health

Department of Health
NORTHERN CAPE

5 YEAR STRATEGIC PLAN 2020/21 - 2024/25

+27 53 830 2148

+27 53 833 4394

dion.theys@gmail.com

DEPARTMENT OF HEALTH

NORTHERN CAPE PROVINCE

5 YEAR STRATEGIC PLAN
2020/21-2024/25

TABLE OF CONTENTS

FOREWORD BY MEMBER OF THE EXECUTIVE COUNCIL

The 5-year strategic plan outlines, among others, the implementation of priority public health interventions as envisaged in the National Health Insurance Bill that is expected to be passed into law by Parliament, as well as the fundamental premises of the Presidential Health Compact. This plan is also aligned to ensure that a vision of Building a Modern, Growing and Successful Northern Cape Province, is realized.

Firstly, we reaffirm our commitment of strengthening the Primary Health Care and Emergency Medical Services as part of our key Apex projects. Our priority is to ensure that these key services are dependable and relevant to communities because they are at the coal-face of service delivery. We have no doubts in our minds that implementing systemic and targeted interventions will contribute significantly towards the goals of reducing maternal, infant and child mortality, increasing average Life Expectancy, as well as other key objectives outlined in the National Development Plan.

Secondly, we will spare no effort in implementing a customized interventions aligned to the policy imperatives of the 6th Administration. These will include: - systematically addressing and delivering on core issues such as population Wellness and Mental Health, Infection Prevention and Control, eradication of patient queues and moving towards a paper-free environment through the Digitization of Health Records, development and implementation of User-friendly Mobile Applications, strengthening Clinical and Corporate Governance, rollout of effective Community Health Awareness Programmes, and development of progressive stakeholder and inter-governmental partnerships to address the social determinants of health. Of equal urgency is the training and development of the employee workforce, to inculcate professionalism, management accountability and a patient-orientated ethos.

Thirdly, speaking in broader terms, in our new 5-year Strategy the Department will ensure the incorporation of all the building blocks for a successful healthcare system, namely, striving for Universal Health Coverage, attaining the goals of Primary Healthcare Reengineering, achieving the National Core Standards (including efficient maintenance and repairs of health facilities), and the strengthening of Health Systems.

Lastly, we will work tirelessly towards ensuring that the state of readiness of provincial health infrastructure respond positively to the coronavirus pandemic and beyond future outbreaks.

Together, we can combat the spread of dreadful diseases in society.

Ms Mase Manopole (MPL)
Northern Cape MEC for Health
Date:

STATEMENT BY THE HEAD OF DEPARTMENT (HOD)

Building a modern, growing and successful provincial health system, in line with the provincial government's vision of a modern, growing and successful province, is at the apex of the Department of Health's 5-year strategic plan.

This strategic plan is aligned with the nine health goals prescribed in the government's National Development Plan 2030, aimed at eliminating poverty and reducing inequality over the next 10 years. These goals include:

1. Average male and female life expectancy at birth increases to 70 years
2. Progressively improve TB prevention and cure
3. Reduce maternal, infant and child mortality
4. Significantly reduce prevalence of non-communicable chronic diseases
5. Reduce injury, accidents and violence by 50 percent from 2010 levels
6. Complete health systems reforms
7. Primary healthcare teams provide care to families and communities
8. Universal healthcare coverage through NHI
9. Fill posts with skilled, committed and competent individuals

This means having a strategic plan that aims to improve access to the full range of healthcare services for all our people; it means having a workforce that can provide healthcare at the highest quality, with maximum effectiveness and maximum efficiency; it means having buildings and equipment that are fit for purpose, and it means providing healthcare as close to where people live as is practical and affordable.

Long-term health outcomes are shaped by a wide variety of factors outside the health system, such as lifestyle, diet, education, sexual behaviour, exercise, road accidents and the level of violence. The Department will increase its focus on these issues as part of health reforms in primary healthcare services. The re-engineering of primary healthcare, with a strong focus on household coverage, will be strengthened to take healthcare to the people and to assist individuals and communities take ownership for their own health and wellbeing.

The challenges we face in healthcare are immense, but the opportunities for improvements are also huge. We face pressing issues in seeking sustainability: from our ageing demographics as people live longer, to the increasing burden of non-communicable chronic diseases. We observe internationally the acceleration of science and discovery with, for example, the falling cost of genome sequencing leading to tens of thousands of new drugs in the pipeline, some of which have already had a profound impact in developing cures, particularly in cancer, but are increasingly associated with unaffordable costs. We are witnessing the progress in technology spanning the digitalisation of health and healthcare to mass access to social media, wearables, the internet of things, big data, artificial intelligence, nanotechnology, augmented reality, robotics and 3D printing, which together will radically transform society, increasing interconnectivity and modernising the structures of healthcare systems.

Telehealth technologies are beginning to enable people to send personal information to healthcare providers who can remotely diagnose health problems; other technologies will enable real-time monitoring; and technologies such as smartphone apps and wearables will help promote healthy behaviors and enable sustained behaviour modification. Increasingly we can envisage a scenario whereby healthcare will be delivered as a seamless continuum of care, away from the clinic-centred point of care model and with a greater focus on prevention and early intervention.

The combined advances in clinical science, data science and information & communication technology, and their convergence through the Fourth Industrial Revolution, are paving the way for unprecedented changes

which will profoundly transform healthcare. Health systems will become much more connected, efficient, pre-emptive, precise, democratised and affordable. Not only will this improve the health of individuals, it will also reduce the massive imbalances people face across our vast province.

Although much of this still seems far away, this strategic plan sets out the building blocks that will take us forward into the Fourth Industrial Revolution and Universal Health Coverage.

I commend this five-year strategic plan to you.

Dr DG Theys

Acting Head of Department

OFFICIAL SIGN OFF

It is hereby certified that this Strategic Plan (or Annual Performance Plan):

- Was developed by the management of the Northern Cape Department of Health under the guidance of the **Honorable MEC: Ms. Mase Manopole**
- Takes into account all the relevant policies, legislation and other mandates for which the Northern Cape is responsible
- Accurately reflects the Impact, Outcomes and Outputs which the Northern Cape Department of Health will endeavor to achieve over the period [years covered by the plan].

