Province of the
EASTERN CAPE
HEALTH

OPERATIONAL PLAN 2018/19

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ABBREVIATIONS & ACRONYMS

ACRONYMS

AGSA	Auditor-General SA
APP	Annual Performance Plan
AIP	Audit Intervention Plan
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAC	Basic Accounting System
BANC	Basic Antenatal Care
CCMDD	Central Chronic Medicine Dispensing and Distribution
CFO	Chief Financial Officer
CoE	Compensation of Employees
CSSD	Central Sterile Supply Department
CIBD	Construction Industry Development Board
CHCs	Community Health Centres
CHCWs	Community Health Care Workers
DCSTs	District Clinic Specialist Teams
DDG	Deputy Director General
DHIS	District Health Information System
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short-Course
DPC	Disease Prevention and Control
DPSA	Department of Public Service and Administration
DM	District Municipality
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ECSECC	Eastern Cape Socio-Economic Consultative Status
ELHC	East London Hospital Complex
EMS	Emergency Medical Services
GHS	General Household Survey
HST	Health Sciences and training
HAST	HIV & AIDS, STI and TB control
HCT	HIV Counseling and Testing
HCSS	Health Care Support Services
HFM	Health Facilities Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPTD	Health Professionals Training and Development (Grant)
HRM	Human Resource Management
HRD	Human Resource Development
HRH	Human Resources for Health
ICT	Information and Communications Technology
IMR	Infant mortality rate
ISHP	Integrated School Health Programme
IT	Information Technology
MDGs	Millennium Developmental Goals
MDR-TB	Multi-drug resistant TB
MEC	Member of the Executive Council
METROs	Medical Emergency Transport and Rescue Organizations
MMC	Medical Male Circumcision
MMR	Maternal mortality ratio
MTCT	Mother-To-Child-Transmission
MOU	Maternal Obstetric Unit
MTSF	Medium Term Strategic Framework
NCDs	Non-Communicable Diseases
NCS	National Core Standards
NDoH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NNMR	Neonatal Mortality Rate
NSDA	Negotiated Service Delivery Agreement
NTSG	National Tertiary Services Grant
O&P	Orthotic and Prosthetic
OHH	Outreach Households
OPD	Outpatient Department
OSD	Occupational Specific Dispensation
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PERSAL	Personnel and Salaries
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PMR	Perinatal Mortality Rate
PMTCT	Prevention of Mother-To-Child Transmission
PSS	Patient Satisfaction Surveys
PPPs	Public-Private Partnerships
RPHC	Revitalization of PHC
RPHC	Re-engineering the Primary Health Care System
SADHS	South Africa Demographic and Health Survey
SCM	Supply Chain Management
SDIP	Service Delivery Improvement Plan
SOP	Standard Operating Procedure
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
THS	Traditional Health Services
TROA	Total clients Remaining On ART
WBOTs	Ward-Based Outreach Teams
XDR-TB	Extreme Drug Resistance Tuberculosis

PART A: STRATEGIC OVERVIEW

PART A: STRATEGIC OVERVIEW

1. INTRODUCTION AND OVERVIEW

To be appropriated by Vote

Responsible MEC	MEC for health
Administration Department	Provincial Department of Health
Accounting Officer	Head of Department

2. CORE FUNCTIONS OF THE DEPARTMENT

The core competency of the Provincial Department of Health is the provision of health services, in other words, promotive, preventative, curative and rehabilitative health services

3. VISION

A quality health service to the people of the Eastern Cape Province, promoting a better life for all.

4. MISSION

To provide and ensure accessible, comprehensive, integrated services in the Eastern Cape, emphasizing the primary health care approach, optimally utilizing all resources to enable all its present and future generations to enjoy health and quality of life.

5. VALUES

The department's activities will be anchored on the following values in the next five years and beyond:

- Equity of both distribution and quality of services
- Service excellence, including customer and patient satisfaction
- Fair labour practices
- Performance-driven organization
- High degree of accountability
- Transparency

6. OVERVIEW OF THE MAIN SERVICES

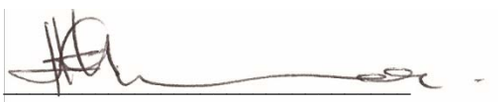
The Department operates through 8 programmes whose activities are spread out within 3 main branches i.e. Corporate Service Branch, Clinical Branch and Finance Branch. The core business of the Department is driven through Programme 2 (District Health Services), Programme 4 (Provincial Hospital Services) with the remainder of the programmes offering the necessary support. This operational plan is based on the 2018/19 Annual Performance Plan of the Department and reflects the activities that the Department will engage during 2018/19 financial year. Monitoring and evaluation to determine if the targets outlined in the plan have been attained, will be made through quarterly and annual reports including the In- Year monitoring system.

This is 2018/19 Operational Plan for the Eastern Cape Department of Health as approved below:

OFFICIAL SIGN-OFF OF THE 2018/19 OPERATIONAL PLAN

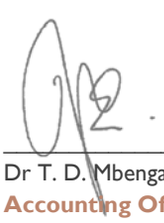
It is hereby certified that this Operational Plan:

- Was developed by the Provincial Department of Health in the Eastern Cape Province;
- Was prepared in line with the current Strategic Plan and APP of the Eastern Cape Department of Health under the guidance of the MEC for Health, Dr P.P. Dyantyi;
- Accurately reflects the activities and quarterly performance targets which the Provincial Department of Health in the Eastern Cape will endeavour to achieve given the resources made available in the budget for 2018/19.



Ms E.L. Nemavhandu:
Acting Chief Director: Strategy and Organizational Performance
Date: 12 / 03 / 2018

Mr S. Kaye:
Chief Financial Officer
Date: 12 / 03 / 2018



Dr T. D. Mbengashe:
Accounting Officer
Date: 12 / 03 / 2018

APPROVED BY:

Dr P.P. Dyantyi:
Executive Authority
Date: 12 / 03 / 2018

7. STRATEGIC GOALS

The Eastern Cape Department of Health in its quest to contribute to its obligations of the National Development Plan (NDP) 2030, identified three strategic goals to focus on, to ensure that the Departmental mandate is fulfilled. These goals are:

- Prevent and reduce the disease burden and promote health
- Improve quality of care and
- Universal health coverage

STRATEGIC GOALS OF THE EASTRN CAPE DEPARTMETN OF HEALTH 2020

The Five-year (2015/16 – 2019/20) Strategic Plan of the Department of Health has three strategic goals aligned to those of the National Department of Health, and will be implemented in the year 2017/18. The strategic objectives are linked to the Medium Term Strategic Framework (MTSF) and the National Health Council Priorities.

Table A1: ECDOH Strategic Plan Goals, Objectives, Outcomes and Linkage with the MTSF Expected Outcomes for 2014 - 2019

MTSF 2014-2019 (Expected Outcomes)	Strategic Goal	Strategic Objectives	ECDOH Strategic Plan Expected Outcomes
• HIV & AIDS and Tuberculosis prevented and successfully managed; • Maternal, infant and child mortality reduced.	• Prevent and reduce the disease burden and promote health	• HIV infection rate reduced by 15% by 2019; • TB death rate reduced by 30% in 2019; • Child Mortality Reduced to less than 34 per 1000 population by 2019; • Maternal Mortality Ratio Reduced to less than 105 per 100 000 population by 2019; • 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019 • Screening coverage of chronic illnesses increased to more than a million by 2019	• Progressively ensure all HIV positive patients eligible for treatment are initiated on ART; • Increase TB cure rate to 50%; • Ensure 90% of children are vaccinated and monitored for growth; • Reduce Maternal Mortality Ratio to 215 per 100 000 live births; • Reduce hypertension and diabetes incidence; • Ensure 100% of quintile 1&2 schools are providing school health services
• Improved quality of health care	• Improved quality of care	• Patient/Client satisfaction rate increased to more than 75% in health services by 2019; • Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019;	• Improved quality of health care • Ensure all facilities are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards
• Efficient Health Management Information System for improved decision making	• Improved quality of care	• 100% of health facilities connected to web-based DHIS through broadband by 2019	• Efficient Health Management • Information System for improved decision making • Implement web based district health information system at 90% of all facilities
• Improved human resources for health	• Improved quality of care	• First year Health professional students receiving bursaries by 2019	• Improved human resources for Health • Increase enrollment of Medicine, Nursing and Pharmacy students annually by 10% per annum.
• Improved health • management and leadership	• Improved quality of care	• Clean audit opinion achieved by 2019	• Improved health management and Leadership • Clean audit opinion from the Auditor General
• Improved health facility planning and infrastructure delivery	• Improved quality of care	• Health facilities refurbished to comply with the National norms and standards by 2019	• Improved health facility planning and infrastructure delivery • Compliance with Norms &

MTSF 2014-2019 (Expected Outcomes)	Strategic Goal	Strategic Objectives	ECDOH Strategic Plan Expected Outcomes
			Standards for all new Infrastructure Projects
• Universal Health coverage achieved through implementation of National Health Insurance; • Re-engineering of Primary Health Care	• Universal health coverage Improved quality of care	• 100% Ward Based Outreach Teams (WBOT) coverage by 2019	• Universal Health coverage achieved through implementation of National Health Insurance; • Re-engineering of Primary Health Care • Appoint Ward Based Outreach Teams (WBOTs) in 23 Rural Districts (as classified by the Dept. of Rural Development)

Table A2: Summary of Provincial payments and estimates by programme: Health

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2017/18
	2014/15	2015/16	2016/17		2017/18		2018/19	2019/20	2020/21	
1. Administration	576 459	668 261	706 937	687 001	694 905	663 403	695 199	741 857	773 107	4.8
2. District Health Services	8 939 147	9 516 426	10 420 604	10 937 544	11 162 640	11 392 808	12 031 947	12 899 136	13 899 332	5.6
3. Emergency Medical Services	850 947	946 270	1 067 653	1 222 366	1 352 642	1 359 928	1 284 612	1 432 230	1 539 458	(5.5)
4. Provincial Hospital Services	2 818 809	4 927 742	3 250 197	3 322 570	3 590 420	3 276 014	3 857 135	4 100 859	4 410 158	17.7
5. Central Hospital Services	2 444 026	823 221	2 913 621	3 108 963	3 280 237	3 816 133	3 447 737	3 656 376	3 913 787	(9.7)
6. Health Sciences And Training	726 252	769 372	749 372	853 145	832 946	811 619	885 346	943 485	983 851	9.1
7. Health Care Support Services	92 399	93 129	101 861	130 759	130 759	119 235	125 512	132 371	141 240	5.3
8. Health Facilities Management	1 101 815	1 199 522	1 295 934	1 444 817	1 292 032	1 331 999	1 372 071	1 316 896	1 382 526	3.0
Total payments and estimates	17 549 854	18 943 943	20 506 179	21 707 165	22 336 581	22 771 139	23 699 560	25 223 210	27 043 459	4.1

Table A3: Summary of Provincial payments and estimates by economic classification: Health

R thousand	Outcome 2014/15	Outcome 2015/16	Outcome 2016/17	Main appropriation 2017/18	Adjusted appropriation 2017/18	Revised estimate 2017/18	Medium-term estimates 2018/19	Medium-term estimates 2019/20	Medium-term estimates 2020/21	% change from 2017/18
Current payments	16 173 844	17 091 967	18 669 958	20 072 946	20 745 678	20 769 512	21 982 246	23 537 504	25 305 900	5.8
Compensation of employees	11 576 336	12 562 282	13 454 333	14 415 655	14 670 660	14 699 278	15 860 414	16 950 849	18 185 086	7.9
Goods and services	4 595 260	4 522 995	5 206 207	5 657 290	6 075 018	6 067 691	6 121 833	6 586 655	7 120 814	0.9
Interest and rent on land	2 248	6 690	9 418	–	–	2 543	–	–	–	(100.0)
Transfers and subsidies to:	355 268	571 824	558 634	290 342	282 430	692 108	287 404	296 670	315 455	(58.5)
Provinces and municipalities	9 122	13 229	8 451	3 427	4 181	4 181	1 200	–	–	(71.3)
Departmental agencies and accounts	15 542	35 417	18 877	46 661	11 013	11 013	12 479	14 728	17 060	13.3
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	10 152	6 596	18 145	11 838	13 589	175.1
Households	330 604	523 178	531 306	240 254	257 084	670 318	255 580	270 104	284 806	(61.9)
Payments for capital assets	1 020 742	1 280 152	1 277 587	1 343 877	1 308 473	1 309 519	1 429 910	1 389 036	1 422 104	9.2
Buildings and other fixed structures	672 696	881 906	654 895	727 420	626 733	610 535	810 500	814 616	771 695	32.8
Machinery and equipment	348 046	397 400	622 692	616 457	681 740	698 984	619 410	574 420	650 409	(11.4)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	-	-	-	-	-	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	846	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	17 549 854	18 943 943	20 506 179	21 707 165	22 336 581	22 771 139	23 699 560	25 223 210	27 043 459	4.1

Table A2 and A3 above show the summary of payments and estimates per programme and economic classification. It indicates that total payments grew from R17.549 billion in 2014/15 to a revised estimate of R22.771 billion in 2017/18. In 2018/19, the budget is projected to grow by 4.1 per cent to R23.699 billion from the 2017/18 revised estimate as funds were provided amongst others for wage inflation, Ideal Clinic Realisation, National Health Insurance implementation, building capacity to address medico legal claims and fighting TB, HIV and AIDS.

Compensation of Employees and Goods and Services are the key cost drivers of the department and show growth of 7.9 and 0.9 per cent respectively.

Transfers to provinces and municipalities show a significant decrease of 58.5 per cent from the revised estimates of 2017/18 in line with signed SLAs with existing municipalities for the devolution of the environmental services. There is also a decrease by 61.9 per cent in transfers to households due to the high revised estimate which takes into account payments for bursaries to non-employees, leave gratuity and medico-legal claims. Expenditure for the payment of capital assets increased by 9.2 per cent.

PART B
PROGRAMME AND SUB-PROGRAMME PLANS

PROGRAMME 1: HEALTH ADMINISTRATION AND MANAGEMENT

PART B:
PROGRAMME AND SUB-PROGRAMME PLANS

1. PROGRAMME 1: HEALTH ADMINISTRATION AND MANAGEMENT

The Health Administration and Management programme comprises of two main components: the Administration component, which refers to the Executive Authority and lies with the Office of the Member of Executive Council (MEC); and the second component, which is the Management of the organisation and is primarily the function of the Office of the Superintendent General.

1.1 Sub-programme: Health Administration - office of the MEC

SUB - PROGRAMME PURPOSE

To provide political and strategic direction to the Department by focusing on transformation and change management.

Priorities for the next three years

- Give political and strategic direction to the Department;
- Engage all governance structures of the Department, i.e. Hospital boards, Clinic Committees, Provincial Health Council, and Lilitha Education Nursing Council.

Strategic Goal being addressed:

- **Strategic Goal 2:** Improved quality of care

Table ADMIN 1: Provincial strategic objectives, annual and quarterly targets for office of the MEC

Table MEC 1: Quarterly Activities for management 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets			
								Q1	Q2	Q3	Q4
Provide political and strategic direction to the Department by focusing on transformation on and change management	Development and Submission of Statutory documents	Number of statutory documents tabled at Legislature	AGSA Audit report	Quarterly	6 statutory documents	2 statutory documents	8	-	1	2	5

1.2 Sub-programme: Health Management

Sub-programme purpose

To manage human, financial, information and infrastructure resources. This is where all the policy, strategic planning and development, coordination, monitoring and evaluation, including regulatory functions of head office, are located.
The management component under the Superintendent General's supervision is comprised of three clusters with their sub-components (branches) as listed below:

Finance Branch

- Financial Management Services
- Integrated Budget Planning and Expenditure Review
- Supply Chain Management (SCM)

Corporate Services Branch

- Information, Communication and Technology (ICT)
- Human Resource Management (HRM)
- Human Resource Development (HRD)
- Corporate Services
- Infrastructure
- Internal Audit
- Strategy & Organisational Performance

Clinical Branch

- District Health Services
- Hospital Services
- Communicable Diseases
- Health Programmes
- Clinical Support Services
- Quality Assurance

Priorities for the next three years

- To facilitate effective human resources planning development and management in order to improve provision of health services
- To implement corporate systems to support the service delivery imperatives of the department
- To achieve a clean regulatory audit opinion
- To review and develop of the three-year Annual Performance Plan (APP) and one year Operational Plan of the Department and to ensure alignment to national and provincial priorities
- To review and assist the Central, Regional and Tertiary hospitals develop of their plans in line with the indicative MTSF
- To communicate the strategic imperatives of the department all employees of the department, especially at sub-district & facility levels
- To monitor the performance of health programs through the development and production of quarterly, mid-year and annual report
- To coordinate the auditing of Pre-determined Objectives and Sector Audit
- To support the improvement of management systems through the implementation of the MPAT process

Strategic Goal being addressed:

Strategic Goal 2: Improved quality of care

Budget Allocation for Programme 1: 2018/19

Budget	R'000
Compensation of employees	440,856
Goods and services	246,329
Transfers	**1,613**
Capital assets	**6,401**
Total Budget	**695,199**

