervision of health science trainees on the public service platform	• Number and percentage of statutory posts funded from this grant (per category and discipline) and other funding sources • Number and percentage of registrars posts funded from this grant (per discipline) and other funding sources • Number of specialists posts funded from this grant (per discipline) and other funding sources • Number of posts needed per funded category	380 788	Annual
Comprehensive HIV/AIDS Component	-To enable the health sector to develop and implement an effective response to HIV/AIDS -Prevention and protection of health	• Number of new patients started on antiretroviral therapy (ART) • Total number of patients on antiretroviral	1 924 794	Annual

	workers from exposure to hazards in the workplace -To enable the health sector to develop and implement an effective response to TB	therapy remaining in care • Number of male condoms distributed • Number of female condoms distributed • Number of infants tested through the polymerase chain reaction test at 10 weeks • Number of clients tested for HIV (including antenatal) • Number of medical male circumcisions performed • Number of clients started on Pre-Exposure Prophylaxis • Number of HIV positive clients initiated on TB preventative therapy • Number of patients tested for TB using Xpert • Number of eligible HIV positive patients tested for TB using urine lipoarabinomannan assay • Drug sensitive TB treatment start rate (under five years and five years and older) • Number of rifampicin resistant/ multi drug resistant TB patients started on treatment		
District Health Component	-To enable the health sector to develop and implement an effective Malaria response in support of the implementation of the National Strategic Plan on Malaria Elimination	• Number of malaria-endemic municipalities with 95 per cent or more indoor residual spray coverage • Percentage of confirmed malaria cases notified	463 841	Annual

	-To enable the health sector to prevent cervical cancer by making available HPV vaccinations for grade five school girls in all public and special schools and progressive integration of HPV into integrated school health programme. -To ensure provision of quality community outreach services through ward based primary health care outreach teams by ensuring community health workers receive remuneration, tools of trade and training in line with scope of work	within 24 hours of diagnosis in endemic areas • Percentage of confirmed malaria cases investigated and classified within 72 hours in endemic areas • Percentage of identified health facilities with recommended malaria treatment in stock • Percentage of identified health workers trained on malaria elimination • Percentage of population reached through malaria information education and communication on malaria • prevention and early health-seeking behaviour interventions • Percentage of vacant funded malaria positions filled as outlined in the business plan • Number of malaria camps refurbished and/or constructed • 80 per cent of grade five school girls aged nine years and above vaccinated for HPV first dose in the school • reached • 80 per cent of schools with grade five girls reached by the HPV vaccination team with first dose • 80 per cent of grade five school girls aged nine years and above vaccinated for HPV second dose in the		
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		• schools reached. • 80 per cent of schools with grade five girls reached by the HPV vaccination team with second dose • Number of community health workers receiving a stipend • Number of community health workers trained • Number of HIV clients lost to follow-up traced • Number of TB clients lost to follow traced		
National Health Insurance Component	-To expand the healthcare service benefits through the strategic purchasing of services from healthcare providers	• Number of health professionals contracted (total by discipline) • Percentage increase in the number of clients of all ages seen at ambulatory (non-inpatient) services for mental health conditions • Percentage reduction in the backlog of forensic mental observations • Number of patients seen per type of cancer • Percentage reduction in oncology treatment including radiation oncology backlog	97 796	Annual
Health Facility Revitalization grant	-To help to accelerate maintenance, renovations, upgrades, additions, and construction of infrastructure in health -To help on replacement and commissioning of health technology in existing and	• Number of primary health care facilities constructed or revitalised • Number of hospitals constructed or revitalised • Number of facilities maintained or refurbished	552 983	Annual

	revitalised health facility -To enhance capacity to deliver health infrastructure -To accelerate the fulfilment of the requirements of occupational health and safety			
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Annexure C: Consolidated Indicators
Not Applicable