Name: Z. M. F. I Signature:

Manager Programme 1: Administration

Name: R. Stryfcom Signature:

Manager Programme 2: District Health Services

Name : M. Mufelo Signature:

Manager Programme 3: Emergency Medical Services

Name: RL Jones Signature:

Manager Programme 4: Regional and Specialised Hospitals

Name: DR Katsaura Signature:

Manager Programme 5: Tertiary and Central Hospitals

Name: Z. C. Kim Signature:

Manager Programme 6: Health Sciences and Training

Name: PP Banda Signature:

Manager Programme 7: Health Support Services

Name: Mabena L Signature:

Manager Programme 8: Infrastructure

Name: DM Gaborone Signature:

Chief Financial Officer

Name: M. Mlotha Signature:

[Head for Planning]

Name: Dr. D. Theys Signature:

Accounting Officer

Approved by:

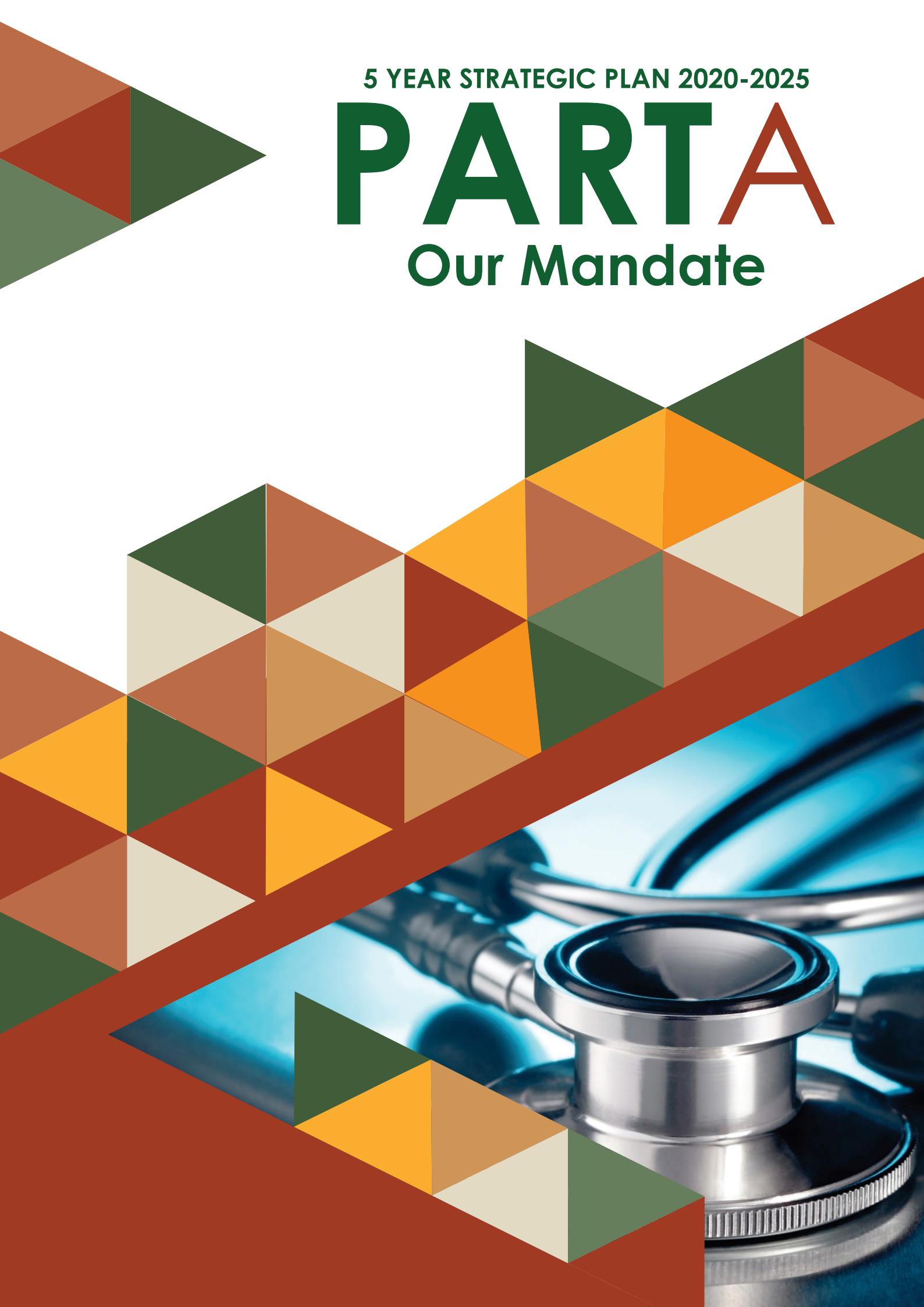
Name: G M Mangope Signature:

Executive Authority

5 YEAR STRATEGIC PLAN 2020-2025

PART A

Our Mandate



PART A: OUR MANDATE

1. Constitutional Mandate

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

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

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

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

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

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

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

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

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

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

National Health Act, 2003 (Act No. 61 of 2003)
Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2. Other legislation applicable to the Department

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.1. National Health Insurance Bill

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

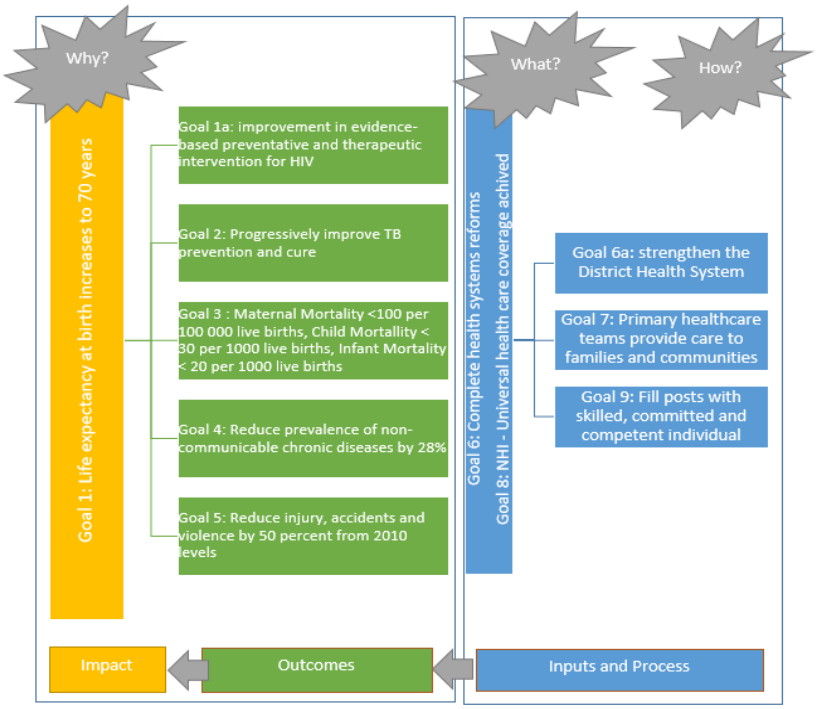
In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator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