Table ADMIN 2: Quarterly Activities for Management 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
FINANCE												
Clean audit opinion achieved by 2019	Monitor the Integrated Audit Improvement Strategy (IAIS)	Audit opinion from Auditor-General	AGSA Audit report	Annually	Unqualified Audit Report	Unqualified audit report	Unqualified audit report	-	-	-	Unqualified audit report	
Ensure level 3 MPAT	Ensure that all policies are in place and enforce the implementation thereof	Level 3 MPAT	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	Human resources MPAT Level 3	Level 3	Level 3	-	-	-	Level 3	
	Minimise unauthorised expenditure	Over expenditure(percentage)	BAS + IYM reports	Quarterly	1%	1%	1%	1%	1%	1%	1%	
	Improved revenue generation	Amount of revenue generated(rand value)	BAS and DELTA9	Quarterly	R 156,7m	R165,5mil	R165,5mil	R165,5mil	R165,5mil	R165,5mil	R165,5mil	
ICT												
100% of Health facilities connected to Web based DHIS by 2019.	Identification of sites per district Submission of prescribed forms Implementation, commissioning and monitoring	Percentage of Hospitals with broadband access	Internet rollout report	Quarterly	26%	100%	100%	100%	100%	100%	100%	
		Numerator			6	89(6New)	89	89	89	89	89	
		Denominator			23	89	89	89	89	89	89	
	Identification of sites per district Submission of prescribed forms Implementation, commissioning and monitoring	Percentage of PHC with broadband access	Internet rollout report	Quarterly	28.5%	97.4%	100%	97.4%	97.9%	99.5%	100%	
		Numerator			686(220) new)	752	772 (20 new)	752 (0 new)	756 (4 new)	768 (12 new)	772 (4 new)	
		Denominator			772	772	772	772	772	772	772	
Ensure good corporate governance	Identify sites by scrutinizing the Telkom account and extracting the sites to be	Percentage of upgraded telephone systems(PABX)	Commissioning reports at individual sites Telkom account	Quarterly	44%	100%	100%	56%	73.8%	88%	100%	
		Numerator			74	168	168 94(20	168 94(20	168 94(20	168 94(20	168 94(20	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	upgraded	Denominator			168	168	168	168	168	168	168	
HRM												
To facilitate effective human resources planning, development and management in order to improve provision of health services	Ensure that all policies are in place and enforce the implementation thereof	Human resources MPAT Level 4	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	Human resources MPAT Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	
	Conduct Provincial Employee Satisfaction Survey	Employee satisfaction rate	Employee satisfaction survey report	Annual	65%	75%	75%	75%	75%	75%	75%	
	Attend to Employee Relations Cases	Employee wellness utilization rate	Statistics and Case Database	Quarterly	3%	3%	3%	2.5%	2.7%	2.8%	3%	
	Finalize Employee Relations cases within 90 days	Percentage of employee relations cases finalized within 90 days.	Statistics	Quarterly		100%	100%	25%	50%	75%	100%	
	Process the exit benefits of employees exiting the service within 3 months of termination	Percentage of employees whose exit benefits are paid within 3 months.	Persal reports	Quarterly	90%	100%	100%	100%	100%	100%	100%	
To facilitate effective human resources planning, development and management in	Conduct Health Risk Assessments for employees	No. of Health Risk Assessments sessions done	Health Risk Assessment report and attendance registers	Quarterly	80	90	90	20	25	20	25	
	Conduct Job Evaluation	% of Job Evaluation conducted	Job evaluation report	Quarterly	50%	100%	100%	25%	50%	85%	100%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
order to improve provision of health services	Conduct diagnostic review of Employee Relations cases and write plan for corrective action and support	Employee relations utilization rate	Statistics and Case Database	Quarterly	100%	5%	5%	4.5%	4.7%	4.8%	5%	
SOP												
	Customize & Distribute the template Consolidate the inputs into the APP Conduct consultation session Prepare tender for final printing submit to the SG for Print summarised version of APP & distribute (districts & facilities)	Approved 3 year Annual Performance Plan	Submission letter, Tabling letter	Quarterly	APP approved and submitted	APP approved and submitted	Submission of APP 2018/19	-	Submission of the 1st draft of the 2018/19APP	Submission of the 2nd draft of the 2018/19APP	Submission of the finalised 2018/19 Annual performance plan	
	Provide managers with the template for of the Operational Plan Consolidate inputs and revise quarterly targets	Approved 1year 2018/19 Operational Plan	Tabling letter	Annual	OP approved and submitted	OP approved and submitted	Submission of OP 2018/19	-	Provide programme manager with the template	Development of the Operational Plan	Submission of the finalised 2018/19 Operational plan	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Support visits to sub – districts & do build capacity share government priorities and assist them in the development of their operational plans.	Number of sessions hosted to communicate the strategic imperatives	Reports	Quarterly			Eight consolidated reports submitted	Develop a report on the communication session attended for NMM and BCM Sub -districts	Develop a report on the communication session attended for Joe Gqabi and Chris Hani Sub -districts	Develop a report on the communication session attended for Amathole and Sara Baartman Sub- districts	Develop a report on the communication session attended for OR Tambo and Alfred Nzo Sub - districts	
Unqualified audit opinion achieved by 2019	Facilitate review and development of the DHER by all districts.	2017/18 DHER reports developed	Web based DHER report	Annually	8 District 2015/16DHER reports available	8 District 2016/17 DHER reports.	8 District 2017/18 DHER reports submitted to NDOH.	2017/18 DHER templates, website address and passwords distributed to all districts	08 DHER reports produced and submitted to National office by 30 July 2018.	-	-	
							Provincial DHER Report developed		Provincial DHER Report developed			

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Host Provincial Planners, Monitoring, & Evaluation Forum. Facilitate the review and development of District Health Plans based on the Departmental Annual Performance Plan and other International, National and provincial imperatives Circulate 2019/20-21/22 Standardized DHP template to all districts. 8 capacity building sessions on revised DHP framework for 8 districts.	No of provincial planners, monitoring and evaluation forum hosted. 2019/20-21/22 DHPs revised and submitted to NDOH.	Planners and Monitoring & Evaluation forum Report Submission letter to NDOH.	Bi annual Annually	2 planners forum hosted 2017/18 DHP s for eight districts submitted to NDOH	1 planners forum hosted 18/19-20/21 DHP s for eight districts submitted to NDOH	2 planner's forum hosted. Approved 19/20-21/22 DHP s submitted to NDOH	- Assessment report on APP – DHP alignment.	Provincial Planners Forum Hosted. 1st Draft 2019/20- 21/22 DHP submitted to NDOH	- 2nd Draft 2019/20- 21/22 DHP s developed and submitted to NDOH	Provincial Planners Forum Hosted. Final 2019/20-21/22 DHP s developed and submitted to NDOH	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate the review development of district operational plans. Operational plans template developed and circulated to districts	2019/20 Operational plans for districts assessed for alignment to DHP	Report on Operational plans alignment to APP and DHP	Annually	08 district operational plans assessed	08 district Operational plans assessed	08 Operational plans assessed for alignment to APP and DHP.	-	-	Operational plans template developed and circulated to districts	08 Operational plans assessed for alignment to the APP.	
	Support the review of development of Service delivery improvement plan. Process mapping of key services. Support development of Standard operating procedures.	2018/ 19 Service delivery improvement plan reviewed	2018/ 19 Service delivery improvement plan	Annually	2014/15 – 17/18 SDIP	Draft 2018/19-20/21 SDIP	2018 /19 - 20/21 Reviewed SDIP	Process mapping for Maternal and child health services	Process mapping for Maternal and child health services		Reviewed 2018/19-20/21 SDIP	
To implement systems for effective planning, Monitoring and Evaluation process in order to improve the provision of health services.(DQI)	Measure Health facilities that submitted DHIS,ETR, Tier.Net data & ART Cohort data in compliance with Routine Data Flow Policy timelines. (Timeliness and Submission)	% Health Districts that submitted DHIS data in compliance with Routine Data Flow Policy target dates (Timeliness and Submission)	Monthly data quality index reports	Quarterly	87%	95%	95%	95%	95%	95%	95%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Measure Health facilities that submitted complete DHIS data elements on PHC, Hospital, EHS ,WBOT, ISHP, EMS, Monthly ART and ART Cohort (Completeness 2017 NIDS document & data sets)	% Health Districts that submitted complete DHIS data elements in compliance with revised facility SOP timelines.	Monthly data quality index reports	Quarterly	93%	90%	90%	90%	90%	90%	90%	
	Measure Health facilities that complied with absolute validation rules& ETR data clean up per District.	% Health Facilities that complied with absolute validation rules	Monthly data quality index reports	Quarterly	71%	75%	72%	72%	72%	72%	72%	
	Compile Pre-submission data verification report.	Number of Pre-submission data verification report compiled	Pre-submission data verification report compiled reports	Quarterly	12 reports	12 reports	12 reports	3 reports	3 reports	3 reports	3 reports	
	Convene NIDS training workshops	Number of Districts trained on NIDS	Training reports and attendance registers	Quarterly	Nil	Nil	8 Districts Trained	1	3	3	1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Institutionalize DHIMS Policy and SOP's by capacitating Programme Managers Facilitate and prepare logistics for the workshop Requests for slots in Programmes, PHC and Hospitals Services planned meetings for the discussion on DHIMS and SOP's	Number of DHIMS and SOP's workshops conducted for Programme Managers	Workshop Reports Attendance Registers	Quarterly	Nil	Nil	4	1	1	1	1	
	Facilitate and prepare logistics for the workshop Requests for slots in Programmes, PHC and Hospitals Services planned meetings for the discussion on DHIMS and SOP's	Number of DHIMS and SOP's workshops conducted for Operational Managers and CEO's	Workshop Reports Attendance Registers	Quarterly	Nil	Nil	6	1	2	2	1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To implement , maintain and support systems and programmes	-Orientation on new developments in DHIS, ETR and Tier .Net - Communication on new developments in DHIS, ETR and Tier .Net -Ensure distribution of updated builds, data files, fixes and system upgraded versions for functionality to 6 Districts and 2 Metro's. -Ensure timely and appropriate Response to data request -Give regular feedback to districts and Programmes	Information systems support provided to 6 districts and 2 metros	Attendance Register System support report	Quarterly	8	8	8	8	8	8	8	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To conduct Performance review of the districts through Quarterly meetings	-Send Communication to relevant stakeholders -Prepare and present Programme performance reports per target set. -Assist with logistics for the meeting -Compile Minutes of all the events before, during and after the Quarterly meeting.	Number of performance review meetings held	Attendance Register Performance review report	Quarterly	3	4	4	1	1	1	1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To facilitate migration of all health facilities from DHIS 1.4 to e Register and DHIS 2	-Support health facilities transitioned to Web DHIS. -Registration of data capturers on the Web Instance and completion of the online signatures. -Creation of users on the web -On site training on data capturing and importance of submitting complete data -Validation of data after capturing -Training of data capturers on the eSummary for those not connected. -Training of clinicians on eRegister. -Training of Data Capturers on DHIS WEB Instance -Trainer Of Trainee Co-ordination.	Number of health facilities transitioned to Web DHIS	Reports attendance registers	Quarterly	5	50	120	30	60	90	120	
To strengthen THIS and ETR.NET Implementation	Identify eligible facilities for integration of Tier and ETR .Net	Number of facilities with Tier.Net & ETR module captured at facility level increased	List of the facilities capturing on Tier.Net & ETR module	Quarterly	402	402	470	118	118	118	116	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Contribute towards the achievement of a clean audit in 2018/19	Develop HIMS intervention audit strategy Coordinate and Share HIMS audit findings provincially Monitor action plans developed based on HIMS audit findings provincially	Approved HIMS Audit intervention strategy	Availability of Approved HIMS strategy	Annual	Approved HIMS Strategy	Approved HIMS Strategy	Approved HIMS Strategy	-	-	-	Approved HIMS Strategy	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To establish a functional information management governance structure	-Communicate the intention to launch the information structure -Preparatory meetings conducted for the launch -Appointment of Health Information Management Systems Committee members Prepare logistics for the launch meeting Develop Terms of Reference for Health Information Management Systems Committee Launch of Health Information Management Systems Committee Convene Health Information Management Systems Committee quarterly meetings	Launched Health Information Management Systems Committee Quarterly Health Information Management Systems Committee Meetings conducted	Health Information Management Systems Committee minutes and attendance registers	Quarterly	New Indicator	New Indicator	Established functional Health Information Management Systems Committee	Launch of Health Information Management Systems Committee	Health Information Management Systems Committee quarterly meetings convened	Health Information Management Systems Committee quarterly meetings convened	Established functional Health Information Management Systems Committee	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Prevent disease and reduce its burden	Coordinate influenza vaccination	No. of district trained on influenza vaccination.	Attendance Registers	Annually	8	8	8	2	2	2	2	
		Influenza vaccine utilization rate	Report	Annually	86.4%	93%	90%	90%	90%	90%	90%	
	Post-influenza vaccination evaluation	Evaluation conducted	Report	Annually	-	-	8 districts	2	2	2	2	
	Epidemic Preparedness & Response	No. of Outbreak Response Team meetings held	Minutes Attendance Registers	Quarterly	-	-	4 meetings	1	1	1	1	
			Epidemic Preparedness Plan for 2019/20	Annually	-	-	Epidemic Preparedness plan (EPR) developed	Draft	Circulate for inputs	Finalize the EPR plan	Approval and budget allocation	
		% of outbreaks investigated within 24 hours of detection	Report	Quarterly	6/9	80%	90%	90%	90%	90%	90%	
	Coordinate surveillance	AFP Detection rate (per 100 000 pop <15years)	Report	Quarterly	2.5	2.7	3	3	3	3	3	
		Stool adequacy		Quarterly	71%	51%	80%	80%	80%	80%	80%	
		Measles detection rate (non-febrile rash measles)		Quarterly	2 per 100,000	2 per 100,000	2 per 100,000 pop	2 per 100,000	2 per 100,000	2 per 100,000	2 per 100,000	
Prevent disease and reduce its burden	Coordinate surveillance	No. of hospital piloting Notifiable Medical Conditions (NMC) database	Report Attendance Register	Quarterly			5 hospitals	0	5	Monitor	Monitor	
Provide information needed for decision making and planning	Coordinate research	No. of Research Committee meetings held	Minutes; Attendance Register	Quarterly	4 meetings	One meeting	4 meetings	1	1	1	1	
		Research agenda for the department	Research Agenda (document)	Quarterly			Research agenda	Data collection	Data collection	Development of research agenda	Finalize research agenda	
		% of research protocols approved	Line-list of research being conducted	Quarterly	100%)	99%	95%	95%	95%	95%	95%	
	Programme or policy evaluation	No. of evaluations conducted	Report	Once off		1	2	Inception report	Approval by the Departmental Evaluation Steering Committee	Data collection	Data collection & draft report.	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Antenatal HIV survey	No. of research projects/Surveys conducted	Report	Annually		Survey done	Survey (x1)		Training & distribution of survey equipment	Data collection	Report (without the results)	
	Research seminars	No. of research seminars	Reports Attendance registers	Bi-annually			2	1	-	1	-	
Monitoring and reporting on performance at provincial level	Coordinate, compile and submit compliance Performance Reports to relevant authorities.	No. of Reports submitted	Reports	Quarterly	15	15	15	1. Quarterly Performance Reporting System (QPRS)	1. QPRS 2. POA	1. QPRS	1. QPRS	
								2. Fin and Non-fin quarterly report 3. Program of action (POA) 4. 1st Draft Annual Report (AR)	3. Fin and Non-fin quarterly report 4. Final AR 5. Half-year over-sight report	2. Fin and Non-fin quarterly report 3. POA	2. Fin and Non-fin quarterly report 3. POA	
	Ensure collection of Portfolio of Evidence (POE).	No. of Portfolio of Evidence (POE).	Documents	Quarterly	15	15	15	Collection of POE (4)	Collection of POE(5)	Collection of POE (3)	Collection of POE (3)	
	Coordinate provincial quarterly performance reviews	No. of Quarterly reviews conducted	Minutes and attendance registers	Quarterly	4	4	4	1	1	1	1	
	Support Program managers to develop performance improvement plans (PIP)	No. of Performance program improvement plans (PIP) developed.	Program improvement plans	Quarterly		4	4	1	1	1	1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Coordinate and produce ADHOC reports	No. of ADHOC reports	Reports	Quarterly		5	5	ADHOC report (1)	ADHOC report (1)	ADHOC report (1)	ADHOC report (2)	
Support improvement of administrative and Management Systems	Facilitate the Management Performance Improvement Tool (MPAT)	MPAT level 3	MPAT results	Annually	2	2	2	-	-	MPAT self-assessment done and submitted	MPAT Final assessment done	
	Facilitate development and implementation of MPAT improvement plan	No. of improvement plans developed	Improvement plan document	Annually	1	1	1	-	-	-	Develop MPAT Improvement plan	
District Support for Performance Improvement at District and Facility levels	Attend and participate during district performance review meetings	No. of district review meetings attended	Attendance Register	Quarterly	4	4	4	1	1	1	1	
	Organize M&E Indaba for program and facility Managers	No. of M& E Indaba organized	Attendance Registers	Bi-Annually	2	2	2	-	M& E Indaba organized	-	M& E Indaba organized	
	Mentor facility managers and staff on M&E systems	No. of Mentorship meetings	Attendance Registers	Bi-Annually	2	2	2	-	1 Mentorship meeting organized	-	1 Mentorship meeting organized	
Improvement of pre-determined Objectives audit outcomes through collaborative activities with Internal Audit Unit (IA).	Liaise with IA unit and prepare facilities on audit processes in order to improve audit outcomes.	No. of Facilities visited in preparation of auditing.	Attendance Registers IA report	Quarterly	-	-	12	3 Facilities visited in preparation of audit processes	3 Facilities visited in preparation of audit processes	3 Facilities visited in preparation of audit processes	3 Facilities visited in preparation of audit processes	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To contribute towards achievement of unqualified audit opinion by 2016	Manage and distribute RFI to relevant facilities (selected for auditing). Communicate, Support ,follow up and report all facilities selected for auditing Coordinate and share auditing findings to all districts 6 &2 Metro's Monitor action plans developed based on audit findings for all 6 Districts and 2 Metro's	Approved Audit intervention strategy.	Availability of Approved Strategy	Annual	Approved Strategy	Approved Strategy	Approved Strategy	-	-	Approved Strategy	-	

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

2. PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

Programme Purpose

To ensure the delivery of primary health care services through the implementation of the District Health System.