Annexure D: District Development Model

Annexure D: District Development Model

District Municipality	Municipality Name	Project Name	Longitude	Latitude	Budget allocated for the 2023/2024 F/Y R'000	Implementing Agent Name
Capricorn (DC35)						
Capricorn (DC35)	Blouberg (LIM351)	Helene Franz Hospital Projects	29.113	-23.284	10 000	Department of Health
Capricorn (DC35)	Lepele-Nkumpi (LIM355)	Lebowakgomo EMS station Upgrade EMS station	29.483721	-24.3192015	16 057	Department of Public Works
Capricorn (DC35)	Polokwane (LIM354)	Mankweng Hospital Upgrade Laundry Building	29.725	-23.87944	2 000	Department of Public Works
Capricorn (DC35)	Polokwane (LIM354)	Pietersburg Hospital Mass water storage tanks	29.46128	-23.88984	8 260	Department of Health
Capricorn (DC35)	Polokwane (LIM354)	Pietersburg hospital repurposing of ICU Ward & Ward F	29.461	-23.89	7 000	Department of Health
Capricorn (DC35)	Polokwane (LIM354)	Pietersburg hospital Upgrade MCCE (Phase B)	29.46128	-23.88984	20 000	Department of Health
Capricorn (DC35)	Polokwane (LIM354)	Sovenga Nursing College Campus Student Nurses residential accommodation	29.72543	-23.87548	5 000	Department of Health
Capricorn (DC35)	Blouberg (LIM351)	WF Knobel Hospital Project	29.072119	-23.380415	27 000	Department of Health
Total DC35	8				53 792	
Mopani (DC33)						
Mopani (DC33)	Greater Giyani (LIM331)	Giyani Nursing College Campus: Student accommodation	30.42295	-23.31891	15 000	Department of Health
Mopani (DC33)	Greater Tzaneen (LIM333)	Letaba Hospital A6 Replacement Female Medical Ward, upgrade waste store, etc	30.26933	-23.87417	200	Department of Public Works
Mopani (DC33)	Maruleng (LIM335)	Sekororo Hospital Projects	30.44767	-24.2515	5 300	Department of Health
Total DC47	3				20 500	
Sekhukhune (DC47)						
Sekhukhune (DC47)	Elias Motsoaledi (LIM472)	Bosele EMS Station	29.7315487	-25.0230599	14 824	Department of Public Works
Sekhukhune (DC47)	Makhuduthamaga (LIM473)	Jane Furse Hospital Upgrade of Stand By Generators & Related Infrastructure	29.86767	-24.76383	950	Department of Health
Sekhukhune (DC47)	Elias Motsoaledi (LIM472)	Philadelphia Hospital MCCE complex and related areas, Phase A	29.14855	-25.25923	3 000	Department of Health
Total (DC47)	3				18 774	
Vhembe (DC34)						
Vhembe (DC34)	Musina (LIM341)	Messina Hospital: Upgrade of Stand By Generators & Related Infrastructure	30.043	-22.342	1 600	Department of Health
Vhembe (DC34)	Thulamela (LIM343)	Thohoyandou Nursing College Campus Projects	30.48497	-22.94564	6 000	Department of Health
Total (DC34)	2				7 600	
Waterberg (DC36)						
Waterberg (DC36)	Lephalale (LIM362)	Ellisras Hospital Projects	27.70334	-23.67810	40 000	Department of Health
Waterberg (DC36)	Modimolle/Mookgophong (LIM368)	FH Odendaal Hospital Projects	28.42212	-24.7014	70 000	Department of Health
Waterberg (DC36)	Modimolle/Mookgophong (LIM368)	MDR FH Odendaal Hospital: Electrical Upgrades	28.3948	-24.70138	3 000	Department of Health
Waterberg (DC36)	Modimolle/Mookgophong (LIM368)	MDR FH Odendaal Hospital Kitchen	28.3948	-24.70138	3 000	Department of Health
Waterberg (DC36)	Modimolle/Mookgophong (LIM368)	Modimolle EMS Station: New EMS Station	Site To be Confirmed		1 000	Department of Public Works
Waterberg (DC36)	Modimolle/Mookgophong (LIM368)	Phagameng Clinic Replacement of the existing clinic on a new site	Site To be Confirmed		1 000	Department of Public Works
Waterberg (DC36)	Bela-Bela (LIM366)	Warmbad Hospital Projects	28.28873	-24.88592	17 000	Department of Health
Total (DC36)	7				135 000	