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

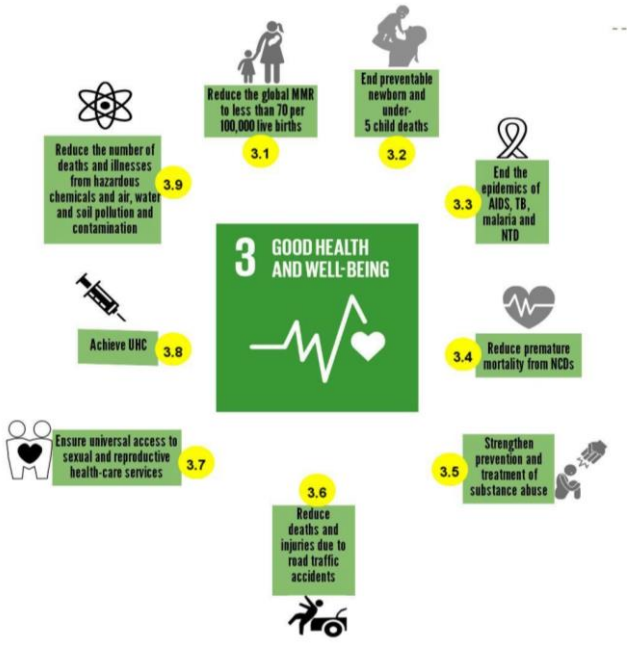
An external evaluation of the first phase of National Health Insurance was published in July 2019. Phase 2 of the NHI Programme commenced during 2017, with official gazetting of the National Health Insurance as the Policy of South Africa. The National Department of Health drafted and published the National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

3.2. National Development Plan: Vision 2030

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



3.3. Sustainable Development Goals



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

(1) 3.1 - By 2030, reduce the global maternal **mortality ratio to less than 70 per 100,000 live births**

(2) 3.2 - By 2030, end **preventable deaths of newborns and children under 5 years of age**, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

(3) 3.3 - By 2030, **end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases** and combat hepatitis, water-borne diseases and other communicable diseases

(4) 3.4 - By 2030, **reduce by one third premature mortality from non-communicable diseases** through prevention and treatment and promote mental health and well-being
(5) 3.5 - Strengthen the **prevention and treatment of substance abuse,** including narcotic drug abuse and harmful use of alcohol
(6) 3.6 - By 2020, **halve the number of global deaths and injuries from road traffic accidents**
(7) 3.7 - By 2030, **ensure universal access to sexual and reproductive health-care services**, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
(8) 3.8 - Achieve **universal health coverage, including financial risk protection**, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
(9) 3.9 - By **2030, substantially reduce the number of deaths and illnesses from hazardous chemicals** and air, water and soil pollution and contamination
(10) 3.a - Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
(11) 3.b - **Support the research and development of vaccines and medicines** for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
(12) 3.c - Substantially **increase health financing and the recruitment, development, training and retention of the health workforce** in developing countries, especially in least developed countries and small island developing States
(13) Strengthen the capacity of all countries, in particular developing countries, for **early warning, risk reduction and management of national and global health risks**

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

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

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

	MTSF 2019-2024 Goals	Strategic Objectives	Presidential Health Summit Compact Pillars
Survive and Thrive	**Goal 1: Increase Life Expectancy improve Health and Prevent Disease**	1. *Improve health outcomes by responding to the quadruple burden of disease of South Africa* 2. *Inter sectoral collaboration to address social determinants of health*	*N/A*

	MTSF 2019-2024 Goals	Strategic Objectives	Presidential Health Summit Compact Pillars
Transform	**Goal 2: Achieve UHC by Implement NHI**	3. *Progressively achieve Universal Health Coverage through NHI*	*Pillar 4: Engage the private sector in improving the access, coverage and quality of health services; and* *Pillar 6: Improve the efficiency of public sector financial management systems and processes*
	Goal 3: Quality Improvement in the Provision of care	4. *Improve quality and safety of care*	*Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care.*
		5. *Provide leadership and enhance governance in the health sector for improved quality of care*	*Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels*
		6. *Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health*	*Pillar 8: Engage and empower the community to ensure adequate and appropriate community based care*
		7. *Improve equity, training and enhance management of Human Resources for Health*	*Pillar 1: Augment Human Resources for Health Operational Plan*
		8. *Improving availability to medical products, and equipment*	*Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery* *Pillar 6: Improve the efficiency of public sector financial management systems and processes*
		9. *Robust and effective health information systems to automate business processes and improve evidence based decision making*	*Pillar 9: Develop an Information System that will guide the health system policies, strategies and investments*
	Goal 4: Build Health Infrastructure for effective service delivery	10. *Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities*	*Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities*

4. Relevant Court Rulings

1. MT Mashiya- Opposed Labour Review matter in the Labour Court Cape Town. Set down Notice for 04 September 2019.Case nr 591/2014

Mr Mashiya withdrawn his application. No order as to costs.

2. MEC Health vs Nehawu and EMS Staff. Urgent High Court Interdict against striking members on

26 February 2020.

Northern Cape Division Case nr 477/2020.Return date 03 April 2020.

3. MEC Health vs Nehawu and other Nehawu Respondents. Urgent High Court Interdict granted.

Return date 03April 2020.

4. HI Pretorius-MVA matter in the Magistrate Court. The matter was settled on the 19 January 2019.Claimed R59 791.06. Settled for R45 300.00 together with 80% of the taxed costs.

5. Bestor CC vs MEC Health. High Court matter. Merits conceded on 3rd of December 2018.The quantum amount of R76 00 000.00 currently still in dispute. Matter is ongoing. Dispute regarding provision of documents set down for 17 April 2020 for arguments.

6. Mindmatter vs Department of Health. Claim received for R122 318 776.40. Matter referred for Arbitration between the Parties.02-12 September 2019.

Matter was settled between the Parties for R40 00000 (forty million).

7. Bigen Africa Services vs Department of Health. Notice of Motion, High Court case nr 2273/19 received on 25 October 2019. Amount claim for R10 783 178.50 for unpaid invoices.

Matter was settled and repayment structure was agreed between the Parties.

8. Bigen Africa Service vs Department of Health. Notice of Motion, High Court case nr 2694/19 received on 12 December 2019.Amount claim for R17 642 454.68 for unpaid invoices.

Matter was settled and repayment structure was agreed upon between the Parties.

5 YEAR STRATEGIC PLAN 2020-2025

PART B

Our Strategic Focus

PART B: OUR STRATEGIC FOCUS

5. VISION

A modern health system delivering quality care to a growing province

6. MISSION

The Department aims to provide better health care, better access and better value to the people of the Northern Cape, through community wide, modern efficient and individually focused initiatives to maximize wellness and prevent illness.