Programme Description

The District Health Service (DHS) programme is composed of nine sub-programmes, namely:

2.1 District Management
2.2 Community Health Clinics
2.3 Community Health Centres (CHCs)
2.4 Community-based Services
2.5 Other Community Services
2.6 HIV & AIDS, STI and TB (HAST) Control
2.7 Maternal, Child and Women's Health & Nutrition
2.8 Coroner Services
2.9 District Hospitals

Priorities for the Next three years

- To implement the model for the delivery of health services in the Eastern Cape based on the re-engineering of primary health care (PHC) services
- To implement and strengthen NHI preparatory in the pilot district
- To prevent and reduce morbidity and mortality related to TB, HIV/AIDS and STIs
- To reduce perinatal, infant and child mortality and maternal mortality within the province
- To improve early detection and management of people with chronic conditions

Strategic goal being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care
Strategic goal 3: Universal Health Care Coverage

Strategic Objectives being addressed:

Strategic objective 1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019
Strategic objective 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic objective 2.4 Patient/Client satisfaction rate increased to more than 75% in health services by 2019
Strategic objective 3.2 100% Ward Based Outreach Teams (WBOT) coverage by 2019

Budget Allocation for Programme 2 2018/19

Budget	R'000
Compensation of employees	8,600,082
Goods and services	3,224,664
Transfers	**63,473**
Capital assets	**143,728**
Total Budget	**12,031,947**

2.1 Sub-Programme District Management

The sub-programme manages the effectiveness and functionality as well as the coordination of health services, referrals, supervision, evaluation and reporting as per provincial and national policies and requirements.

Table DM 1: Quarterly Targets for District Health Services sub programme 2.1

Table DHS 1: Quarterly targets for District Management, Clinics and CHCs sub- programmes for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	Facilitate implementation of Ideal clinics and national core standards compliance	PHC utilisation rate[1]	Stats SA, facility register, patient records	Quarterly	2.7	2.5	2.8	2.8	2.8	2.8	2.8	
		Numerator			18 096 847	16 958 196	17 991126	4 497 782	4 497 782	4 497 781	4 497 781	
		Denominator			6 741 704	6 692 804	6 425 402	6 425 402	6 425 402	6 425 402	6 425 402	

[1] Utilisation rate is an annualised indicator and the numerator is multiplied by 4 to get the actual number of visits.

2.2 Sub- Programme Clinics

The sub-programme manages the provision of preventive, promotive, curative and rehabilitative care, including the implementation of priority health programmes through accessible fixed clinics, outreach services (reengineering of PHC services) and mobile services in 26 sub-districts.

Quarterly Targets for District Health Services for Clinics sub-programme 2.2

Table DHS 1: Quarterly targets for District Management, Clinics and CHCs sub- programmes for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Implementation of ICRM according to the approved business plan	Ideal clinic status rate	ICRM system	Quarterly	New indicator	New indicator	13.6%	3.4%	6.8%	10.2%	13.6%	
		Numerator					100	25	50	75	100	
		Denominator					731	731	731	731	731	
Patient experience of care rate increased to more than 75% in health services by 2019	Strengthening implementation of complaints management policy	Complaints Resolution Rate	Complaints register, redress report	Quarterly	85%	80%	80%	80%	80%	80%	80%	
		Complaint resolution within 25 working days rate	Complaints register, redress report	Quarterly	81.6%	96.3%	85%	85%	85%	85%	85%	
		Numerator					2 661	665	665	666	665	
		Denominator					3 131	782	783	783	783	

2.3 Sub – Programme Community Health Centres (CHCs)

The sub-programme renders 24-hour health services, maternal health at midwifery units and the provision of trauma services, as well as the integration of community-based mental health services within the down referral system.

Quarterly Targets for District Health Services for CHCs sub-programme 2.3

Table DHS 1: Quarterly targets for District Management, Clinics and CHCs sub- programmes for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Implementation of ICRM according to the approved business plan	Ideal CHC status rate	ICRM system	Quarterly	New indicator	New indicator	39%	9.7%	19.5%	29.2%	39%	
		Numerator					16	4	8	12	16	
		Denominator					41	41	41	41	41	
Patient experience of care rate increased to more than 75% in health services by 2019	Strengthening implementation of complaints management policy	Complaints Resolution Rate	Complaints register, redress report	Quarterly	85%	80%	80%	80%	80%	80%	80%	
		Complaint resolution within 25 working days rate	Complaints register, redress report	Quarterly	81.6%	96.3%	85%	85%	85%	85%	85%	
		Numerator					651	162	163	163	163	
		Denominator					767	191	192	192	192	

2.4 Sub programme: Community Based Services – Disease Prevention and Control (Non -Communicable Diseases)

Sub programme purpose

The Community-based Services sub-programme manages the implementation of the Community-based Health Services Framework. This includes:

- Implementation of disease-prevention strategies at a community level
- Promoting healthy lifestyles through health education and support
- Providing chronic and geriatric services including rehabilitation as a supportive service
- Providing oral health services at a community level (including schools and old age homes)
- Strengthening the prevention of mental disorders, substance, drug, and alcohol abuse to reduce unnatural deaths

Strategic Goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Strategic Objectives being addressed:

Strategic objective 1.2 Screening coverage of chronic illnesses increased to more than a million by 2019

Table DPC 1: Quarterly targets for Disease Prevention and Control Sub- programme for 2018/19

Table DPC 1: Quarterly targets for Disease Prevention and Control sub- programme for 2018/19												
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**				**Budget R'000**
								Q1	**Q2**	**Q3**	**Q4**	
Screening coverage of chronic illnesses increased to more than a million by 2019	NCD quarterly reviews Avail chronic diseases guidelines and IEC material and basic equipment in Ideal clinics Support training of chronic conditions guidelines (diabetes hypertension and mental health) Support district in diabetes awareness (November), hypertension (May) and mental health (July) Support district in mental illness awareness (July	Clients 40 years and older screened for hypertension	Facility registers	Quarterly	New indicator	1 425 631	1 476 740	369 185	369 185	369 185	369 185	
		Clients 40 years and older screened for diabetes	Facility registers	Quarterly	New indicator	1 542 304	1 484 812	371 203	371 203	371 203	371 203	
		Mental disorders screening rate	Facility registers	Quarterly	6.5%	14.1%	10%	10%	10%	10%	10%	
		Numerator			41 486	1 700 018	1 784 834	446 208	446 208	446 209	446 209	
		Denominator			19 117 991	12 053 673	17 848 340	4 462 085	4 462 085	4 462 085	4 462 085	

2.5 Sub-Programme: Other Community Services

Sub programme purpose

The Other Community Services sub-programme manages the devolution of municipal health service from the Department of Health to the district municipalities and metros, (health care waste management and other hazardous substances control), and implements a port health strategy to control the spread of communicable diseases through ports of entry into the province.

Strategic Goals being addressed:

Strategic goal 1: Improved quality of care

Strategic Objectives being addressed:

Strategic objective 2.5 100% Compliance with the Waste Management Act by 2019

Table OCS 1: Quarterly targets for Other Community Services sub – programme for 2018/19

Table OCS 1: Quarterly targets for Other Community Services sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
100% Compliance with the Waste Management Act by 2019	Delegation of waste officers per hospital Conduct situational analysis on medical waste management in Hospitals	Percentage of health facilities complying with SANS waste disposal requirements	Waste segregation audit tool, audit report	Quarterly	100%	85%	85.3%	85.3%	85.3%	85.3%	85.3%	
		Numerator			89	76	76	76	76	76	76	
		Denominator			89	89	89	89	89	89	89	

2.6 Sub-programme: HIV & AIDS, STI & TB (HAST) Control

2.6.1 PURPOSE

To control the spread of HIV infection, reduce and manage the impact of the disease to those infected and affected in line with PGDP goals, and to control the spread of TB, manage individuals infected with the disease and reduce the impact of the disease in the communities.

Strategic Goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health

Strategic Objectives being addressed:

Strategic objectives 1.4 HIV infection rate reduced by 15% by 2019
Strategic objectives 1.5 TB death rate reduced by 30% in 2019

Table HAST 1: Quarterly targets for HIV & AIDS, STI AND TB Control sub – programme for 2018/19

Table HAST 1: Quarterly targets for HIV & AIDS, STI AND TB Control sub – programme for 2018/19												
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification on**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**				**Budget R'000**
								Q1	**Q2**	**Q3**	**Q4**	
HIV infection rate reduced by 15% by 2019	Facilitate scaling up and implementation of the HAST District Implementation plans (DIP) to achieve 90-90-90 targets	Client remain on ART end of month –total			414 733	436 078	500 317	476 316	478 316	489 316	500 317	
	Support districts to conduct data mop up Conduct support visits Conduct in-service trainings	TB/HIV co-infected client on ART rate	Tier.net and the Adult clinical record	Quarterly	97.3%	95.4%	95%	95%	95%	95%	95%	
		Numerator			18 748	16 096	18 585	4646	4646	4647	4646	
		Denominator			19 274	16 864	19 563	4890	4 891	4 891	4 891	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	HIV test done - total	Tier.net and the Adult clinical record	Quarterly	1 932 800	1 272 398	1 588 892	447 223	447 223	447 223	247 223	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	Male Condoms distributed	Patients records	Quarterly	119 498 754	42 671 000	103 074 048	25 768 512	25 768 512	25 768 512	25 768 512	
	Provision of medical supplies in all health facilities in the province in order to scale up Male Medical Circumcision	Medical male circumcision performed - Total[2]	Tier.net and the Adult clinical record	Quarterly	56 859	31 822	29 374	1,469	13,218	1469	13,218	

[2] The circumcision indicator includes both MMC and TMC

Table HAST 1: Quarterly targets for HIV & AIDS, STI AND TB Control sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
TB death rate reduced by 30% in 2019	To review submitted data by the district monthly. Support district in conducting orientation on revised GENX pert Ultra Algorithm. Conduct support visits to districts focusing on Nelson Mandela, Sarah Baartman and Alfred Nzo.	TB client 5yrs and older start on treatment rate	Facility TB Screening tool, patient records	Quarterly	New indicator	95%	95%	95%	95%	95%	95%	
		Numerator				25 137	6 284	6 284	6 284	6 285	6 284	
		Denominator				26 460	6 615	6 615	6 615	6 615	6 615	
	Facilitate use of NHLS lab link for tracking patients. Review data submitted by district monthly Assist district to conduct data mop up Visit districts to provide support during programme reviews.	TB client treatment success rate	ETR.Net, clinical record, facility register, patient records	Quarterly	84.8%	85%	85%	85%	85%	85%	85%	
		Numerator			14 948	17410	4352	4353	4353	4352	17410	
		Denominator			17 633	20483	5120	5121	5121	5121	20483	

Table HAST 1: Quarterly targets for HIV & AIDS, STI AND TB Control sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Review data submitted by district monthly and provide feedback. Visit districts to provide support during programme reviews. Facilitate use of NHLS lab link for tracking patients Assist Nelson Mandela and Sarah Baartman to conduct awareness to affected communities.	TB client lost to follow up rate	Clinical record, facility register, patient records	Quarterly	7.1%	5%	5%	5%	5%	5%	5%	
		Numerator			1 252	1 024	256	256	256	256	1 024	
		Denominator			17 633	20 483	5 120	5 121	5 121	5 121	20 483	
	Review data submitted by district monthly and provide feedback. Visit districts to provide support during programme reviews.	TB death rate	ETR.net, TB register, patient records	Annually	5.3%	4.3%	5%	5%	5%	5%	5%	
		Numerator			936	567	1 024	256	256	256	256	
		Denominator			17 633	13 317	20 483	5 120	5 121	5 121	5 121	
TB death rate reduced by 30% in 2019	Receive GENEXpert alerts weekly, distribute them to districts and follow up on initiated clients Review data submitted by district monthly and provide feedback. Visit MDR de-centralized sights to conduct support.	TB MDR confirmed initiation rate.	EDR.net, MDR TB register, patient	Quarterly	90%	94%	90%	90%	90%	90%	90%	
		Numerator			2 700	3 102	1 710	427	427	428	428	
		Denominator			3 000	3 300	1 900	475	475	475	475	

Table HAST 1: Quarterly targets for HIV & AIDS, STI AND TB Control sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Receive GENEXpert alerts weekly, distribute them to districts and follow up on initiated clients Review data submitted by district monthly and provide feedback. Monitor implementation of the shortened regimen Support the de-centralized sights to conduct clinical audits	TB MDR treatment success rate	EDR.net, MDR TB register, patient	Quarterly	49.7%	40%	50%	50%	50%	50%	50%	
		Numerator			823	1 200	1 097	274	274	274	275	
		Denominator			1 655	3 000	2 194	548	549	548	549	

2.7 Maternal, Child and Women's Health and Nutrition (MCWH&N)

2.7 Programme Purpose

To reduce mother, new born and child mortality through strengthened maternal and child as well as nutrition health services across the Eastern Cape Province

Strategic Goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health

Strategic Objectives being addressed:

Strategic objectives 1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019
Strategic objectives 1.8 Child Mortality reduced to less than 34 per 1000 population by 2019
Strategic objectives 3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019
Strategic objectives 1.2 Screening coverage of chronic illnesses increased to 90 000 by 2019

Table MCWHN 1 : Quarterly targets for Maternal, Child and Women's Health and Nutrition sub – programme for 2018/19

Table MCWHN 1 : Quarterly targets for Maternal, Child and Women's Health and Nutrition sub – programme for 2018/19												
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification on**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**				**Budget R'000**
								Q1	**Q2**	**Q3**	**Q4**	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Community mobilisation through campaigns and WBOT	Antenatal 1st visit before 20 weeks rate	Facility registers, patient records	Quarterly	63.8%	64.3%	65%	65%	65%	68%	65%	
		Numerator			67 292	51 051	68 556	17 139	17 139	17 139	17 139	
		Denominator			105 472	79 380	105 472	26 368	26 368	26 368	26 368	
	Strengthening of Mom Connect so that mothers get informed during pregnancy.	Mother post-natal visit within 6 days rate	Facility registers, patient records	Quarterly	60%	61.6%	63%	63%	63%	63%	63%	
		Numerator			59 497	46 052	62 762	15 690	15 690	15 691	15 691	
		Denominator			99 623	74 766	99 623	24 905	24 906	24 906	24 906	
	Facilitate increased access and initiation to life-long ART for HIV positive	Antenatal client initiated on ART rate	Facility registers, patient records	Quarterly	93.3	84.7%	95%	95%	95%	95%	95%	
		Numerator			16 581	9 365	16 883	4 220	4 221	4 221	4 221	
		Denominator			17 772	11 056	17 772	4 443	4 443	4 443	4 443	
1.8 Child Mortality reduced to less than 34 per 1000 population by 2019	Monthly tracing of defaulters to ensure that they receive all scheduled Vaccine before 1year. Ensure data Verification at facilities by districts.	Immunisation coverage under 1 year	Facility registers, patient records	Quarterly	78.6%	73.6%	87%	87%	87%	87%	87%	
		Numerator			103 757	119 475	141 147	141 147	141 147	141 147	141 147	
		Denominator			131 801	162 238	162 238	162 238	162 238	162 238	162 238	
	Engage CBO, Community Leaders & WBOT to ensure that every eligible child receive their second dose within 2year of life.	Measles 2nd dose coverage	Facility registers, patient records	Quarterly	91.6%	68.2%	72%	72%	72%	72%	72%	
		Numerator			125 914	113 464	119 800	119 800	119 800	119 800	119 800	
		Denominator			137 503	166 389	166 389	166 389	166 389	166 389	166 389	
	Intensify Community based IMCI trainings for WBOT, IYA, traditional healers and other community structures	Diarrhea case fatality rate	Facility registers, patient records	Quarterly	3.7%	4.1%	3.5%	3.5%	3.5%	3.5%	3.5%	
Child Mortality reduced to less than 34 per 1000		Numerator			201	93	200	50	50	50	50	
		Denominator			5 727	2 288	5 727	1 431	1 432	1 432	1 432	
	Training of new professional nurses on IMCI to ensure 60%	Pneumonia case fatality rate	Facility registers, patient records	Quarterly	3%	3.6%	3.5%	3.5%	3.5%	3%	3%	
		Numerator			188	96	218	54	54	55	55	

Table MCWHN 1 : Quarterly targets for Maternal, Child and Women's Health and Nutrition sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
population by 2019	saturation in each facility.	Denominator			6 232	2 854	6 232	1558	1558	1558	1558	
	To intensify community based interventions for early identification of malnourished children.	Severe acute malnutrition case fatality rate	Facility registers, patient records	Quarterly	10.2%	14.4%	9%	9%	9%	9%	9%	
		Numerator			226	130	199	49	50	50	50	
	Revitalization Growth Monitoring and Promotion sites in all districts. Ensure continuous availability of nutritional supplements.	Denominator			2 221	900	2 221	555	555	556	555	
40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	Establish monitoring and evaluation teams that is inclusive of ECDoE and Soc Dev. Increase the number of school nurses to improve performance Implement: health promoting schools strategy	School Grade 1 screening coverage	Learner profile form, Attendance register	Quarterly	33 854	37 746	39 441	7 573	11 934	11 934	8000	
		School Grade 8 screening coverage	Learner profile form, Attendance register	Quarterly	18 801	21 695	25 615	6 653	7 987	7 987	2 988	
Maternal Mortality Ratio Reduced to less than 105 per 100 000 population by 2019	Training of health professionals on new national Adolescent and Youth policies Prepare all facilities to be youth friendly	Delivery in 10 to 19 years in facility rate	Facility registers, patient records	Quarterly	New Indicator	15.4%	10%	10%	10%	10%	10%	
		Numerator				11 486	10 624	2 656	2 656	2 656	2 656	
		Denominator				74 766	106 243	26 561	26 561	26 561	26 561	
	Training of all health personnel on expanded methods of contraception and guidelines (this includes doctors).	Couple year protection rate	Facility registers, patient records	Quarterly	5.6%	35.8%	65%	65%	65%	65%	65%	
		Numerator			890 539	671 626	1 218 312	1 218 312	1 218 312	1 218 312	1 218 312	
		Denominator			1 796 910	1 874 326	1 874 326	1 874 326	1 874 326	1 874 326	1 874 326	
Screening coverage of	Orientation of professional nurses on	Cervical cancer screening	Facility registers, patient records	Quarterly	60.9%	43.7%	63%	63%	63%	63%	63%	