Better health

- Delivering better health for our people through community-wide and individually focussed initiatives;
- These aim to maximise health and wellness and prevent illness;

Better care

- Delivering better care through quick access to modern services;
- Care will be delivered in the most appropriate setting and in clean and infection-free facilities by well-trained, motivated & professional staff;

Better value

- Delivering better value through efficient allocation and use of resources

7. VALUES

- Professionalism
- Teamwork
- Integrity
- Excellence

8. SITUATIONAL ANALYSIS

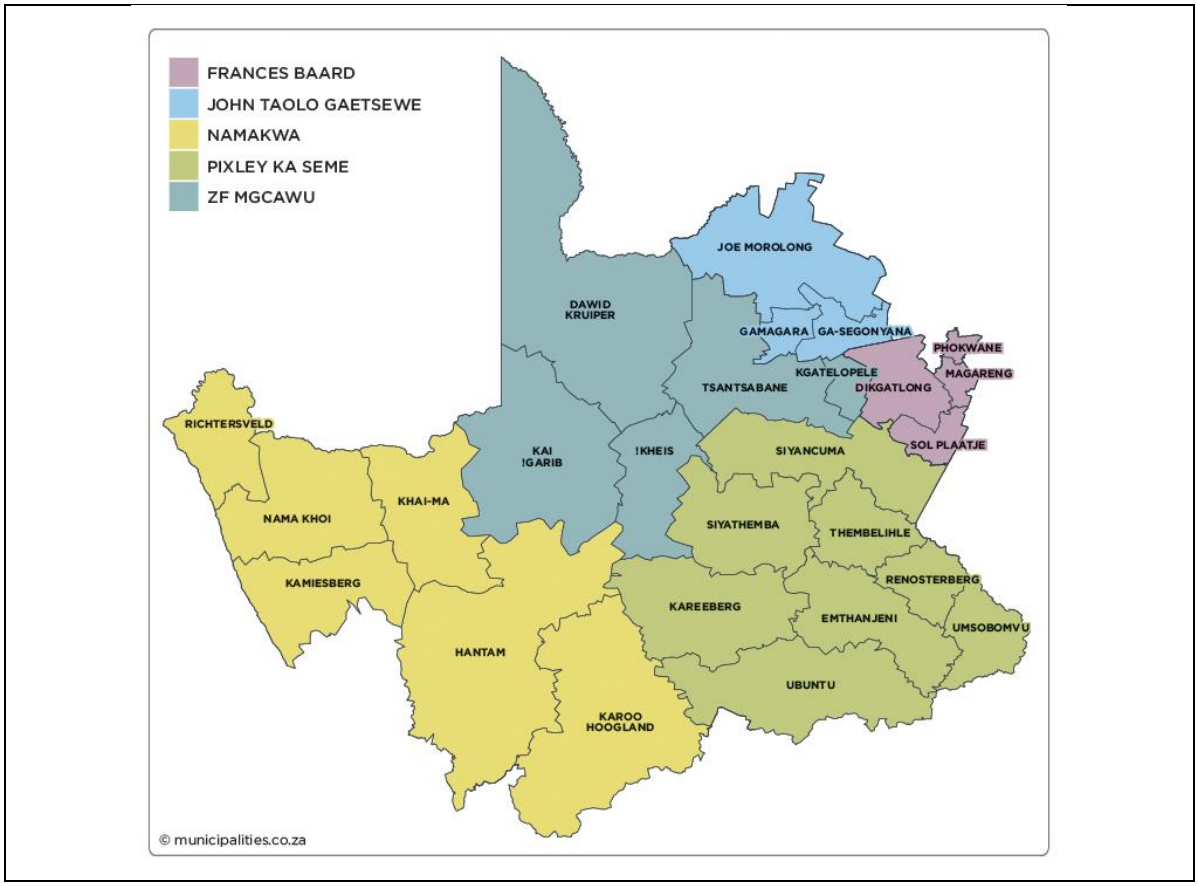
8.1. Overview of the province

The Northern Cape is the largest province in South Africa, taking up nearly a third of the country's land area. It covers an area of 372 889 km2 and has a population of 1 263 875, the least populous of South Africa's provinces. It shares borders with four other provinces, namely Western Cape, Eastern Cape, Free State and North West; as well as borders with the states of Namibia and Botswana, respectively.

The economy of the Northern Cape has been dominated by iron ferro alloys, with the mines linked to the coast by significant investments in rail transport. As a result, its economy has been closely linked to the price of iron ore, with rapid growth during the commodity boom and a significant slowdown since then. Through the intervention of the mining sector and other economic developments like the SKA and farming in other parts of the province, the Department will be able to render improved and better health care services to the people of the Northern Cape.

Furthermore, about 56.8% of the population in the northern cape speaks Afrikaans followed by 33.4% Setswana speaking, 5.2% IsiXhosa speaking, 2.4% English speaking and only 1.1% Sesotho speaking (StatsSA Community Survey, 2016). There is not much issues around the language barriers in the province, except in the areas of Namakwa and other parts where the Khoisan language is beginning to find expression. The other is the sign language for patients with impaired hearing and bray language where health professionals should be trained to respond to the patients who need the interventions.

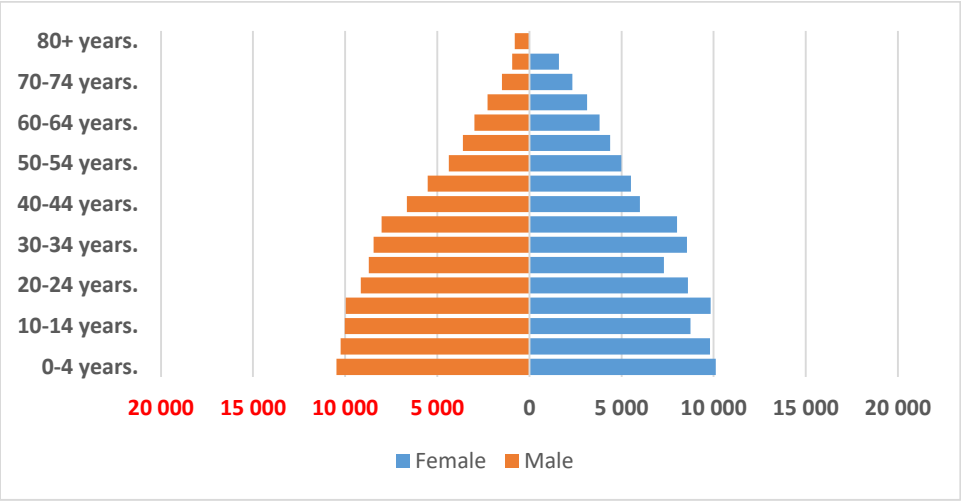
Demographic Data	
Geographical area	372,889 Km2
Total population Northern Cape Mid-year estimates 2018	1,263,875
Population density (SA Mid-year estimates 2018)	3.1/Km2



8.2. External Environment Analysis

8.2.1. Demography

Figure 1: Total population by age group and sex (Northern Cape)



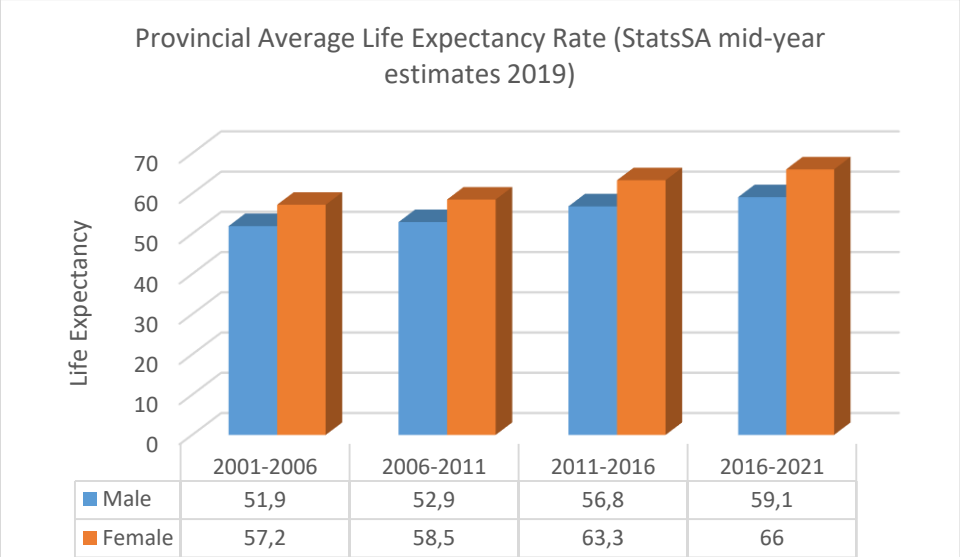
Source: Mid-Year Population Estimates, July 2019 (Statistics SA)

The Northern Cape has the smallest share of the South African Population constituting just over 2.2% of the population. Furthermore, age cohort 0 to 4 years constitutes the largest proportion of the total population (124 890 – 9.9%). This implies high birth rates in the province and thus indicates the need for the department to properly prioritize areas such as early childhood development as well as mother and child healthcare. The

budget allocation should therefore be reviewed to plan towards early childhood development in order to manage the high birth rate.

8.2.2 Life Expectancy

Figure 2: Provincial average life expectancy at birth (2001-2021)



	2001-2006	2006-2011	2011-2016	2016-2021
Male	51,9	52,9	56,8	59,1
Female	57,2	58,5	63,3	66

Source: Mid-Year Population Estimates, 2019 (Statistics SA)

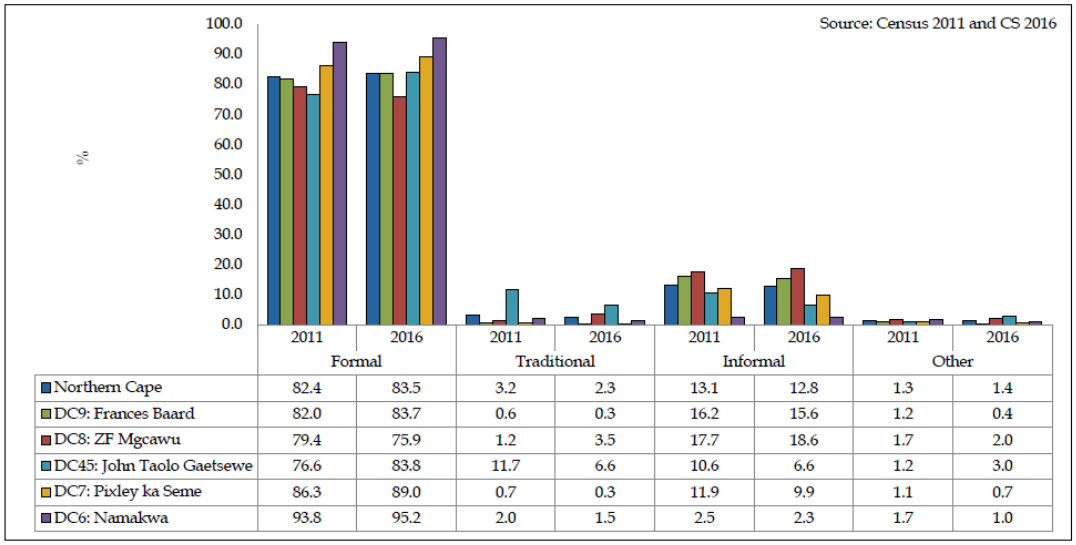
Life expectancy at birth reflects the overall mortality level of a population. According to the mid-year population estimates 2019, the average provincial life expectancy at birth increased for both males (59,3years) and females (66 years) in the Northern Cape. The life expectancy increased incrementally for each period but more significantly in the period 2011–2016 due to the uptake of antiretroviral therapy over time. The Department should continue with interventions that are in place to ensure that mortalities due to communicable and non-communicable diseases are well managed and reduced.

8.2.3. Social Determinants of Health for Province and Districts

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

Health is influenced by the environment in which people live and work as well as societal risk conditions such as polluted environments, inadequate housing, poor sanitation, unemployment, poverty, racial and gender discrimination, destruction and violence. Therefore, the province should dedicate its fiscal to the Districts as reflected in the approach of NHI.

Figure 3: Type of dwellings occupied by households in the Northern Cape, 2011-2016



	Formal		Traditional		Informal		Other	
	2011	2016	2011	2016	2011	2016	2011	2016
Northern Cape	82.4	83.5	3.2	2.3	13.1	12.8	1.3	1.4
DC9: Frances Baard	82.0	83.7	0.6	0.3	16.2	15.6	1.2	0.4
DC8: ZF Mgcawu	79.4	75.9	1.2	3.5	17.7	18.6	1.7	2.0
DC45: John Taolo Gaetsewe	76.6	83.8	11.7	6.6	10.6	6.6	1.2	3.0
DC7: Pixley ka Seme	86.3	89.0	0.7	0.3	11.9	9.9	1.1	0.7
DC6: Namakwa	93.8	95.2	2.0	1.5	2.5	2.3	1.7	1.0

- There was an increase in the proportion of households living in formal dwellings in the Northern Cape.
- Namakwa district has the biggest proportion of households occupying formal dwellings when compared to other districts in the province at 95.2%, followed by Pixley ka Seme at 89.0%.
- John Taolo Gaetsewe district had the biggest percentage increase in the proportion of households living in formal dwellings from 76.6% in 2011 to 83.8% in 2016. There was also a decrease in the proportion of traditional dwellings in this district municipality.

Source: Mid-Year Population Estimates, 2019 (Statistics SA)

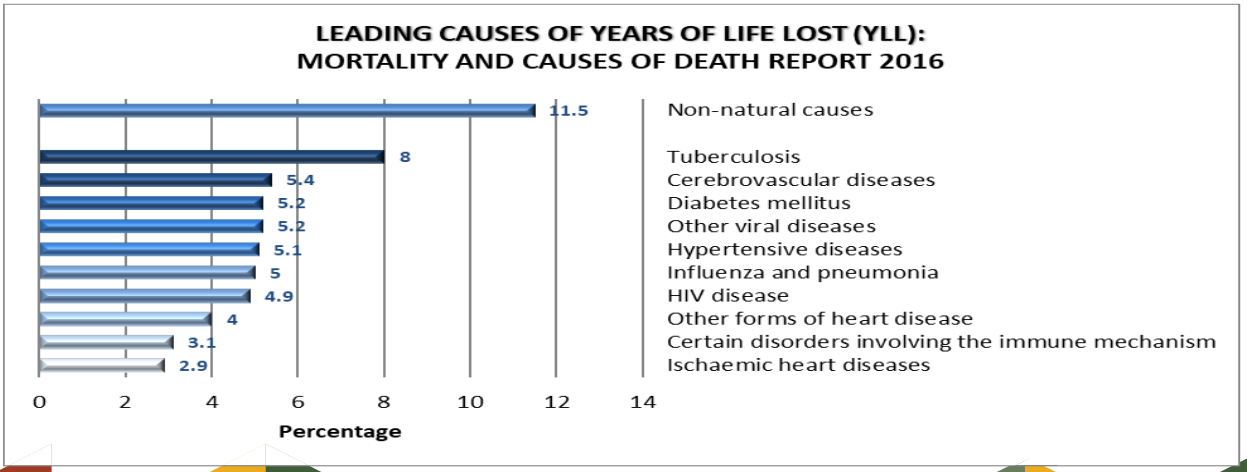
8.2.4. Epidemiology and quadruple burden of disease