Table MCWHN 1 : Quarterly targets for Maternal, Child and Women's Health and Nutrition sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
chronic illnesses increased to more than a million by 2019	the new policy on Cervical and Breast cancer. Training of professionals on the new method of Pap Smear taking(liquid base).	coverage 30 years and older										
		Numerator			91 936	66 858	96 375	96 375	96 375	96 375	95 051	
		Denominator			150 874	152 977	152 977	152 977	152 977	152 977	150 874	
Child Mortality reduced to less than 34 per 1000 population by 2019	Contracting of nurses to increase the learner and school coverage Strengthen the implementation of the e-health strategy through functionality mobile data capturing system	Human Papilloma Virus Vaccine 1st dose	Facility registers, patient records	Annually	64 592	50 972	50 972	-	-	-	50 972	
		Human Papilloma Virus Vaccine 2nd dose	Facility registers, patient records	Annually	55 553	57 123	57 123	-	57 123	-	-	
	Strengthen Community Based Interventions e.g WBOT, ISHP Ensure that all WBOT and school health teams use standardized tick register for data collection.	Vitamin A dose 12-59 months coverage	Facility registers, patient records		60.7%	57.1%	65%	65%	65%	65%	65%	
		Numerator			343 643	778 120	884 730	884 730	884 730	884 730	884 730	
		Denominator			1 132 122	1 361 124	1 361 124	1 361 124	1 361 124	1 361 124	1 361 124	
	Increase number of MBFI facilities. Intensify community based awareness strategies e.g dialogues and campaigns	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Facility registers, patient records Facility registers, patient records	Quarterly	32.8%	46.9%	45%	45%	45%	45%	45%	
		Numerator			35 273	25 232	47 033	47 033	47 033	47 033	47 033	
		Denominator			104 517	53.757	104 517	104 517	104 517	104 517	104 517	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Training of All health professionals on ESMOE BANC	Maternal mortality in facility ratio	Facility registers, patient records	Quarterly	135/100 000	120/100 000	120/100 000	120/100 000	120/100 000	120/100 000	120/100 000	

Table MCWHN 1 : Quarterly targets for Maternal, Child and Women's Health and Nutrition sub – programme for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Child Mortality reduced to less than 34 per 1000 population by 2019	Training of All health professionals on HBB MSSN Intra-partum care	Neonatal death in facility rate	Facility registers, patient records	Quarterly	10.8/1000	13.9 /1000	12 /1000	12 /1000	12 /1000	12 /1000	12/1000	
		Numerator			1 098	1 038	12 176	3 044	3 044	3 044	3 044	
		Denominator			101 468	74 625	101 468	25 367	25 367	25 367	25 367	
	Engage CBO, Community Leaders & WBOT to ensure that every eligible child receive their first dose within 1year of life.	Measles 1st dose coverage	Facility registers, patient records	Quarterly	93.6%	70%	72%	72%	72%	72%	72%	
		Numerator			124 376	90 218	92 662	92 662	92 662	92 662	92 662	
		Denominator			132 841	128 697	128 697	128 697	128 697	128 697	128 697	
	To intensify community based interventions for early identification of growth faltering.. Revitalization Growth Monitoring and Promotion sites in all districts	Child <2 underweight incidence	Facility registers, patient records	Quarterly	15.7/1000	8.5/1000	15/1000	15/1000	15/1000	15/1000	15/1000	
		Numerator			4 255	2 249	3 956	3 956	3 956	3 956	3 956	
		Denominator			271 156	263 721	263 721	263 721	263 721	263 721	263 721	

2.8 Sub-Programme: Coroner Services

Programme Purpose

To strengthen the capacity and functionality of forensic pathology institutions within the province and facilitate access to forensic pathology services at all material times.

The Coroner Services sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding unnatural deaths.

Strategic Goals being addressed:

Strategic goal 1: Improved quality of care

Strategic Objectives being addressed:

Strategic objective 1.9 Post – mortems conducted within 72hrs increased to 95% by 2019

2.8.2 Provincial Strategic Objectives, Indicators and Annual Targets for Coroner Services

Table CS 1: Quarterly targets for Coroner Services sub - programme for 2018/19

Table CS 1: Quarterly targets for Coroner Services sub - programme for 2018/19											
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**			
								Q1	**Q2**	**Q3**	**Q4**
Post – mortems conducted within 72hrs increased to 90% by 2019	Integration with EMS Procure new fridges, Refrigerated truck and a LODOX Improve staffing complement	Percentage of post-mortem performed within 72 hours	Death register, forensic pathology database	Quarterly	94%	94%	95%	95%	95%	95%	95%
		Numerator			8 391	2316	8 465	2 116	2 116	2 117	2 116
		Denominator			8 911	2454	8 911	2 227	2 228	2 228	2 228

2.9 District Hospitals

Sub programme purpose

To provide comprehensive and quality district Hospital services to the people of the Eastern Cape Province.

Strategic Goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Strategic Objectives Being Addressed:

Strategic objectives 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic objectives 2.4 Patient satisfaction rate increased to more than 75% in health services by 2019
Strategic objectives 1.10 80% of Hospitals meeting national efficiency targets by 2019

Table DH 1: Quarterly targets for District Hospital sub- programme for 2018/19

Table DH 1: Quarterly targets for District Hospital sub- programme for 2018/19												
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**				**Budget R'000**
								Q1	**Q2**	**Q3**	**Q4**	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate the implementation of National Core standard assessment	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New indicator	14%	27%	13.6%	18.1%	21.2%	27%	
		Numerator				9	18	9	12	14	18	
		Denominator				66	66	66	66	66	66	
80% of hospitals meeting national efficiency targets by 2019	Strengthen clinical care best practices	Average Length of Stay	Facility register	Quarterly	5 days	4.9 days	4.8 days	4.8 days	4.8 days	4.8 days	4.8 days	
		Inpatient Bed Utilisation Rate	Facility register	Quarterly	56%	54.3%	66%	66%	66%	66%	66%	
		Numerator			1 226 237	899 982	1 189 972	297 493	297 493	297 493	297 493	
		Denominator			2 188 445	1 656 399	1 802 989	450 747	450 747	450 747	450 749	
	Monitor cost drivers and ensure implementation of cost control measures where deviations are noted	Expenditure per PDE (patient day equivalent)	BAS	Quarterly	R3, 346	R2,768	R2 950	R2 950	R2 950	R2 950	R2 950	
Patient satisfaction rate increased to more than 75% in health services by 2019	Strengthen the implementation of complaints management policy	Complaint Resolution rate	Facility complaints registers, redress report	Quarterly	94.2%	80%	80%	80%	80%	80%	80%	
		Complaint Resolution within 25 working days rate	Facility complaints registers, redress report	Quarterly	90.5%	98%	85%	85%	85%	85%	85%	
		Numerator			2 914	2 191	2 736	684	684	684	684	
		Denominator			3 219	2 236	3 219	804	804	804	804	

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

3. PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

3.1 Programme Purpose

To render an efficient, effective and professional emergency medical services as well as planned patient transport services including disaster management services to the citizens of the Eastern Cape Province.

3.2 Priorities for the next three years

- Improve call taking and dispatching ability by rolling out the computerised call-taking and dispatching system to the Centres.
- Increase the EMS fleet to include dedicated fleet for inter hospital , XDR /MDR and Maternity transfers

Strategic Goals being addressed:

Strategic goal 3: Universal Health Coverage

3.3 Quarterly Targets for Programme 3: EMS

Budget Allocation for Programme 3 - 2018/19

Budget	R'0S00
Compensation of employees	812,429
Goods and services	335,212
Transfers	**3,226**
Capital assets	**133,746**
Total Budget	**1,284,612**

Table EMS 1 : Quarterly Activities for EMS for 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Proportion of EMS response time improved to 85% by 2019	Deploy human and material resources closer to communities platform Measure response times utilizing live tracking	EMS P1 urban response under 15 minutes rate	Institutional EMS registers	Quarterly	41.%	31.4%	50%	50%	50%	50%	50%	
		Numerator			14 285	9 243	17 527	4 381	4 382	4 382	4 382	
		Denominator			35 054	29 446	35 054	8 763	8 763	8 764	8 764	
	Deploy human and material resources closer to communities Measure response times utilizing live tracking	EMS P1 rural response under 40 minutes rate	Institutional EMS registers	Quarterly	58%	58.2%	60%	60%	60%	60%	60%	
		Numerator			57 946	38 533	60 060	15 015	15 015	15 015	15 015	
		Denominator			100101	66 206	100 101	25 025	25 025	25 026	25 025	
	Establish a dedicated fleet for inter-facility transfers Monitor dedicated fleet utilization	EMS inter-facility transfer rate	Institutional EMS registers	Quarterly	34%	30.1%	30%	30%	30%	30%	30%	
		Numerator			207 027	135 707	185 488	46 372	46 372	46 372	46 372	
		Denominator			618 295	450 962	618 295	154 573	154 574	154 574	154 574	

PROGRAMME 4:
PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

4. PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

4.1 Purpose

To provide cost-effective, good quality regional hospital services and specialised services, which include psychiatry and TB hospital services.

Sub-Programmes

General (Regional) Hospital Services: Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers

- Cecilia Makiwane
- Frontier
- St Elizabeth
- Dora Nginza
- Mthatha

TB Hospital Services: To convert current tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions that allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols

- Jose Pearson
- Nkqubela
- Majorie Parish
- PZ Meyer
- Majorie Parks
- Winter Berg
- Osmond
- Khotsong
- Empilweni
- Themba

Psychiatric Mental Hospital Services: Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for training of health workers and research

- Elizabeth Donkin Psychiatric Hospital
- Komani Psychiatric Hospital
- Tower Psychiatric Hospital – provide long-term
- Cecilia Makiwane Hospital acute psychiatric Unit
- Holy Cross Hospital acute psychiatric Unit
- St Barnabas Hospital acute psychiatric Unit
- Mthatha Regional Hospital acute psychiatric Unit
- Dora Nginza Hospital - 72 hour observation Unit plus

4.1.1 Priorities for the next three years

- To strengthen the capacity and functionality of regional hospitals within the province
- To improve mother and child health and contributing towards the achievement of MDGs
- To improve clinical management of TB patients
- To strengthen the functionality of psychiatric hospitals within the province in order to improve outcomes for clients through the use of effective treatments and rehabilitation programmes
- To implement the National Core Standards engaging SMME contractors in health facilities management projects

4.2 Quarterly Targets for Regional Hospitals

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Budget Allocation for Programme 4 - 2018/19

Budget	R'000
Compensation of employees	2,998,035
Goods and services	804,378
Transfers	**18,013**
Capital assets	**36,710**
Total Budget	**3,857,135**

Table RH: 1 Quarterly targets for Regional Hospitals in 2018/19

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate the conducting of self-assessment at facility level	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	100%	40%	100%	20%	40%	40%	-	
		Numerator			5	2	5	1	2	2	-	
		Denominator			5	5	5	5	5	5	-	
	Facilitate development of quality improvement plan at facility level after self-assessments	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	100%	100%	100%	100%	
		Numerator			4	4	4	4	4	4	4	
		Denominator			4	4	4	4	4	4	4	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate training of committees and field workers Monitor implementation of the tools for CSS	Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	20%	100%	100%	100%	100%	100%	100%	
		Numerator			1	5	5	5	5	5	5	
		Denominator			5	5	5	5	5	5	5	
	Facilitate training of committees and field workers Monitor implementation of the tools for CSS	Patient Experience of Care	PSS forms, PSS report	Quarterly	70%	70%	70%	70%	70%	70%	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of specialists and Health Professionals Facilitate conducting of out-reach and in-reach	Average length of stay	Facility registers, patient registers	Quarterly	5.5days	6 days	5 days	5 days	5 days	5 days	5 days	
	Monitor availability of policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient registers	Quarterly	64%	68%	75%	75%	75%	75%	75%	
		Numerator			516 669	394 113	434 808	108 702	108 702	108 702	108 702	
		Denominator			807 433	579 744	579 744	144 936	144 936	144 936	144 936	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
NCD coverage increased to 1300/1000 000 through management of chronic illnesses by 2019	Conduct formalized cataract outreach services	Cataract surgery rate (Uninsured Population) (Regional hospital)	Facility registers, patient registers	Quarterly	913/ 1000 000	1 438/ 1000 000	1300/ 1000 000	200/ 1000 000	600/ 1 000 000	900/ 1 000 000	1300/ 1000 000	
1.9 80% of hospitals meeting national efficiency targets by 2019	IYM and functionality of Cost Containment Committees	Expenditure per patient day equivalent (PDE)	BAS, facility registers	Quarterly	R1,895	R3,241	R3,089	R3,089	R3,089	R3,089	R3,089	
Patient satisfaction rate increased to more than 75% in health services by 2019	Monitor implementation of Complaint management system	Complaints resolution rate	Facility complaints registers, redress report	Quarterly	92.7%	80%	80%	80%	80%	80%	80%	
		Complaint resolution within 25 working days rate	Facility registers, redress report	Quarterly	92%	98.4%	85%	85%	85%	85%	85%	
		Numerator					481	120	120	120	121	
		Denominator					567	141	142	142	142	
	Monitor functionality of Hospital Boards Induction of Hospital Boards	No of hospitals with functional hospital boards	Facility registers, redress report	Quarterly	5	5	5	2	2	1	-	

4.2 SUB – PROGRAMME: SPECIALISED TB HOSPITALS

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Table TBH: 1 Quarterly Activities for Specialised TB Hospitals for 2018/19

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Conduct in-service training of Quality Assurance managers and Nursing service Managers , on, 7 National Core Standards including the 6 priority areas, for all the 10 TB hospitals Ensure provision of technical assistance by Quality Assurance unit, on the analysis of quality assurance assessment reports, for all the 10 TB hospitals	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard review tool	Quarterly	100%	80%	100%	40%	70%	90%	100%	
		Numerator			11	8	10	4	7 (3 new)	9 (2 new)	10	
		Denominator			11	10	10	10	10	10	10	
	Facilitate development of the Quality improvement plans by all the TB hospitals Facilitate implementation of the quality improvement plans by all the TB hospitals	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	100%	100%	100%	100%	
		Numerator			10	10	10	1	5	9	10	
		Denominator			10	10	10	1	5	9	10	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate implementation of satisfaction surveys by all 11 hospitals. Facilitate development of Quality improvement plans for client satisfaction	Patient Experience of care Survey Rate	Patient experience of care survey report	Quarterly	70%	100%	100%	10%	50%	90%	100%	
		Numerator			7	10	10	1	5(4new)	9(4 new)	10(1 new)	
		Denominator			10	10	10	10	10	10	10	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate analysis of the quality Assessment reports. Facilitate development of Quality improvement plans	Patient Experience of care satisfaction Rate	Patient experience of care satisfaction report	Quarterly	75.6	77%	75%	75%	75%	75%	75%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate development of MDR technical review committees in all the Sub-districts Facilitate improvement of infection prevention and control by isolating patients according to drug resistance patterns.	Average length of stay	Mid night sensors	Quarterly	94.2days	77 days	90 days	90 days	90 days	90 days	90 days	
	Ensure admission of all MDR patients on Bed aquiline until culture conversion. Facilitate admission of all patients abusing drugs and alcohol , in order to give them counselling sessions on adherence to treatment	Inpatient Bed Utilisation Rate	Mid night sensors	Quarterly	60.3%	49.9%	71%	71%	71%	71%	71%	
		Numerator			326 478	185 114	291532	72 883	72 883	72 883	72 883	
		Denominator			548 658	370 850	410 609	102 652	102 653	102 652	102 652	
	Monitor implementation of Drug Resistance TB policy in prescribing drugs for all the patients with confirmed MDR-TB.	Expenditure per patient day equivalent (PDE)	BAS, midnight sensors	Quarterly	R5,737	R1,222	R1,800	R1,800	R1,800	R1,800	R1,800	
Patient satisfaction rate increased to more than 75% in health services by 2019	Ensure availability and use of Complaints registers in all the 10 TB hospitals Facilitate analysis of the Complaints register so as to resolve complaints within 25 days	Complaints resolution rate	Complaints registers at facilities	Quarterly	98%	80%	80%	80%	80%	80%	80%	
	Ensure availability and use of Complaints registers in all the 10 TB hospitals Facilitate analysis of the Complaints register so as to resolve complaints within 25 days	Complaint resolution within 25 working days rate	Complaints registers at facilities	Quarterly	94.3%	95.9%	85%	85%	85%	85%	85%	
		Numerator					128	32	32	32	32	
		Denominator					151	37	38	38	38	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Receive GENEXpert alerts weekly, distribute them to districts and follow up on initiated clients Review data submitted by district monthly and provide feedback. Monitor implementation of the shortened regimen Support the de-centralized sights to conduct clinical audits	TB MDR treatment success rate	EDR.net, MDR TB register, patient	Quarterly	49.7%	40%	50%	50%	50%	50%	50%	
		Numerator			823	1 200	1 097	274	274	274	275	
		Denominator			1 655	3 000	2 194	548	549	548	549	

4.3 SUB – PROGRAMME: SPECIALISED PSYCHIATRIC HOSPITALS

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Table SPH: 1 Quarterly Activities for Specialized Psychiatric Hospitals for 2018/19

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Conduct self-assessments	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	100%	82.7%	100%	33%	66.6%	100%	-	
		Numerator			3	2	3	1	2	3		
		Denominator			3	3	3	3	3	3	-	
	Develop and implement Quality Improvement Plans (QIPs)	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	100%	100%	100%	100%	
		Numerator			3	3	3	3	3	3	3	
		Denominator			3	3	3	3	3	3	3	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct Patient Satisfaction Surveys (PSS)	Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	0%	75%	75%	75%	75%	75%	75%	
		Numerator			0	2	2	2	2	2	2	
		Denominator			3	3	3	3	3	3	3	
	Analyse reports of the PSS	Patient Experience of Care Satisfaction Rate	PSS forms, PSS report	Annually	70%	70%	70%	-	-	-	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and in reach Monitor availability of clinical policies, protocols, guidelines and	Average length of stay	Facility registers, patient records	Quarterly	8days	5.5days	5.5days	5.5days	5.5days	5.5days	5.5days	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	procedure manuals											
	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and inreach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	75%	75%	75%	75%	75%	75%	75%	
Patient satisfaction rate increased to more than 75% in health services by 2019	Monthly monitoring of Complaints Committee	Complaints resolution rate	Complaints registers at facilities	Quarterly	87.5%	80%	80%	80%	80%	80%	80%	
	Monthly monitoring of Complaints Committee	Complaint resolution within 25 working days rate	Complaints registers at facilities	Quarterly	95%	80.7%	90%	90%	90%	90%	90%	
		Numerator					70	17	18	18	17	
		Denominator					78	19	20	20	19	

PROGRAMME 5: CENTRAL & TERTIARY HOSPITALS

5. PROGRAMME 5: CENTRAL & TERTIARY HOSPITALS

5.1 Programme Purpose for Central Hospitals

To strengthen and continuously develop the modern central and tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are two Tertiary Hospitals and one Central Hospital in the Eastern Cape Province:

Sub-Programmes

Central Hospital

- Nelson Mandela Academic Hospital

5.1.2 Priorities for the next three years

- To strengthen oncology services
- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved
- Name of central Hospital: Nelson Mandela Academic Hospital

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Strategic Objectives being addressed:

Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019
Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019

BUDGET ALLOCATION FOR PROGRAMME 5 - 2018/19

Budget	R'000
Compensation of employees	2,349,996
Goods and services	973,088
Transfers	**17,900**
Capital assets	**106,753**
Total Budget	**3,447,737**

Table CHS: 1 Quarterly Activities for Central Hospitals for 2018/19

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate conducting of self-assessment at facility level	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	100%	100%	100%	100%	100%	100%	100%	
	Facilitate development of quality improvement plan at facility level after self-assessments	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	100%	100%	100%	100%	
	Develop specifications and procure for health technology equipment Facilitate conduction of fire drills Develop Clinical Risk Management and protocols	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	80%	100%	100%	100%	100%	100%	100%	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate Training of Quality Assurance Committees Monitor implementation of the development tool	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	0%	100%	100%	100%	100%	100%	100%	
	Analyse reports of the PSS	Patient Experience of Care Satisfaction Rate	PSS forms, PSS report, patient satisfaction module	Annually	70%	70%	70%	-	-	-	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of Health Professionals	Average length of stay	Facility registers, patient records	Quarterly	11.5days	9.3 days	6 days	6 days	6 days	6 days	6 days	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate conducting of outreach and in reach Monitor availability of clinical policies, protocols, guidelines and procedure manuals											
	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and inreach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	83.9%	80.7%	75%	75%	75%	75%	75%	
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R3,948	R4,050	R4,247	R4,247	R4,247	R4,247	R4,247	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate training and implementation of Complaints Management Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	99.6%	80%	80%	80%	80%	80%	80%	
	Facilitate training and implementation of Complaints	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	100%	99.3%	80%	80%	80%	80%	80%	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Management Committee	Numerator					291	72	73	73	73	
		Denominator					364	91	91	91	91	

5.2 Programme Purpose for Tertiary Hospital Services

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are three Tertiary Hospitals in the Eastern Cape Province:

5.2.1 Sub-Programmes

Tertiary Hospitals

- Livingstone Hospital
- Frere Hospital
- Fort England

5.2.2 Priorities for the s

- To strengthen oncology services
- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Strategic Objectives being addressed:

Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019
Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019

Table THS: 1 Quarterly Activities for Tertiary Hospitals for 2018/19

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate conducting of self-assessment at facility level	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	100%	100%	100%	100%	100%	100%	100%	
		Numerator			2	2	2	2	2	2	2	
		Denominator			2	2	2	2	2	2	2	
	Facilitate development of quality improvement plan at facility level after self-assessments	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	100%	100%	100%	100%	
		Numerator			2	2	2	2	2	2	2	
		Denominator			2	2	2	2	2	2	2	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct Patient Satisfaction Surveys (PSS)	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	0%	100%	100%	100%	100%	100%	100%	
		Numerator			2	2	2	2	2	2	2	
		Denominator			2	2	2	2	2	2	2	
	Analyse reports of the PSS	Patient Experience of Care Satisfaction Rate	PSS forms, PSS report, patient satisfaction module	Annually	70%	70%	70%	-	-	-	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and in reach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Average length of stay	Facility registers, patient records	Quarterly	5.7 days	6 days	6 days	6 days	6 days	6 days	6 days	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate recruitment of Health Professionals. Facilitate conducting of outreach and in reach. Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	74.8%	76.6%	75%	75%	75%	75%	75%	
		Numerator			452 728	348 793	455 143	113 785	113 786	113 786	113 786	
		Denominator			605 237	455 144	606 858	151 714	151 714	151 714	151 716	
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R3,357	R3,278	R3,878	R3,878	R3,878	R3,878	R3,878	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate training and implementation of Complaints Management Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	94.9%	80%	80%	80%	80%	80%	80%	
	Facilitate training and implementation of Complaints Management Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	95%	97.8%	85%	85%	85%	85%	85%	
							198	49	49	50	50	
							233	58	58	59	59	

5.3 Programme Purpose for Specialised Tertiary Hospital

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There is one Specialised Tertiary Hospital in the Eastern Cape Province:

5.3.1 Sub-Programmes

Specialised Tertiary Hospitals

- Fort England (specialised psychiatric Hospital)

5.3.2 Priorities for the next three years

- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Strategic Objectives being addressed:

Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019

Table STH 1: Quarterly Targets for Specialised Psychiatric Hospitals for 2018/19

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Conduct self-assessments	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	100%	100%	100%	100%	100%	100%	100%	
	Develop and implement Quality Improvement Plans (QIPs)	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	100%	100%	100%	100%	
	Conduct self-assessments Develop and implement Quality Improvement Plans (QIPs)	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	100%	100%	100%	100%	100%	100%	100%	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct Patient Satisfaction Surveys (PSS)	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	0%	75%	75%	75%	75%	75%	75%	
	Analyse reports of the PSS	Patient Satisfaction rate	PSS forms, PSS report, patient satisfaction module	Annually	70%	70%	70%	-	-	-	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and in reach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	85%	81.4%	85%	85%	85%	85%	85%	
		Numerator				79558	306 250	306 250	306 250	306 250	306 250	
		Denominator				85693	360 294	360 294	360 294	360 294	360 294	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and inreach Monitor availability of clinical policies, protocols, guidelines and procedure manuals											
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R1, 442	R1, 593	R1,600	R1,600	R1,600	R1,600	R1,600	
Patient satisfaction rate increased to more than 75% in health services by 2019	Monthly monitoring of Complaints Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	64.5 %	80%	80%	80%	80%	80%	80%	
	Monthly monitoring of Complaints Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	48%	100%	80%	80%	80%	80%	80%	
		Numerator					19	4	5	5	5	
		Denominator					24	6	6	6	6	

PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

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

6.1 Programme Purpose

To develop a capable health workforce for the Eastern Cape provincial health system as part of a quality people value stream.

6.2 Priorities for the next three years

- Manage the bursary scheme effectively to ensure a flow of health professionals in to the Department
- In-service learning for primary services (clinical, human resources and finance) by providing effective knowledge to practice programmes, short learning programmes and related skills development interventions
- Implement a comprehensive management development and leadership programme
- Facilitate the implementation of the learnership and internship (workplace experience) programmes
- Implement career management strategies through succession planning that underpin recruitment and retention of critical skills
- Establishment of an academic platform to enhance the supply of the critical health professions skills in line with the human resources for health plan

Strategic goals being addressed:

Strategic goal 2: Improved quality of care
Strategic Objectives being addressed:
First year Health professional students receiving bursaries by 2019
To manage and monitor the performance of the employees of the department through work contracts

6.3 First year Health professional students receiving bursaries by 2019

Budget Allocation for Programme 6 - 2018/19

Budget	R'000
Compensation of employees	562,303
Goods and services	116,703
Transfers	**183,179**
Capital assets	**23,161**
Total Budget	**885,346**

6.4 Quarterly Targets for Health Sciences and Training

Table HST 1: Health Sciences and Training, 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
First year Health professional students receiving bursaries by 2019	Recruitment and payment of fees Administering the signing of bursary contracts and safe keeping thereof	Number of Bursaries awarded for first year medicine students	DoH bursary database	Annual	13	13	10	10	10	10	10	
	Recruitment (advert), selection and registration if new nursing students across all nursing academic programmes	Number of Bursaries awarded for first year nursing students	DoH bursary database	Annual	350	350	350	350	350	350	350	
To manage and monitor the performance of the employees of the department through work contracts	PMDS register compiled Capturing on persal	% of SMS members with signed Performance Agreements	Persal PMDS Reports	Annually	100%	100%	100%	100%	100%	100%	100%	
		% of all Employees with signed Performance Agreements			80%	100%	100%	100%	100%	100%	100%	

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

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

7.1 Programme Purpose

To render quality, effective and efficient transversal health (orthotic & prosthetic, rehabilitation, laboratory, social work services and radiological services) and pharmaceutical services to the communities of the Eastern Cape. Health Care Support Services consist of two sub-programmes: Transversal Health Services and Pharmaceutical Services.

Transversal Health Services consists of:

- The orthotic & prosthetic (O&P) services sub-programme, which has three existing O&P centres that are at different levels of staffing and different level of functionality in terms of equipment and infrastructure. The centres are based within the three Hospitals namely the PE Provincial Hospital, in East London at Frere Hospital, and in Mthatha at Bedford Orthopaedic Hospital. The prescriptions received from medical professionals and the referrals especially from the outreach programme determine the need for the service.
- Rehabilitation, laboratory, social work and radiological services are rendered at all Hospitals and/or community health centres.

Pharmaceutical Services is responsible for

- Coordination of the full spectrum of the Pharmaceutical Management Framework including drug selection, supply, distribution and utilization.
- Pharmaceutical standards development and monitoring for health facilities and the two medical depots are coordinated under this programme.

Priorities for the next three years

- To improve systems for the provision of assistive devices and rehabilitation equipment to persons with disabilities
- To strengthen systems to ensure uninterrupted availability of essential medicines at all levels

Strategic Goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improve Quality of Care

Strategic Objectives being addressed:

Strategic objective 1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019
Strategic objective 1.12 90% availability of essential drugs in all health facilities by 2019

Budget Allocation for Programme 7 - 2018/19

Budget	R'000
Compensation of employees	64,602
Goods and services	60,334
Transfers	-
Capital assets	**577**
Total Budget	**125,512**

Table HCSS 1: Quarterly targets for Health Care Support Services in 2018/19

Table HCSS 1: Quarterly targets for Health Care Support Services in 2018/19												
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**				**Budget R'000**
								Q1	**Q2**	**Q3**	**Q4**	
95% of clients eligible for assistive devices provided with wheelchair s, hearing aids, prostheses & orthoses by 2019	Procure wheelchairs Issue the wheelchairs to eligible applicants	Percentage of eligible applicants supplied with wheelchairs	Facility register	Quarterly	88%	46%	50%	50%	50%	50%	50%	
		Numerator			2 523	1 331	2 755	688	689	689	689	
		Denominator			2 863	2 890	5 510	1 377	1378	1378	1377	
	Order the hearing aid as per measurement Issue and Fit the hearing aid to eligible applicants	Percentage of eligible applicants supplied with hearing aids	Facility register	Quarterly	81%	86.4%	60%	60%	60%	60%	60%	
		Numerator			2 110	644	1500	375	375	375	375	
		Denominator			2 512	745	2500	625	625	625	625	
	Design the Prosthesis Fit and Issue the prosthesis to eligible applicants	Percentage of eligible applicants supplied with prostheses	OP Centres reports	Quarterly	71%	17.7%	30%	30%	30%	30%	30%	
		Numerator			1 287	260	639	159	160	160	160	
		Denominator			1 812	1 462	2131	532	533	533	533	
	Design the orthoses Issue the orthoses to eligible applicants	Percentage of eligible applicants supplied with orthoses	OP Centres reports	Quarterly	96.4%	74%	60%	60%	60%	60%	60%	
		Numerator			23 848	4 944	5568	1392	1392	1392	1392	
		Denominator			24 744	6 698	9280	2 320	2 320	2 320	2 320	
95% availability of essential drugs in all health facilities by 2019	Maintain 3 month buffer stock within the depots Monitor availability of essential drugs	Percentage of order fulfillment of essential drugs at the depots.	MEDSAS	Quarterly	84%	90.9%	90%	90%	90%	90%	90%	
		Numerator			366 124	576 075	576 075	144 018	144 019	144 019	144 019	
		Denominator			435 664	640 084	640 084	160 021	160 021	160 021	160 021	
		Essential medicines stock-out rate at the depots	MEDSAS	Quarterly	<5%	<5%	<5%	<5%	<5%	<5%	<5%	
		Numerator			<2	<2	<3	<3	<3	<3	<3	
		Denominator			39	39	60	60	60	60	60	

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8. PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8.1 Programme Purpose

To improve access to health care services through provision of new health facilities, upgrading and revitalisation, as well as maintenance of existing facilities, including the provision of appropriate health care equipment.

The programme consists of four sub-programmes and other facilities:

- Community Health Facilities
- Emergency Medical Services
- District Hospital Services
- Provincial Hospital services
- Other facilities

Priorities for the next three years

- To facilitate and provide infrastructural support in terms of the upgrading of the existing structures for health services delivery, as well as other organisational building requirements
- To facilitate general maintenance in all spheres of the organisation
- To facilitate the provision of essential equipment in health facilities
- To ensure the implementation of PGDP requirements by engaging SMME contractors in health facilities management projects

Strategic Goals being addressed:

Strategic goal 2: Improved quality of care

Strategic objectives being addressed:

Strategic objective 2.7 Health facilities refurbished to comply with the National norms and standards by 2019

BUDGET ALLOCATION FOR PROGRAMME 8 - 2018/19

Budget	R'000
Compensation of employees	32,111
Goods and services	361,125
Transfers	-
Capital assets	987,835
Total Budget	**1,372,071**

Table HFM 1: Quarterly targets for Health Facilities Management 2018/19

Table HFM 1: Quarterly targets for Health Facilities Management 2018/19												
Strategic objective	**Planned Activities**	**Performance indicator**	**Means of verification**	**Frequency quarterly/ annually**	**Baseline 2016/17**	**Estimate 2017/18**	**Annual target 2018/19**	**Quarterly Targets**				**Budget R'000**
								Q1	**Q2**	**Q3**	**Q4**	
Health facilities refurbished to comply with the National norms and standards by 2019	Projects Site visit and inspections and month monitoring meetings with Implementing Agents.	2.7.1 Number of health facilities that have undergone major refurbishment in NHI pilot district	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	10 major	7 major	4 major	-	-	-	4 major	
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	2.7.2 Number of health facilities that have undergone minor refurbishment in NHI pilot district	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	70 minor	90 minor	90 minor	-	-	-	90 minor	
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	2.7.3 Number of health facilities that have undergone major refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	13 major	4 major	7 major	-	-	-	7 major	
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	2.7.4 Number of health facilities that have undergone minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	70 minor	17 minor	17 minor	-	-	-	17 minor	
	Bilateral meetings to	Establish Service Level	Signed and approved SLA	Annually	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

Table HFM 1: Quarterly targets for Health Facilities Management 2018/19

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2016/17	Estimate 2017/18	Annual target 2018/19	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	discuss contents of changes / amendments made on the SLA with both Implementing Agents.	Agreements (SLAs) with Departments of Public Works (and any other implementing agent)										

ANNEXURE

ANNEXURE: TECHNICAL INDICATOR DESCRIPTIONS

PROVINCIAL OPs 2018/19

PROGRAMME 1: HEALTH ADMINISTRATION& MANAGEMENT

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performanc e	Responsi-bility
Provide political and strategic direction to the Department by focusing on transformatio n on and change management	Number of statutory documents tabled at Legislature	Statutory documents submitted and tabled at the Provincial Legislature	Tracks the number of statutory documents submitted and tabled at the Provincial Legislature	Copies of the document	Not applicable	Unavailability of statutory documents	Output	Categorical	Annual	No	Compliance with legislative requirements	Office of the MEC
2.1 Clean audit opinion achieved by 2019	2.1.1 Audit opinion from Auditor General	Audit opinion for Provincial Departments of Health for financial performance	To strengthen financial management monitoring and evaluation	Documented Evidence: Annual Report Auditor General's Report	N/A Categorical	N/A	Outcome	N/A	Annual	No	Unqualified Audit Opinion from the Auditor General	Chief Financial Officers of Provincial Departments of Health
	2.1.2 Level 4 MPAT	The level of compliance (out of 4 levels in the tool) that the department of health has to achieve.	The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	MPAT report	The tool has Structure Questionnaire s	Minimal as there are controls	Output	Categorical	Annual	No	Level 4	GM: SOP
2.2 100% of health facilities connected to web-based DHIS through broadband by	2.2.1 Percentage of Hospitals with broadband access	Percentage of Hospitals with broadband access	To track broadband access to hospitals	Network reports that confirm availability of broadband; OR Network	Numerator: Total Number of hospitals with minimum 2 Mbps connectivity	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity to ensure that	ICT Directorate / Chief Directorate

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2019				rollout report for sites that are not yet live	Denominator Total Number of Hospitals						South African health system can implement the eHealth Programme	
	2.2.2 Percentage of fixed PHC facilities with broadband access	Percentage of fixed PHC facilities with broadband access	To ensure broadband access to PHC facilities	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	Numerator: Total Number of fixed PHC facilities with minimum 1Mbps connectivity Denominator Total Number of fixed PHC Facilities	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity	ICT Directorate / Chief Directorate

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

SUB PROGRAMME 2.1, 2.2 & 2.3: DISTRICT DEVELOPMENT

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	1.1.1 PHC utilisation rate	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	Daily Reception Headcount register (or HPRS where available) and DHIS Denominator: Stats SA	Numerator: SUM ([PHC headcount under 5 years] + [PHC headcount 5-9 years] + [PHC headcount 10-19 years] + [PHC headcount 20 years and older]) Denominator: Sum([Population - Total)]	Dependent on the accuracy of estimated total population from Stats SA	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate underutilization of facility	DHS Manager
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.22 Ideal clinic status rate	Fixed PHC health facilities that have obtained Ideal Clinic status	Monitors outcomes of self (Ideal clinics) assessments to ensure they are ready for inspections conducted by Office of Health Standards Compliance.	Ideal Clinic review tools	Numerator: SUM ([Ideal clinic status Denominator: Fixed PHC clinics/ fixed CHCs/ CDCs])	None	Process/Activity	Percentage	Annual	Yes	Higher Ideal clinic status rates ensures clinics will have positive outcomes and is ready for inspections conducted by Office of Health Standards Compliance.	District Health Services and Quality Assurance Directorates
2.4 Patient/Client satisfaction rate increased to more than 75% in health services by 2019	2.4.27 Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	DHIS, complaints register,	Numerator: SUM ([Complaint resolved within 25 working days]) Denominator: SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC Facilities	Quality Assurance