Epidemiologically South Africa is confronted with a quadruple BOD because of HIV and TB, high maternal and child morbidity and mortality, rising non-communicable diseases and high levels of violence and trauma.

Years of Life Lost

Years of Life Lost (YLLs) are an estimate of premature mortality based on the age at death and thus highlight the causes of death that should be targeted for mortality prevention. The biggest contributor to YLL in Northern Cape is TB, followed by HIV, other forms of heart disease and Hypertensive diseases

Tuberculosis maintained its rank as the leading cause of death in South Africa. Diabetes mellitus was the second leading natural cause of death, followed by other forms of heart disease and cerebrovascular disease. Human immunodeficiency virus (HIV) disease is in the fifth position. Overall, the results show a considerable burden of disease from non-communicable disease.



THE 10 LEADING CAUSES OF DEATHS IN THE NORTHERN CAPE PROVINCE

Table: Ten underlying causes of deaths, Northern Nape, 2015

Causes of death(based on ICD10)	Northern Cape (2015)		
	Rank	No. of deaths	%
Tuberculosis	1	1 065	7,7
Human immunodeficiency virus [HIV] disease	2	879	6,4
Diabetes mellitus	3	695	5,1
Hypertensive diseases	4	690	5
Chronic lower respiratory diseases	5	653	4,7
Cerebrovascular Diseases	6	642	4,7
Influenza and pneumonia	7	567	4,1
Ischaemic heart diseases	8	488	3,5
Certain Disorders involving the immune mechanism	9	477	3,5
Other forms of Heart Disease	10	403	2,9
Other natural causes		5 712	41,5
Non-natural causes		1 487	10,8
Total All causes		13 758	100

Source: Mortality & Causes of death in South Africa, 2015; Statistics South Africa

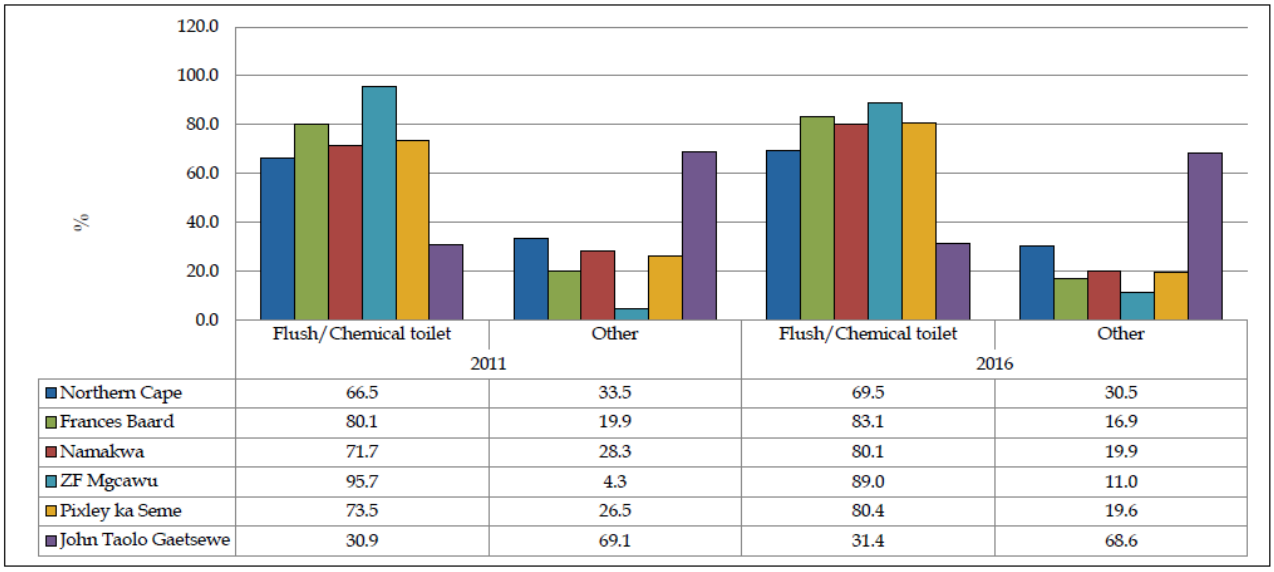
Table: Ten underlying causes of deaths, Northern Nape, 2016

Causes of death(based on ICD10)	Northern Cape (2016)		
	Rank	No. of deaths	%
Tuberculosis	1	937	6,8
Human Immunodeficiency virus (HIV) Disease	2	848	6,1
Other forms of heart disease	3	762	5,5
Hypertensive diseases	4	761	5,5
Cerebrovascular diseases	5	718	5,2
Diabetes Mellitus	6	642	4,6
Chronic lower respiratory diseases	7	601	4,3
Influenza and pneumonia	8	570	4,1
Ischaemic heart diseases	9	489	3,5
Certain disorders involving the immune mechanism	10	485	3,5
Other natural causes		5 599	40,4
Non-natural causes		1 458	10,5
All causes		13 868	100

Source: Mortality & Causes of death in South Africa, 2016; Statistics South Africa

The table above clearly depicts that in the Northern Cape province, Tuberculosis is the number one cause of death as reported by Statistics South Africa in the "Mortality and causes of death in South Africa" report for both 2015 (7,7%) and 2016 (6,8%). In 2016, Human immunodeficiency virus [HIV] disease was reported as the second leading cause of death at 6.1% followed by other forms of heart disease at 5.5%.

Figure 4: Households with access to improved sanitation in the Northern Cape, 2011-2016

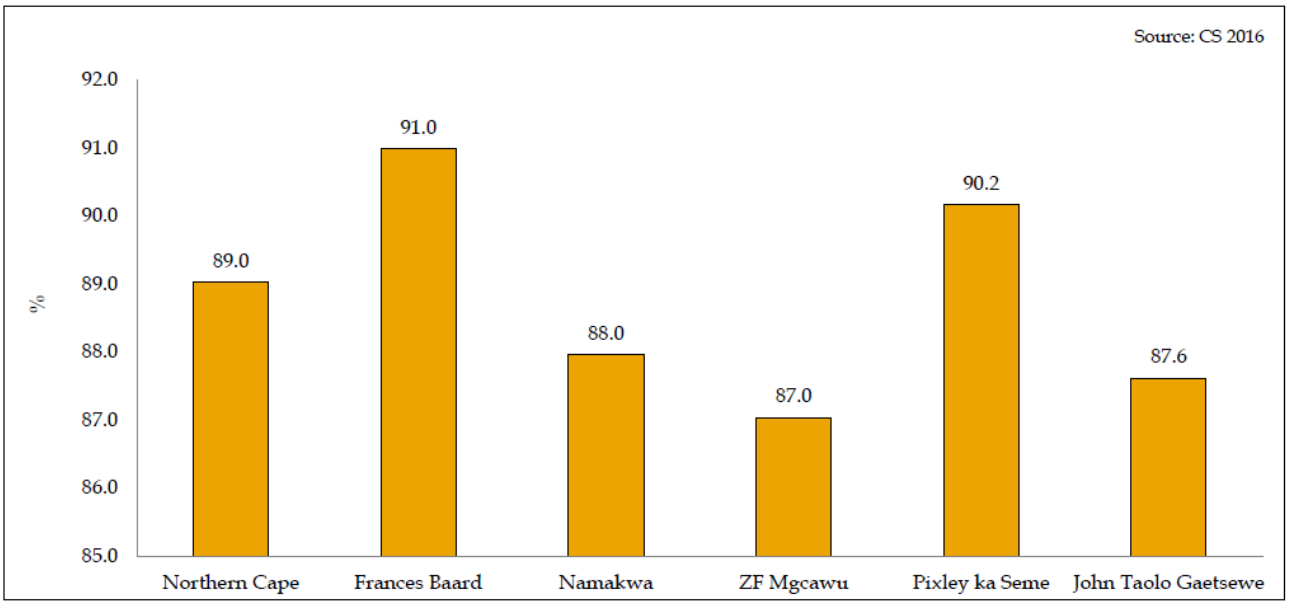


	2011		2016	
	Flush/Chemical toilet	Other	Flush/Chemical toilet	Other
Northern Cape	66.5	33.5	69.5	30.5
Frances Baard	80.1	19.9	83.1	16.9
Namakwa	71.7	28.3	80.1	19.9
ZF Mgcawu	95.7	4.3	89.0	11.0
Pixley ka Seme	73.5	26.5	80.4	19.6
John Taolo Gaetsewe	30.9	69.1	31.4	68.6

Source: Census 2011 and CS 2016

- There was an increase in the proportion of households with access to improved sanitation in Northern Cape.
- Although there was a drop in sanitation access for the ZF Mgcawu district between 2011 and 2016, it still had the highest proportion of households with access to improved sanitation facilities when compared to other districts in the province at 89.0%, followed by Frances Baard at 83.1%.
- Namakwa district had the highest percentage increase in the proportion of households with access to sanitation (+8,4%) from 71.7% in 2011 to 80.1% in 2016. John Taolo Gaetsewe district had the least proportion of households with access to improved sanitation facilities when compared to other districts with only 31.4 % of households having access to flush or chemical toilets in 2016.

Figure 5: Households with access to electricity in the Northern Cape, 2011-2016



- Frances Baard and Pixley ka Seme districts have the highest proportions of households with access to electricity at 91.0% and 87.6% respectively in 2016.
- ZF Mgcawu and John Taolo Gaetsewe districts have the least proportions of households with access to electricity at 87.0% and 87.6 % respectively in 2016.

Key Observations:

The Northern Cape is moving towards a modern growing and successful province therefore there is a need to ensure that far rural areas are having electricity. This will assist in ensuring that the CCMDD system is functioning properly in those areas to ensure that patients have access to their medication.

The department will ensure that patients are properly tracked and assisted through the Health Patient Registration System to enhance the system to track and assist patients more effectively and efficiently. Furthermore, there will a number of technology interventions that will be put in place in far rural areas e.g. Skype, video conversations, and conference calls etc. in order to ensure that the specialist and medical officers communicates to address challenges in far reaching areas.

8.3. Internal Environment Analysis

8.3.1. Service Delivery Platform/Public Health Facilities

Facility Type	Frances Baard DM	Zwelentlanga Fatman Mgcawu DM	Pixley-Ka-Seme DM	John Taolo Gaetsewe DM	Namakwa DM
Clinic	26	15	28	39	23
Community Health Centre	4	6	8	5	10
Satellite Clinic	6	15	4		10
Special Clinic		0	0		Mobiles -2 Health post-15
District Hospital	2	2	3	2	2
Regional Hospital	0	1	0		0
Provincial Tertiary Hospital	1	0	0		0
Specialised TB Hospital	1	0	0		0
Grand Total	40	39	43	44	62

8.3.2. Universal Health Coverage (Population and Service Coverage)

Major demographic characteristics

Due to unemployment and poverty the majority of health services rendered to the community by the public sector which puts pressure on the already limited resources. The youth make up a significant part of the total population and this increases the burden on service delivery for prevention strategies due to the fact that prevalence of HIV & TB is higher for this age group.

Social determinants of health

Approximately 30% of the population are unemployed and 10% of households live with an annual income below R4,800 or less than R400 per month. All this adds to the deprivation index of the district. The income status impacts on revenue collection at hospital services as patients are not being able to pay for services rendered.

Epidemiological (disease) profile of the District

In the district the majority of deaths amongst people from 25 - 65+ are caused by Non-communicable diseases with HIV & TB the highest amongst the 15 – 24 years age group.

Due to the absence of private facilities not only the uninsured population is dependent on the health care facilities but also the insured population. These facilities serve a population of 193 195 people.

Service packages implemented in these facilities sometimes also cover elements in the next level of care due to the vastness and challenges with referral paths. This however assists to bring services closer to the communities of the Pixley ka Seme district.

Community Health Workers Programme

Pixley ka Seme District has 400 CHW's placed throught the primary health sector. Officials are trained in Phase 1 and Phase 2 which enabled them to do screening for Hypertension, Diabetes, Pregnancy, TB and Mental Health illnesses.

The services rendered by CHW's are intergrated with the PHC services and overseen by a Professional Nurse from the clinic to which they are allocated.

WBPCHOT

WBPCHOT strategy is a National model that was implemented in SA 2011 with the aim of rendering Health care services at the door step of our communities and zooming into HH registering and profiling HH information to determine a type of service needed

This programme has employed 330 CHW's across the District in a bid to fight the new HIV infections, retaining in care those already on treatment and conduct structured screenings in communities Including HTS services and Health campaigns.

This cadres of community based Health workers are strategically placed at all Health Care facilities and other small settlements with satellite/mobile points to support all clients on medication.