2.4 SUB-PROGRAMME: COMMUNITY BASED SERVICES: DISEASE PREVENTION AND CONTROL (DPC)

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.2 Screening coverage of chronic illnesses increased to more than a million by 2019	1.2.1 Clients 40 years and older screened for hypertension	Number of clients not on treatment for hypertension screened for hypertension in PHC clinics and OPD	This should assist with increasing the number of clients detected and referred for treatment	PHC Comprehensive Tick Register	SUM ([Client 40 years and older screened for hypertension])	The new data collection tools may not exist all facilities	Process/ Activity	Sum of Number	Quarterly	No	Greater number of people screened for high blood pressure	CD: health Programmes
	1.2.2 Clients 40 years and older screened for diabetes	Number of clients not diagnosed and not on treatment for diabetes screened for diabetes in PHC clinics and OPD	This should assist with increasing the number of clients with diabetes detected and referred for treatment	PHC Comprehensive Tick Register	SUM([Client 40 years and older screened for diabetes])	The new data collection tools may not exist all facilities	Process/ Activity	Sum of Number	Quarterly	No	Greater number of people screened for raised blood glucose levels	NCD Programme Manager
	1.2.3 Mental disorders screening rate	Clients screened for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioral disorders and substance use disorders at PHC facilities	Monitors access to and quality of mental health services in PHC facilities	PHC Comprehensive Tick Register	Numerator: SUM ([PHC client screened for mental disorders]) Denominator: SUM([PHC headcount under 5 years]) + SUM([PHC headcount 5 years and older])	The new data collection tools may not exist all facilities	Process/ Activity	Percentage	Quarterly	No	Higher percentage of for mental disorders screening	NCD Programme Manager

2.5 SUB-PROGRAMME: OTHER COMMUNITY SERVICES

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.5 100% Compliance with the Waste Management Act by 2019	2.5.1 Percentage of health facilities complying with SANS waste disposal requirements	This measure health facilities that dispose waste in line with SANS 10248 regulation as a proportion of the total health facilities.	To track compliance of health facilities with SANS 10248 regulation on waste management.	Waste disposal management.	Numerator Number of health facilities (Hospitals) that dispose waste in line with SANS 10248 regulation at a given reporting period. Denominator: Number of facilities (Hospitals) during same time period.	No specific limitations anticipated	Output	%	Quarterly	No	Compliance with waste management for purposes of infection control and sustaining a healthy environment.	GM: PHP

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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.5 HIV infection rate reduced by 15% by 2019	1.5.1 Client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month- Any client without an outcome reported in the reporting month Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]	Monitors the total clients remaining on life-long ART at the month	ART Register; TIER.Net; DHIS	Numerator: SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period])	None	Output	Cumulative total	Quarterly	no	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
	1.5.2 TB/HIV co-infected client on ART rate	TB/HIV co-infected clients on ART as a proportion of HIV positive TB clients	Monitors ART coverage for TB clients	TB register; ETR.Net; Tier.Net	Numerator: SUM([TB/HIV co-infected client on ART]) Denominator: SUM([TB client known HIV positive])	Availability of data in ETR.net, TB register, patient records	Outcome	Percentage	Quarterly	No	Higher proportion of TB/HIV co-infected on ART treatment will reduce co-infection rates	TB/HIV manager
1.5 HIV infection rate	1.5.3 HIV test done	Total number of HIV Tests	Monitors the impact of the	PHC Comprehensi	SUM([Antenatal client HIV 1st	Dependent on the	Process	Number	Quarterly	No	Higher percentage	HIV/AIDS Programme

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
reduced by 15% by 2019		done in all age groups	pandemic and assists in better planning for effective combating of HIV and AIDS and decreasing the burden of diseases from TB	ve Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,DHIS	test]) + SUM([Antenatal client HIV re-test]) + SUM([HIV test 19-59 months]) + SUM([HIV test 5-14 years]) + SUM([HIV test 15 years and older (excl. ANC)])	accuracy of facility register					indicate increased population knowing their HIV status.	Manager
	1.5.4 Male Condoms Distributed	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).	Monitors distribution of male condoms for prevention of HIV and other STIs, and for contraceptive purposes. Primary distribution sites (PDS) report to sub-districts on a monthly basis	Numerator: Stock/Bin card	SUM([Male condoms distributed])	None	Process	Percentage	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in the province	HIV/AIDS Cluster
	1.5.6 Medical male circumcision - total	Medical male circumcisions performed 15 years and older as a proportion of total medical male circumcisions performed	Monitors medical male circumcisions performed under supervision	Theatre Register/ PHC tick register, DHIS	SUM ([Males 10 to 14 years who are circumcised under medical supervision]) +([Males 15 years and older who are circumcised under medical supervision])	Assumed that all MMCs reported on DHIS are conducted under supervision	Output	Rate	Quarterly	No	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager
1.6 TB death rate reduced by 30% in 2019	1.6.1 TB client 5 years and older start on treatment	TB client 5 years and older start on treatment as a proportion	Monitors trends in early identification of children with TB	PHC Comprehensive Tick Register	Numerator SUM ([TB client 5 years and older start on treatment])	- Accuracy dependent on quality of data from reporting	Process/Activity	Rate	Quarterly	No	Screening will enable early identification of TB suspect in health facilities	TB Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
	rate	of TB symptomatic client 5 years and older test positive	symptoms in health care facilities		Denominator: SUM([TB symptomatic client 5 years and older tested positive])	facility						
	1.6.2 TB client treatment success rate	TB clients successfully completed treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors success of TB treatment for ALL types of TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM ([TB client successfully completed treatment]) Denominator: SUM ([TB client start on treatment)]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Higher percentage suggests better treatment success rate.	TB Programme Manager
	1.6.3 TB Client loss to follow up rate	TB clients who are lost to follow up (missed two months or more of treatment) as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra-	Monitors the effectiveness of the retention in care strategies. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator SUM [TB () client lost to follow up] Denominator: SUM [TB client initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		pulmonary).										
	1.6.4 TB Client death rate	TB clients who died during treatment as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM ([TB client death during treatment]) Denominator: SUM([TB client start on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Annually	Yes	Lower levels of death desired	TB Programme Manager
	1.6.6 TB MDR treatment success rate	TB MDR client successfully completing treatment as a proportion of TB MDR confirmed clients started on treatment	Monitors success of MDR TB treatment	TB Register; EDR Web	Numerator TB MDR client successfully complete treatment Denominator: SUM ([TB MDR confirmed client initiated on	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Annually	Yes	Higher percentage indicates a better treatment rate	TB Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					treatment])							

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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	1.7.1 Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Monitors early utilisation of antenatal services	PHC Comprehensive Tick Register	Numerator: SUM ([Antenatal 1st visit before 20 weeks]) Denominator: SUM ([Antenatal 1st visit 20 weeks or later]) + SUM ([Antenatal 1st visit before 20 weeks])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
	1.7.2 Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used postnatal visits within 6 days after delivery	PHC Comprehensive Tick Register	Numerator: SUM ([Mother postnatal visit within 6 days after delivery]) Denominator: SUM([Delivery in facility total])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
	1.7.3 Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total	Monitors implementation of PMTCT guidelines in terms of ART initiation of	ART Register, Tier.Net	Numerator: SUM ([Antenatal client start on ART])	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive	MNCWH programme manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		number of antenatal clients who are HIV positive and not previously on ART	eligible HIV positive antenatal clients.		Denominator: Sum([Antenatal client known HIV positive but NOT on ART at 1st visit]) + SUM([Antenatal client HIV 1st test positive]) + SUM([Antenatal client HIV re-test positive])						clients on HIV Treatment	
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.1 Infant 1st PCR test positive around 10 weeks rate	Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 10 weeks	Monitors PCR positivity rate in HIV exposed infants around 10 weeks	PHC Comprehensive Tick Register	Numerator SUM [Infant PCR test positive around 10 weeks Denominator: SUM([Infant PCR test around 10 weeks])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Lower percentage indicate fewer HIV transmissions from mother to child	PMTCT Programme
	1.8.2 Immunisation coverage under 1 year	Children under 1 year who completed their primary course of immunization as a proportion of population under 1 year.	Track the coverage of immunization services	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA	Numerator SUM ([Immunised fully under 1 year new]) Denominator: SUM ([Female under 1 year]) + SUM([Male under 1 year])	Road to Health charts are not retained by Health facility. Reliant on under 1 population estimates from Stats SA, and accurate recording of children under 1 year who are fully immunised at	Output	Percentage	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
						facilities (counted only ONCE when last vaccine is administered)						
	1.8.3 Measles 2nd dose coverage	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population..	Monitors protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	PHC Comprehensive Tick Register Denominator: Stats SA	Numerator SUM ([Measles 2nd dose]) Denominator: SUM([Female 1 year]) + SUM([Male 1 year])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher coverage rate indicate greater protection against measles	EPI
	1.8.5 Diarrhea case fatality under 5 years rate	Diarrhea deaths in children under 5 years as a proportion of diarrhea separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with diarrhea	Ward register	Numerator: SUM ([Diarrhea death under 5 years]) Denominator: SUM([Diarrhea separation under 5 years])	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager
	1.8.6 Pneumonia case fatality under 5 years rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations	Monitors treatment outcome for children under 5 years who were separated with	Ward Register	Numerator: SUM ([Pneumonia death under 5 years]) Denominator: SUM([Pneumonia	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		under 5 years in health facilities	pneumonia		separation under 5 years])							
	1.8.7 Severe acute malnutrition case fatality under 5 years rate	Severe acute malnutrition deaths in children under 5 years as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with Severe acute malnutrition (SAM)	Ward register	Numerator: SUM ([Severe acute malnutrition (SA M) death in facility under 5 years]) Denominator: SUM([Severe Acute Malnutrition separation under 5 years	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	3.4.2 School Grade 1 learners screened	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	School Health data collection forms	SUM [School Grade 1 - learners screened}	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
	3.4.3 School Grade 8 learners screened	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Numerator School Health data collection forms	SUM [School Grade 8 - learners screened]	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	1.7.6 Delivery in 10 to 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Monitors the proportion of deliveries in facility by teenagers (young women under 20 years).	Health Facility Register, DHIS	Numerator SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility]	None	Process	Percentage	Quarterly	Yes	Lower percentage indicates better family planning	HIV and Adolescent Health

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					Denominator: SUM([Delivery in facility total])							
	1.7.4 Couple Year Protection Rate (Int)	Women protected against pregnancy by using modern contraceptive methods, including sterilizations, as proportion of female population 15-49 year. Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) + (SUM Female condoms distributed/200) + (SUM Male condoms distributed / 200) + (Male sterilization x 20) + (Female sterilization x 10)	Track the extent of the use of contraception (any method) amongst women of child bearing age	Facility Register	Numerator (SUM ([Oral pill cycle]) / 15) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4.5) + (SUM([Male condoms distributed]) / 120) + (SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) Denominator: SUM {[Female 15-44 years]}	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	MCWH&N Programme

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					+ SUM {[Female 45-49 years]}							
1.2 Screening coverage of chronic illnesses increased to more than a million by 2019	1.2.4 Cervical cancer screening coverage 30 years and older	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older years.	Monitors implementation on cervical screening and policy	PHC Comprehensive Tick Register OPD tick register Denominator: StatsSA	Numerator SUM ([Cervical cancer screening 30 years and older]) Denominator: (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10	Reliant on population estimates from Stats SA, and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.10 Human Papilloma Virus Vaccine 1st dose coverage	Girls 9 years and older that received HPV 1st dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 1st dose]) + SUM([Agg_Girl 10 yrs HPV 1st dose]) + SUM([Agg_Girl 11 yrs HPV 1st dose]) + SUM([Agg_Girl 12 yrs HPV 1st dose]) + SUM([Agg_Girl 13 yrs HPV 1st dose]) + SUM([Agg_Girl 14 yrs HPV 1st dose]) + SUM([Agg_Gi	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					rl 15 yrs and older HPV 1st dose])							
	1.8.11 Human Papilloma Virus Vaccine 2nd dose coverage	Girls 9yrs and older HPV 2nd dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 2nd dose]) + SUM([Agg_Girl 10 yrs HPV 2nd dose]) + SUM([Agg_Girl 11 yrs HPV 2nd dose]) + SUM([Agg_Girl 12 yrs HPV 2nd dose]) + SUM([Agg_Girl 13 yrs HPV 2nd dose]) + SUM([Agg_Girl 14 yrs HPV 2nd dose]) + SUM([Agg_Girl 15 yrs and older HPV 2nd dose])	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager
	1.8.8 Vitamin A dose 12-59 months coverage (Annualised)	Children 12-59 months who received vitamin A 200,000 units, every six months as a proportion of population 12-59 months.	Monitors vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year	DHIS, facility registers, patient records	Numerator Vitamin A dose 12-59 months Denominator: Population 12-59 months*2		Output	Percentage	Quarterly	No	Higher proportion of children 12-29 months who received Vit. A will increase health	MNCWH Programme Manager
	1.8.12 Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd	Infants exclusively breastfed at 14 weeks as a proportion of	Monitors infant feeding practices at 14 weeks to identify where	PHC Comprehensive Tick Register	Numerator SUM ([Infant exclusively breastfed at DTaP-IPV-	Reliant on honest response from mother; and	Output	Percentage	Quarterly	Yes	Higher percentage indicate better exclusive breastfeeding	Cluster: Child Health

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
	dose rate	the DTaP-IPV-Hib-HBV 3rd dose vaccination. Take note that DTaP-IPV-Hib-HBV 3rd dose (Hexavalent) was implemented in 2015 to include the HepB dose	community interventions need to be strengthened		Hib-HBV (Hexavalent) 3rd dose]) Denominator: SUM([Hep B 3rd dose under 1 year]) + SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose])	Accuracy dependent on quality of data submitted health facilities					rate	
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	1.7.5 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 irrespecti ve of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	This is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys. Focuses on obstetric causes (around 30% of all maternal mortality). Provides indication of health system results in terms of prevention of unplanned pregnancies, antenatal care, delivery and	Maternal death register, Delivery Register	Numerator SUM ([Maternal death in facility]) Denominator: SUM([Live birth in facility])+SUM ([Born alive before arrival at facility])	Completeness of reporting	Impact	Ratio per 100 000 live births	Annually	No	Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
			postnatal services									
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.9 Neonatal death in facility rate	Neonatal 0-28 days who died during their stay in the facility as a proportion of live births in facility	Monitors treatment outcome for admitted children under 28 days	Delivery register, Midnight report	Numerator SUM ([Inpatient death 0-7 days]) + SUM ([Inpatient death 8-28 days]) Denominator: SUM([Live birth in facility])	Quality of reporting	Impact	Percentage	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

2.7 SUB-PROGRAMME: CORONER SERVICES

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.9 Post – mortems conducted within 72hrs increased to 95% by 2019	1.9.1 Percentage of post-mortem performed within 72 hours	Measures number of post-mortems performed by Forensic Pathologists within a period of 3 days of receiving the body from the SAPS as a percentage of the total number of bodies received	Tracks the turn-around time for Post Mortems.	Death register	Numerator Number of cold bodies with post-mortem performed within 72 hrs. of receipt of body Denominator: Total number of cold bodies received from SAPS (expressed as percentage)	Depended on accuracy of Forensic Pathology services data base.	Output	%	Quarterly	No	Improved and short turn-around times for post mortems.	GM: PHP

2.8 SUB – PROGRAMME DISTRICT HOSPITALS

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.1 Hospital achieved 75% and more on National Core Standards (NCS) self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self -assessment]) Denominator: SUM([Hospitals conducted National Core Standards self -assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.1 Average Length of Stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient	DHIS, midnight census register	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
			beds									
	1.10.6 Inpatient Bed Utilisation Rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Track the over/under utilisation of district hospital beds	DHIS, midnight census	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator Usable (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
	110.12 Expenditure per patient day equivalent (PDE)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Monitors effective and efficient management of inpatient facilities.	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure, midnight census	Numerator: SUM ([Expenditure - total]) Denominator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD headcount follow-up x 0.3333333])+([Emergency headcount - total x 0.3333333])	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.4 Patient satisfaction rate increased to more than 75% in health services by 2019	2.4.26 Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	Complaints register	Numerator: SUM ([Complaint resolved within 25 working days]) Denominator: SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
3.6: Proportion of EMS response time improved to 85% by 2019	3.6.1 EMS P1 urban response under 15 minutes rate	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time that the first dispatched medical resource arrives on scene	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	Numerator: SUM ([EMS P1 urban response under 15 minutes]) Denominator: SUM([EMS P1 urban calls])	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban areas	EMS Manager
	3.6.2 EMS P1 rural response under 40 minutes rate	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of EMS P1 rural call	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 40 minutes in rural areas	DHIS, institutional EMS registers Patient and vehicle report.	Numerator: SUM ([EMS P1 rural response under 40 minutes]) Denominator: SUM([EMS P1 rural calls])	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
	3.6.3 EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses	DHIS, institutional EMS registers Patient and vehicle report.	Numerator SUM ([EMS inter-facility transfer]) Denominator SUM([EMS clients total])	Accuracy dependent on the reliability of data recorded on the Efficiency Report at EMS stations	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and	EMS Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		proportion of total EMS patients transported				and emergency headcount reported from hospitals.					measures whether capacity exists at the appropriate level of care.	

PROGRAMME 4

SUB-PROGRAMME 4.1: REGIONAL Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.2 Hospitals that achieved a performance of 75% or more on National Core Standards self-assessment	Hospitals that achieved a performance of 75% or more on National Core Standards self-assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Output	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.2 Average Length of Stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, midnight census	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
	1.10.7 Inpatient Bed Utilisation Rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Monitors effectiveness and efficiency of inpatient management	DHIS, midnight census	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Usable (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.3 NCD coverage increased to 1300/1000 000 through management of chronic ils	1.3.1 Cataract surgery rate	Clients who had cataract surgery per 1 million uninsured populations. The population will be divided by 12 in the formula to make provision for annualisation	Monitors access to cataract surgery.	Facility registers, patient registers	Numerator: Cataract surgery total Denominator: Uninsured population	Accuracy dependent on quality of data from health facilities	Quality	Rate per 1 Million	Quarterly	No	Higher levels reflect a good contribution to sight restoration, especially amongst the elderly population.	GM: Hospital Services
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.13 Expenditure per patient day equivalent (PDE)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Monitors effective and efficient management of inpatient facilities.	BAS, Stats SA, Council for Medical Scheme data, DHIS, midnight census	Numerator SUM ([Expenditure - total]) Denominator Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD headcount follow-up x 0.3333333])+([Emergency headcount -	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					total x 0.3333333])							
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.29 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 4.2: SPECIALISED TB Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.3 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.3 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals	DHIS, facility register & Admission	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	GM:DHS

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		specialties	and CHCs with Inpatient beds									
	1.10.8 Inpatient Bed Utilisation Rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties	Monitors effectiveness and efficiency of inpatient management	DHIS, facility register Admission	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
	1.10.14 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All Hospital	Track the expenditure per PDE in TB Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Numerator Total Expenditure Denominator: Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		activity expressed as a equivalent to one inpatient day										
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.30 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 4.3: SPECIALISED PSYCHIATRIC Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.4 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.4.31 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 5

SUB-PROGRAMME 5.1: CENTRAL Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.5 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.4 Average Length of Stay	Average number of patient days that an admitted patient in the district Hospital before separation.	To monitor the efficiency of the central Hospital	DHIS, facility register & Admission	Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	District Health Services

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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		expressed as a equivalent to one inpatient day										
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.32 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 5.2: TERTIARY Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.6 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self - assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.5 Average Length of Stay	Average number of patient days that an admitted patient in the district Hospital before separation.	To monitor the efficiency of the tertiary Hospital	DHIS, facility register & Admission	Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	District Health Services
	1.10.11 Inpatient Bed Utilisation Rate	Patient days during the reporting period,	Track the over/under utilisation of tertiary	DHIS, facility register Admission	Numerator: Inpatient days + 1/2 Day patients	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of	District Health Services

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		expressed as a percentage of the sum of the daily number of usable beds.	Hospital beds		Denominator: Inpatient bed days (Inpatient beds * 30.42) available						bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	
	1.10.17 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All Hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in tertiary v Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Numerator: Total Expenditure in district Hospitals Denominator: Patient Day equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
2.4 Patient Experience of Care increased to more than 75% in health services by	2.4.33 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator:	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2019					Total number of complaints resolved							

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.5 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.4 Average Length of Stay	Average number of patient days that an admitted patient in the district Hospital before separation.	To monitor the efficiency of the central Hospital	DHIS, facility register & Admission	Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	District Health Services

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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performanc e	Responsi-bility
		one inpatient day										
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.32 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 5.2: TERTIARY Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.6 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self - assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.5 Average Length of Stay	Average number of patient days that an admitted patient in the district Hospital before separation.	To monitor the efficiency of the tertiary Hospital	DHIS, facility register & Admission	Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	District Health Services
	1.10.11 Inpatient Bed Utilisation Rate	Patient days during the reporting period,	Track the over/under utilisation of tertiary	DHIS, facility register Admission	Numerator: Inpatient days + 1/2 Day patients	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed	District Health Services

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		expressed as a percentage of the sum of the daily number of usable beds.	Hospital beds		Denominator: Inpatient bed days (Inpatient beds * 30.42) available						utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	
	1.10.17 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All Hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in tertiary v Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Numerator: Total Expenditure in district Hospitals Denominator: Patient Day equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
2.4 Patient Experience of Care	2.4.33 Complaint resolution	Percentage of complaints of users of	To monitor the management	complaints register,	Numerator: Total number of complaints	Accuracy of information is dependent on	Quality	Percentage	Quarterly	No	Higher percentage suggest better	Quality Assurance

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
increased to more than 75% in health services by 2019	within 25 working days rate	Hospital Services resolved within 25 days	of the complaints in Hospitals		resolved within 25 days Denominator: Total number of complaints resolved	the accuracy of time stamp for each complaint					management of complaints in Hospitals	

SUB-PROGRAMME 5.3: SPECIALISED TERTIARY Hospital

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.7 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
	2.4.34 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 6: PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.6 First year Health professional students receiving bursaries by 2019	2.6.1 Number of Bursaries awarded for first year medicine students	Number of new medicine students provided with bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	Bursary contracts	Number of Bursaries awarded for first year medicine students No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	no	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager
	2.6.2 Number of Bursaries awarded for first year nursing students	Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	SANC Registration form	Number of Bursaries awarded for first year nursing students No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager

PROGRAMME 7: PERFORMANCE INDICATORS FOR HEALTH CARE AND SUPPORT

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019	1.11.1 Percentage of eligible applicants supplied with wheelchairs	Clients supplied with wheelchairs as a proportion of the total clients applying for wheelchairs expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Numerator: Number of clients supplied with wheelchairs during a reporting period Denominator: Total clients applied and on waiting list to receive wheelchairs during the same period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to wheelchairs	Clinical Support Manager
	1.11.2 Percentage of eligible applicants supplied with hearing aids	Clients supplied with hearing aids as a proportion of the total clients applying for hearing aids expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Numerator: Number of clients supplied with hearing aids during a reporting period Denominator: Total clients applied and on waiting list to receive hearing aids during the same period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to hearing aids	Clinical Support Manager
	1.11.3 Percentage of eligible applicants supplied with prostheses	Clients supplied with prosthesis as a proportion of the total clients applying for	Tracks the degree to which the department is meeting the need for assistive	DHIS, facility registers	Numerator: Number of clients supplied with prosthesis during a reporting	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to prosthesis	Clinical Support Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		prosthesis expressed as a percentage	devices in the Province		period Denominator: Total clients applied and on waiting list to receive prosthesis during the same period							
	1.11.4 Percentage of eligible applicants supplied with orthoses	Clients supplied with prosthesis as a proportion of the total clients applying for orthosis expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Numerator: Number of clients supplied with orthosis during a reporting period Denominator: Total clients applied and on waiting list to receive orthosis during the same period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to orthosis	Clinical Support Manager
1.12 90% availability of essential drugs in all health facilities by 2019	1.12.1 Percentage of order fulfilment of essential drugs at the depots.	Drug orders fulfilled completely	Ensure availability of essential drugs in all facilities	MEDSAS	Numerator: Number of order fulfilled completely Denominator : Number of orders received x 100	Poor maintenance of stock levels by the depot	Output	Percentage	Quarterly	No	Availability of essential drugs at all facilities	Pharmaceutical Services Manager
	1.12.2 Essential medicines stock-out rate at the depots	Mange number of essential medicine on stock	Ensure availability of essential drugs at the depots	MEDSAS	Numerator: number of essential medicines out of stock Denominator	Poor maintenance of essential medicines stock levels at the depot	Output	Percentage	Quarterly	No	Availability of essential medicine at the depot	Pharmaceutical Services Manager and Depot managers

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					: Total number of essential medicines							

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.7 Health facilities refurbished to comply with the National norms and standards by 2019	2.7.1 Number of health facilities that have undergone major refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone major refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
	2.7.2 Number of health facilities that have undergone minor refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Job card/ invoice, Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
	2.7.3 Number of health facilities that	Number of existing health facilities	Tracks overall improvement and	Practical Completion Certificate	Number of health facilities	Accuracy dependent on reliability of	Input	Number	Annual	No	A higher number will indicate that more facilities	Chief Director: Infrastructure

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

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

SUB PROGRAMME 2.1, 2.2 & 2.3: DISTRICT DEVELOPMENT

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.22 Ideal clinic status rate	Fixed PHC health facilities that have obtained Ideal Clinic status	Monitors outcomes of self (Ideal clinics) assessments to ensure they are ready for inspections conducted by Office of Health Standards Compliance.	Ideal Clinic review tools	Numerator: SUM ([Ideal clinic status Denominator: Fixed PHC clinics/ fixed CHCs/ CDCs])	None	Process/Activity	Percentage	Annual	Yes	Higher Ideal clinic status rates ensures clinics will have positive outcomes and is ready for inspections conducted by Office of Health Standards Compliance.	District Health Services and Quality Assurance Directorates
1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	1.1.1 PHC utilisation rate	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	Daily Reception Headcount register (or HPRS where available) and DHIS Denominator: Stats SA	Numerator: SUM ([PHC headcount under 5 years] + [PHC headcount 5-9 years] + [PHC headcount 10-19 years] + [PHC headcount 20 years and older]) Denominator: Sum([Population - Total)]	Dependent on the accuracy of estimated total population from Stats SA	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate underutilization of facility	DHS Manager
2.4 Patient/Client satisfaction rate increased to more than 75% in health services by 2019	2.4.27 Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	DHIS, complaints register,	Numerator: SUM ([Complaint resolved within 25 working days]) Denominator: SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC Facilities	Quality Assurance

2.4 SUB-PROGRAMME: COMMUNITY BASED SERVICES: DISEASE PREVENTION AND CONTROL (DPC)

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.2 Screening coverage of chronic illnesses increased to more than a million by 2019	1.2.1 Clients 40 years and older screened for hypertension	Number of clients not on treatment for hypertension screened for hypertension in PHC clinics and OPD	This should assist with increasing the number of clients detected and referred for treatment	PHC Comprehensive Tick Register	SUM ([Client 40 years and older screened for hypertension])	The new data collection tools may not exist all facilities	Process/ Activity	Sum of Number	Quarterly	No	Greater number of people screened for high blood pressure	CD: health Programmes
	1.2.2 Clients 40 years and older screened for diabetes	Number of clients not diagnosed and not on treatment for diabetes screened for diabetes in PHC clinics and OPD	This should assist with increasing the number of clients with diabetes detected and referred for treatment	PHC Comprehensive Tick Register	SUM([Client 40 years and older screened for diabetes])	The new data collection tools may not exist all facilities	Process/ Activity	Sum of Number	Quarterly	No	Greater number of people screened for raised blood glucose levels	NCD Programme Manager
	1.2.3 Mental disorders screening rate	Clients screened for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioral disorders and substance use disorders at PHC facilities	Monitors access to and quality of mental health services in PHC facilities	PHC Comprehensive Tick Register	Numerator: SUM ([PHC client screened for mental disorders]) Denominator: SUM([PHC headcount under 5 years]) + SUM([PHC headcount 5 years and older])	The new data collection tools may not exist all facilities	Process/ Activity	Percentage	Quarterly	No	Higher percentage of for mental disorders screening	NCD Programme Manager

2.5 SUB-PROGRAMME: OTHER COMMUNITY SERVICES

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.5 100% Compliance with the Waste Management Act by 2019	2.5.1 Percentage of health facilities complying with SANS waste disposal requirements	This measure health facilities that dispose waste in line with SANS 10248 regulation as a proportion of the total health facilities.	To track compliance of health facilities with SANS 10248 regulation on waste management.	Waste disposal management.	Numerator Number of health facilities (Hospitals) that dispose waste in line with SANS 10248 regulation at a given reporting period. Denominator: Number of facilities (Hospitals) during same time period.	No specific limitations anticipated	Output	%	Quarterly	No	Compliance with waste management for purposes of infection control and sustaining a healthy environment.	GM: PHP

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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.5 HIV infection rate reduced by 15% by 2019	1.5.1 Client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month- Any client without an outcome reported in the reporting month Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]	Monitors the total clients remaining on life-long ART at the month	ART Register; TIER.Net; DHIS	Numerator: SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period])	None	Output	Cumulative total	Quarterly	no	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
	1.5.2 TB/HIV co-infected client on ART rate	TB/HIV co-infected clients on ART as a proportion of HIV positive TB clients	Monitors ART coverage for TB clients	TB register; ETR.Net; Tier.Net	Numerator: SUM([TB/HIV co-infected client on ART]) Denominator: SUM([TB client known HIV positive])	Availability of data in ETR.net, TB register, patient records	Outcome	Percentage	Quarterly	No	Higher proportion of TB/HIV co-infected on ART treatment will reduce co-infection rates	TB/HIV manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.5 HIV infection rate reduced by 15% by 2019	1.5.3 HIV test done	Total number of HIV Tests done in all age groups	Monitors the impact of the pandemic and assists in better planning for effective combating of HIV and AIDS and decreasing the burden of diseases from TB	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net,DHIS	SUM([Antenatal client HIV 1st test]) + SUM([Antenatal client HIV re-test]) + SUM([HIV test 19-59 months]) + SUM([HIV test 5-14 years]) + SUM([HIV test 15 years and older (excl. ANC)])	Dependent on the accuracy of facility register	Process	Number	Quarterly	No	Higher percentage indicate increased population knowing their HIV status.	HIV/AIDS Programme Manager
	1.5.4 Male Condoms Distributed	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).	Monitors distribution of male condoms for prevention of HIV and other STIs, and for contraceptive purposes. Primary distribution sites (PDS) report to sub-districts on a monthly basis	Numerator: Stock/Bin card	SUM([Male condoms distributed])	None	Process	Percentage	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in the province	HIV/AIDS Cluster
	1.5.6 Medical male circumcision - total	Medical male circumcisions performed 15 years and older as a proportion of total medical male circumcisions performed	Monitors medical male circumcisions performed under supervision	Theatre Register/ PHC tick register, DHIS	SUM ([Males 10 to 14 years who are circumcised under medical supervision]) +([Males 15 years and older who are circumcised under medical supervision])	Assumed that all MMCs reported on DHIS are conducted under supervision	Output	Rate	Quarterly	No	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager
1.6 TB death rate reduced by 30% in 2019	1.6.1 TB client 5 years and older start	TB client 5 years and older start on treatment	Monitors trends in early identification	PHC Comprehensive Tick Register	Numerator SUM ([TB client 5 years and older start on treatment])	- Accuracy dependent on quality of data from	Process/Activity	Rate	Quarterly	No	Screening will enable early identification of TB suspect	TB Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
	on treatment rate	as a proportion of TB symptomatic client 5 years and older test positive	of children with TB symptoms in health care facilities		Denominator: SUM([TB symptomatic client 5 years and older tested positive])	reporting facility					in health facilities	
	1.6.2 TB client treatment success rate	TB clients successfully completed treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors success of TB treatment for ALL types of TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM ([TB client successfully completed treatment]) Denominator: SUM ([TB client start on treatment)]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Higher percentage suggests better treatment success rate.	TB Programme Manager
	1.6.3 TB Client loss to follow up rate	TB clients who are lost to follow up (missed two months or more of treatment) as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment,	Monitors the effectiveness of the retention in care strategies. This follows a cohort analysis therefore the clients would have been started on treatment at least 6	TB Register; ETR.Net	Numerator SUM [TB () client lost to follow up] Denominator: SUM [TB client initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		Other, pulmonary and extra-pulmonary).	months prior									
	1.6.4 TB Client death rate	TB clients who died during treatment as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	Numerator: SUM ([TB client death during treatment]) Denominator: SUM([TB client start on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Annually	Yes	Lower levels of death desired	TB Programme Manager
	1.6.6 TB MDR treatment success rate	TB MDR client successfully completing treatment as a proportion of TB MDR confirmed clients started on treatment	Monitors success of MDR TB treatment	TB Register; EDR Web	Numerator TB MDR client successfully complete treatment Denominator: SUM ([TB MDR confirmed client initiated on treatment])	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Annually	Yes	Higher percentage indicates a better treatment rate	TB Programme Manager

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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	1.7.1 Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Monitors early utilisation of antenatal services	PHC Comprehensive Tick Register	Numerator: SUM ([Antenatal 1st visit before 20 weeks]) Denominator: SUM ([Antenatal 1st visit 20 weeks or later]) + SUM ([Antenatal 1st visit before 20 weeks])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
	1.7.2 Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used postnatal visits within 6 days after delivery	PHC Comprehensive Tick Register	Numerator: SUM ([Mother postnatal visit within 6 days after delivery]) Denominator: SUM([Delivery in facility total])	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
	1.7.3 Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	Monitors implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients.	ART Register, Tier.Net	Numerator: SUM ([Antenatal client start on ART]) Denominator: Sum([Antenatal client known HIV positive but NOT on ART at 1st visit]) + SUM([Antenatal client HIV 1st test positive]) + SUM([Antenatal client HIV re-test positive])	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment	MNCWH programme manager
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.1 Infant 1st PCR test positive around 10 weeks rate	Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 10 weeks	Monitors PCR positivity rate in HIV exposed infants around 10 weeks	PHC Comprehensive Tick Register	Numerator SUM [Infant PCR test positive around 10 weeks Denominator: SUM([Infant PCR test around 10 weeks])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Lower percentage indicate fewer HIV transmissions from mother to child	PMTCT Programme
	1.8.2	Children under 1 year	Track the	Numerator:	Numerator	Road to	Output	Percentage	Quarterly	No	Higher	EPI

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
	Immunisation coverage under 1 year	who completed their primary course of immunization as a proportion of population under 1 year.	coverage of immunization services	PHC Comprehensive Tick Register Denominator: StatsSA	SUM ([Immunised fully under 1 year new]) Denominator: SUM ([Female under 1 year]) + SUM([Male under 1 year])	Health charts are not retained by Health facility. Reliant on under 1 population estimates from Stats SA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered)					percentage indicate better immunisation coverage	Programme manager
	1.8.3 Measles 2nd dose coverage	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population..	Monitors protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	PHC Comprehensive Tick Register Denominator: Stats SA	Numerator SUM ([Measles 2nd dose]) Denominator: SUM([Female 1 year]) + SUM([Male 1 year])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher coverage rate indicate greater protection against measles	EPI
	1.8.5 Diarrhea case fatality under 5 years rate	Diarrhea deaths in children under 5 years as a proportion of diarrhea separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with diarrhea	Ward register	Numerator: SUM ([Diarrhea death under 5 years]) Denominator: SUM([Diarrhea separation under 5 years])	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
						quality of data submitted health facilities						
	1.8.6 Pneumonia case fatality under 5 years rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with pneumonia	Ward Register	Numerator: SUM ([Pneumonia death under 5 years]) Denominator: SUM([Pneumonia separation under 5 years])	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
	1.8.7 Severe acute malnutrition case fatality under 5 years rate	Severe acute malnutrition deaths in children under 5 years as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with Severe acute malnutrition (SAM)	Ward register	Numerator: SUM ([Severe acute malnutrition (SA M) death in facility under 5 years]) Denominator: SUM([Severe Acute Malnutrition separation under 5 years	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	3.4.2 School Grade 1 learners screened	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	School Health data collection forms	SUM [School Grade 1 - learners screened}	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
	3.4.3 School Grade 8 learners screened	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Numerator School Health data collection forms	SUM [School Grade 8 - learners screened]	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
1.7 Maternal Mortality Ratio Reduced to	Delivery in 10 to 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in	Monitors the proportion of deliveries in facility by	Health Facility Register, DHIS	Numerator SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility]	None	Process	Percentage	Quarterly	Yes	Lower percentage indicates better family	HIV and Adolescent Health

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
less than 100 per 100 000 population by 2019		health facilities	teenagers (young women under 20 years).		Denominator: SUM([Delivery in facility total])						planning	
	1.7.4 Couple Year Protection Rate (Int)	Women protected against pregnancy by using modern contraceptive methods, including sterilizations, as proportion of female population 15-49 year. Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) + (SUM Female condoms distributed/200) + (SUM Male condoms distributed / 200) + (Male sterilization x 20) + (Female sterilization x 10)	Track the extent of the use of contraception (any method) amongst women of child bearing age	Facility Register	Numerator (SUM ([Oral pill cycle]) / 15) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4.5) + (SUM([Male condoms distributed]) / 120) + (SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) Denominator: SUM {[Female 15-44 years]} + SUM {[Female 45-49 years]}	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	MCWH&N Programme
1.2 Screening coverage of chronic illnesses increased to more than a million by 2019	1.2.4 Cervical cancer screening coverage 30 years and older	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older years.	Monitors implementation on cervical screening and policy	PHC Comprehensive Tick Register OPD tick register Denominator: StatsSA	Numerator SUM ([Cervical cancer screening 30 years and older]) Denominator: (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10	Reliant on population estimates from Stats SA, and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.10 Human Papilloma Virus Vaccine 1st dose coverage	Girls 9 years and older that received HPV 1st dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 1st dose]) + SUM([Agg_Girl 10 yrs HPV 1st dose]) + SUM([Agg_Girl 11 yrs HPV 1st dose]) + SUM([Agg_Girl 12 yrs HPV 1st dose]) + SUM([Agg_Girl 13 yrs HPV	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
			progress and reflect the coverage so far		1st dose]) + SUM([Agg_Girl 14 yrs HPV 1st dose]) + SUM([Agg_Girl 15 yrs and older HPV 1st dose])							
	1.8.11 Human Papilloma Virus Vaccine 2nd dose coverage	Girls 9yrs and older HPV 2nd dose	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 2nd dose]) + SUM([Agg_Girl 10 yrs HPV 2nd dose]) + SUM([Agg_Girl 11 yrs HPV 2nd dose]) + SUM([Agg_Girl 12 yrs HPV 2nd dose]) + SUM([Agg_Girl 13 yrs HPV 2nd dose]) + SUM([Agg_Girl 14 yrs HPV 2nd dose]) + SUM([Agg_Girl 15 yrs and older HPV 2nd dose])	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager
	1.8.8 Vitamin A dose 12-59 months coverage (Annualised)	Children 12-59 months who received vitamin A 200,000 units, every six months as a proportion of population 12-59 months.	Monitors vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year	DHIS, facility registers, patient records	Numerator Vitamin A dose 12-59 months Denominator: Population 12-59 months*2		Output	Percentage	Quarterly	No	Higher proportion of children 12-29 months who received Vit. A will increase health	MNCWH Programme Manager
	1.8.12 Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Infants exclusively breastfed at 14 weeks as a proportion of the DTaP-IPV-Hib-HBV 3rd dose vaccination. Take note that DTaP-IPV-Hib-HBV 3rd dose (Hexavalent) was implemented in 2015 to include the HepB dose	Monitors infant feeding practices at 14 weeks to identify where community interventions need to be strengthened	PHC Comprehensive Tick Register	Numerator SUM ([Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose]) Denominator: SUM([Hep B 3rd dose under 1 year]) + SUM([DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose])	Reliant on honest response from mother; and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	Yes	Higher percentage indicate better exclusive breastfeeding rate	Cluster: Child Health
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100	1.7.5 Maternal mortality in facility ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42	This is a proxy for the population-based maternal mortality ratio, aimed at	Maternal death register, Delivery Register	Numerator SUM ([Maternal death in facility]) Denominator: SUM([Live birth in facility])+SUM([Born alive	Completeness of reporting	Impact	Ratio per 100 000 live births	Annually	No	Lower maternal mortality ratio in facilities indicate on better	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
000 population by 2019		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	monitoring trends in health facilities between official surveys. Focuses on obstetric causes (around 30% of all maternal mortality). Provides indication of health system results in terms of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services		before arrival at facility])						obstetric management practices and antenatal care	
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.9 Neonatal death in facility rate	Neonatal 0-28 days who died during their stay in the facility as a proportion of live births in facility	Monitors treatment outcome for admitted children under 28 days	Delivery register, Midnight report	Numerator SUM ([Inpatient death 0-7 days]) + SUM ([Inpatient death 8-28 days]) Denominator: SUM([Live birth in facility])	Quality of reporting	Impact	Percentage	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

SUB-PROGRAMME: CORONER SERVICES

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.9 Post – mortems conducted within 72hrs increased to 95% by 2019	1.9.1 Percentage of post-mortem performed within 72 hours	Measures number of post-mortems performed by Forensic Pathologists within a period of 3 days of receiving the body from the SAPS as a percentage of the total number of bodies received	Tracks the turn-around time for Post Mortems.	Death register	Numerator Number of cold bodies with post-mortem performed within 72 hrs. of receipt of body Denominator: Total number of cold bodies received from SAPS (expressed as percentage)	Depended on accuracy of Forensic Pathology services data base.	Output	%	Quarterly	No	Improved and short turn-around times for post mortems.	GM: PHP

SUB – PROGRAMME DISTRICT HOSPITALS

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.1 Hospital achieved 75% and more on National Core Standards (NCS) self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self - assessment]) Denominator: SUM([Hospitals conducted National Core Standards self - assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.1 Average Length of Stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, midnight census register	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
	1.10.6	Inpatient bed	Track the	DHIS,	Numerator: Sum	Accurate	Efficiency	Percentage	Quarterly	No	Higher bed	Hospital

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
	Inpatient Bed Utilisation Rate	days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	over/under utilisation of district hospital beds	midnight census	([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator Usable (Inpatient beds * 30.42) available	reporting sum of daily usable beds					utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	Services Manager
	110.12 Expenditure per patient day equivalent (PDE)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Monitors effective and efficient management of inpatient facilities.	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure, midnight census	Numerator: SUM ([Expenditure - total]) Denominator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD headcount follow-up x 0.3333333])+([Emergency headcount - total x 0.3333333])	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager
2.4 Patient satisfaction rate increased to more than 75% in health services by 2019	2.4.26 Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	Complaints register	Numerator: SUM ([Complaint resolved within 25 working days]) Denominator: SUM([Complaint resolved])	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Strategic Objective	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
3.6: Proportion of EMS response time improved to 85% by 2019	3.6.1 EMS P1 urban response under 15 minutes rate	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time that the first dispatched medical resource arrives on scene	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 15 minutes in urban areas	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	Numerator: SUM ([EMS P1 urban response under 15 minutes]) Denominator: SUM([EMS P1 urban calls])	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the urban areas	EMS Manager
	3.6.2 EMS P1 rural response under 40 minutes rate	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of EMS P1 rural call	Monitors compliance with the norm for critically ill or injured patients to receive EMS within 40 minutes in rural areas	DHIS, institutional EMS registers Patient and vehicle report.	Numerator: SUM ([EMS P1 rural response under 40 minutes]) Denominator: SUM([EMS P1 rural calls])	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
	3.6.3 EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses	DHIS, institutional EMS registers Patient and vehicle report.	Numerator SUM ([EMS inter-facility transfer]) Denominator SUM([EMS clients total])	Accuracy dependent on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists	EMS Manager

Strategic Objective	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		transported				reported from hospitals.					at the appropriate level of care.	

PROGRAMME 4

SUB-PROGRAMME 4.1: REGIONAL Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.2 Hospitals that achieved a performance of 75% or more on National Core Standards self - assessment	Hospitals that achieved a performance of 75% or more on National Core Standards self-assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Output	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.2 Average Length of Stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in	DHIS, midnight census	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		all specialities	all hospitals and CHCs with Inpatient beds									
	1.10.7 Inpatient Bed Utilisation Rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialities	Monitors effectiveness and efficiency of inpatient management	DHIS, midnight census	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Usable (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services
1.3 NCD coverage increased to 1300/1000 000 through management of chronic ils	1.3.1 Cataract surgery rate	Clients who had cataract surgery per 1 million uninsured populations. The population will be divided by 12 in the formula to make provision for annualisation	Monitors access to cataract surgery.	Facility registers, patient registers	Numerator: Cataract surgery total Denominator: Uninsured population	Accuracy dependent on quality of data from health facilities	Quality	Rate per 1 Million	Quarterly	No	Higher levels reflect a good contribution to sight restoration, especially amongst the elderly population.	GM: Hospital Services
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.13 Expenditure per patient day equivalent (PDE)	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency	Monitors effective and efficient management of inpatient facilities.	BAS, Stats SA, Council for Medical Scheme data, DHIS, midnight census	Numerator SUM ([Expenditure - total]) Denominator Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.3333333])+ SUM([OPD headcount referred new x 0.3333333])+([OPD	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		headcount + OPD headcount total) * 0.33333333			headcount follow-up x 0.3333333])+([Emergency headcount - total x 0.3333333])							
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.29 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 4.2: SPECIALISED TB Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.3 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self - assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.3 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialties	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, facility register & Admission	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	GM:DHS

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	1.10.8 Inpatient Bed Utilisation Rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties	Monitors effectiveness and efficiency of inpatient management	DHIS, facility register Admission	Numerator: Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) Denominator: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	Hospital Services Manager
	1.10.14 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All Hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in TB Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Numerator Total Expenditure Denominator: Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager
2.4 Patient Experience of Care	2.4.30 Complaint resolution	Percentage of complaints of users of	To monitor the management	complaints register,	Numerator: Total number of complaints	Accuracy of information is dependent	Quality	Percentage	Quarterly	No	Higher percentage suggest better	Quality Assurance

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
increased to more than 75% in health services by 2019	within 25 working days rate	Hospital Services resolved within 25 days	of the complaints in Hospitals		resolved within 25 days Denominator: Total number of complaints resolved	on the accuracy of time stamp for each complaint					management of complaints in Hospitals	

SUB-PROGRAMME 4.3: SPECIALISED PSYCHIATRIC Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.4 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
	2.3.18 Percentage of health facilities compliant with all extreme and vital measures of the national core standards	Percentage of s health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report,	Numerator: Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards Denominator: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core Standards	Quality Assurance

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2.4.31 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 5

SUB-PROGRAMME 5.1: CENTRAL Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	*2.3.5 Hospital achieved 75% and more on National Core Standards self - assessment rate*	*Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment*	*Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance*	*DHIS - National Core Standard review tools*	*Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])*	*Reliability of data provided*	*Quality*	*Percentage*	*Quarterly*	*No*	*Higher assessment indicates commitment of facilities to comply with NCS*	*Quality assurance*
1.10 80% of Hospitals meeting national efficiency targets by 2019	*1.10.4 Average Length of Stay*	*Average number of patient days that an admitted patient in the district Hospital before separation.*	*To monitor the efficiency of the central Hospital*	*DHIS, facility register & Admission*	*Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out*	*High levels of efficiency y could hide poor quality*	*Efficiency*	*Days (number)*	*Quarterly*	*No*	*A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care*	*District Health Services*
	1.10.10 Inpatient Bed Utilisation Rate	*Patient days during the reporting period, expressed as a percentage of the sum of the daily number of*	*Track the over/under utilisation of central Hospital beds*	*DHIS, facility register Admission*	*Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient bed days (Inpatient beds * 30.42)*	*Accurate reporting sum of daily usable beds*	*Efficiency*	*Percentage*	*Quarterly*	*No*	*Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or*	*District Health Services*

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		usable beds.			*available*						*better service levels. Lower bed utilization rate indicates inefficient utilization of the facility*	
	1.10.16 Expenditure per patient day equivalent (PDE)	*Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All Hospital activity expressed as a equivalent to one inpatient day*	*Track the expenditure per PDE in district Hospitals in the province*	*BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure*	*Numerator: Total Expenditure in district Hospitals* *Denominator: Patient Day Equivalent (PDE) as defined above*	*Accurate reporting sum of daily usable beds*	*Efficiency*	*Number (Rand)*	*Quarterly*	*No*	*Lower rate indicating efficient use of financial resources.*	*District Health Services.*
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	*2.4.32 Complaint resolution within 25 working days rate*	*Percentage of complaints of users of Hospital Services resolved within 25 days*	*To monitor the management of the complaints in Hospitals*	*complaints register,*	*Numerator: Total number of complaints resolved within 25 days* *Denominator: Total number of complaints resolved*	*Accuracy of information is dependent on the accuracy of time stamp for each complaint*	*Quality*	*Percentage*	*Quarterly*	*No*	*Higher percentage suggest better management of complaints in Hospitals*	*Quality Assurance*

SUB-PROGRAMME 5.2: TERTIARY Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.6 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self - assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.5 Average Length of Stay	Average number of patient days that an admitted patient in the district Hospital before separation.	To monitor the efficiency of the tertiary Hospital	DHIS, facility register & Admission	Numerator: Inpatient days + 1/2 Day patients Denominator: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of Hospital care. High ALOS might reflect inefficient quality of care	District Health Services
	1.10.11 Inpatient Bed Utilisation Rate	Patient days during the reporting period, expressed as a percentage of	Track the over/under utilisation of tertiary Hospital beds	DHIS, facility register Admission	Numerator: Inpatient days + 1/2 Day patients Denominator:	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher	District Health Services

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		the sum of the daily number of usable beds.			Inpatient bed days (Inpatient beds * 30.42) available						burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	
	1.10.17 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All Hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in tertiary v Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Numerator: Total Expenditure in district Hospitals Denominator: Patient Day equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.33 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator: Total number of complaints resolved	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 5.3: PSCHIATRIC TERTIARY Hospitals

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.7 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - National Core Standard review tools	Numerator: SUM ([Hospital achieved 75% and more on National Core Standards self-assessment]) Denominator: : SUM([Hospitals conducted National Core Standards self-assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
	2.4.34 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Numerator: Total number of complaints resolved within 25 days Denominator Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 6: PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.6 First year Health professional students receiving bursaries by 2019	2.6.1 Number of Bursaries awarded for first year medicine students	Number of new medicine students provided with bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	Bursary contracts	Number of Bursaries awarded for first year medicine students No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	no	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager
	2.6.2 Number of Bursaries awarded for first year nursing students	Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	SANC Registration form	Number of Bursaries awarded for first year nursing students No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager

PROGRAMME 7: PERFORMANCE INDICATORS FOR HEALTH CARE AND SUPPORT

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019	1.11.1 Percentage of eligible applicants supplied with wheelchairs	Clients supplied with wheelchairs as a proportion of the total clients applying for wheelchairs expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Numerator: Number of clients supplied with wheelchairs during a reporting period Denominator: Total clients applied and on waiting list to receive wheelchairs during the same period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to wheelchairs	Clinical Support Manager
	1.11.2 Percentage of eligible applicants supplied with hearing aids	Clients supplied with hearing aids as a proportion of the total clients applying for hearing aids expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Numerator: Number of clients supplied with hearing aids during a reporting period Denominator: Total clients applied and on waiting list to receive hearing aids during the same period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to hearing aids	Clinical Support Manager
	1.11.3 Percentage of eligible applicants supplied with prostheses	Clients supplied with prosthesis as a proportion of the total clients applying for prosthesis	Tracks the degree to which the department is meeting the need for assistive devices in the	DHIS, facility registers	Numerator: Number of clients supplied with prosthesis during a reporting period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to	Clinical Support Manager

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
		expressed as a percentage	Province		Denominator: Total clients applied and on waiting list to receive prosthesis during the same period						prosthesis	
	1.11.4 Percentage of eligible applicants supplied with orthoses	Clients supplied with prosthesis as a proportion of the total clients applying for orthosis expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Numerator: Number of clients supplied with orthosis during a reporting period Denominator: Total clients applied and on waiting list to receive orthosis during the same period	Dependent on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to orthosis	Clinical Support Manager
1.12 90% availability of essential drugs in all health facilities by 2019	1.12.1 Percentage of order fulfilment of essential drugs at the depots.	Drug orders fulfilled completely	Ensure availability of essential drugs in all facilities	MEDSAS	Numerator: Number of order fulfilled completely Denominator : Number of orders received x 100	Poor maintenance of stock levels by the depot	Output	Percentage	Quarterly	No	Availability of essential drugs at all facilities	Pharmaceutical Services Manager
	1.12.2 Essential medicines stock-out rate at the depots	Mange number of essential medicine on stock	Ensure availability of essential drugs at the depots	MEDSAS	Numerator: number of essential medicines out of stock Denominator : Total number of	Poor maintenance of essential medicines stock levels at the depot	Output	Percentage	Quarterly	No	Availability of essential medicine at the depot	Pharmaceutical Services Manager and Depot managers

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
					essential medicines							

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
2.7 Health facilities refurbished to comply with the National norms and standards by 2019	2.7.1 Number of health facilities that have undergone major refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone major refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
	2.7.2 Number of health facilities that have undergone minor refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Job card/ invoice, Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
	2.7.3 Number of health facilities that have	Number of existing health facilities outside NHI	Tracks overall improvement and maintenance	Practical Completion Certificate Capital	Number of health facilities outside NHI	Accuracy dependent on reliability of information	Input	Number	Annual	No	A higher number will indicate that more facilities	Chief Director: Infrastructure and Technical

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

Conclusion

This is 2018/19 Operational Plan of the Department, which stands as a proposal to accelerate service delivery towards the achievement of its vision and mission as set out in the 2015/16-2019/20 strategic plan.

The department is committed to supporting districts, sub-districts and the facilities to achieve the agreed targets.