Towards the surge of 90 90 90 targets this programme is mostly looking at the followings

- 90% of people on treatment with suppressed viral loads (RIC adherent) and this would be reached through establishment of Adherence clubs, CCMDD run by a trained lay persons with the support of clinicians

- 90% of vulnerable groups screened (this would be done through community based screenings by chw's)

- 90% treatment success (through direct dotting of TB patients by chw's and implementing I – ACT programme which is designed to support newly diagnosed clients in facilities and ensure that they become stable on their treatment.

Ward-Based Outreach Teams

District	Sub-district	Total
Pixley ka Seme	Emthanjeni	15
	Thembilihle	4
	Ubuntu	3
	Kareeberg	3
	Umsobomvu	6
	Renosterberg	3
	Siyacuma	16

	Siyathemba	14
ZFM	DAWID KRUIPER 1	4
	DAWID KRUIPER 2	3
	KHAI !GARIB	3
	!KHEIS	2
	TSANTSABANE	3
	KGATELOPELE	1
Namakwa DM	Hantam LM	4
	Kamiesberg LM	4
	Karoo Hoogland LM	3
	Khâi-Ma LM	4
	Nama Khoi LM	9
	Richtersveld LM	6
JTG	Gasegonyana	9
	Gamagara	2
	Joe Morolong	17

Outreach Visits

Indicator/Data Element	Pixley ka Seme	ZFM	Namakwa	JTG	
OHH with adherence support rate	69%	36.1	72.9	34.9	
OHH with child under 5 years care rate	26.5%	13.2	11.0	21.3	
OHH with pregnancy care rate	3.6%	1.7	2.7	2.7	
OHH with postnatal care rate	1.6%	0.76	1.8	1.4	

PHC utilization Rate (Per District)

District	Apr 2018 to Mar 2019
nc Frances Baard District Municipality	2
nc John Taolo Gaetsewe District Municipality	2,2
nc Namakwa District Municipality	3,2
nc Pixley ka Seme District Municipality	2,5
nc Zwelentlanga Fatman Mgcawu District Municipality	2

PHC Expenditure per Headcount (per District) ‘

District	Apr 2018 to Mar 2019 District Hospital
nc Frances Baard District Municipality	3897,5
nc John Taolo Gaetsewe District Municipality	2325,8
nc Namakwa District Municipality	3137,8
nc Pixley ka Seme District Municipality	3538,7
nc Zwelentlanga Fatman Mgcawu District Municipality	992

Hospital Care (Per District)

OPD new client not referred rate	
District	**Apr 2018 to Mar 2019 District Hospital**
nc Frances Baard District Municipality	95,1
nc John Taolo Gaetsewe District Municipality	79,5
nc Namakwa District Municipality	50,5
nc Pixley ka Seme District Municipality	78
nc Zwelentlanga Fatman Mgcawu District Municipality	51,9

8.3.3. MATERNAL, CHILD AND WOMEN'S HEALTH

Maternal Health, Neonatal, PMTCT and Sexual Reproductive Health

The Maternal death ratio in facility excluding coincidental deaths, motor vehicle accidents and death on arrival has steadily increased from 65.9 in 2017/18, 71.3 in 2018/19 to 109.9 2019/2020 (97.2 without coincidental cases) per 100 000 live births against the target of 115/100 000. Most of the avoidable factors contributing to the maternal deaths were from patients managed at district hospitals (2017/18, 77.8%, 2018/19, 83.3% and 2019/2020, 86%). The four main patient related avoidable factors are delay in seeking medical care, no antenatal care and infrequent antenatal care. The three (3) main conditions that are causing maternal deaths are obstetric haemorrhage (OH), hypertensive disorders in pregnancy (HDP) and non-pregnancy infection account to 65.3% of avoidable maternal deaths in the province.

In attempt to reduce maternal deaths, the National Department of Health donated 20 Non pneumatic Anti-Shock Garments (NASG) and were distributed to maternity wards of Tertiary, Regional, 9 district hospitals and EMS respectively except the two in Namakwa district. Training was conducted on the use of NASG to doctors, midwives, EMS and non- clinical staff. The garment will be applied immediately on diagnosis of Post -Partum Haemorrhage (PPH) while the woman is being managed and during the transfer to the next level of care. It assists to stabilize pulse and blood pressure to prevent the woman from going into shock from PPH. Therefore it might be of particular value when there are long ambulance delays or long distances for the ambulance to cover. Districts were supported on skills development, support visits, Perinatal Morbidity and Mortality Meetings (districts and facilities) and protocols on obstetric emergencies.

Neonatal Care

Neonatal death in facility rate increased from 11.6% in 2017/18 and 2018/19 to 11.7/1000 in 2019/2020 against the target of 14.5/1000. The three main causes of deaths among neonates remains: Immaturity, Infection and Hypoxia. Lack of neonatal units in district hospitals, skilled health care workers in the Management of Sick and Small Newborns (MSSN), staff shortage, attrition and infrastructure also have contributed to the deaths throughout the province

Health system strengthening strategy such as Provincial Neonatal and Children under 5 years committee has been established to ensure implementation of the 3 ministerial committee recommendations and also to identify avoidable factors for better health outcomes.

Prevention of Mother to Child transmission (PMTCT)

The PMTCT programme has implemented new changes in 2019/20 from Tenofovir, Emtricitabine and Efavirenz (TEE) to Tenofovir, Lamivudine and Dolutogravir (TLD) fixed dose combination. The changes are due superior efficacy and viral suppression which will benefit reduction in mother to child transmission of HIV. There is minimal potential risk identified of using the above drug is neural tube defects in neonates.

Prevention of Mother to Child transmission remain constant at 1.3% positivity rate around 10 weeks against the target of 1.5% , however the initiation of pregnant women is not achieved due to the quality of data and clients who absconds from the facility before being initiated.

Sexual and Health Reproductive Health

Couple Year Protection Rate sustained performance throughout the year due to the implementation of the long acting Intra Uterine Contraceptive Device (IUCD) method. General improvement was noted on utilisation of cervical cancer tracker tool, despite screening equipment still not procured on time in order to ensure continued screening on client demand. Status quo with CTOP (Choice on Termination of Pregnancy) services remains, due to none implementation at districts as a service package, and lack of training for Midwives due to funding challenges. CTOP services are not easily accessible as it is offered in 4 facilities, ZFM (Postmansburg and Dr Harry Surtie hospitals) Frances Baard (Galeshewe Day Hospital) and JTG (Tshwaragano) which might also have contributed to unwanted pregnancies, high teenage pregnancy and maternal deaths.

Child Health, EPI, School health, Youth and Nutrition

The targets on “under-five year case fatality rate” (Diarrhoea, Pneumonia and Severe Acute Malnutrition) have been achieved against the target 3%, 2,5% and 6% respectively due to improved management of children in hospital and auditing of deaths to identify modifiable factors which are corrected to improve inpatient care.

The immunisation coverage under 1 year is achieved which contribute to the improvement of the herd immunity of the province. There is a challenge with Measles 2nd dose which is not achieved. The programme is currently improving its Public Private Partnership (PPP) to assist with Expanded Programme on Immunisation (EPI) services. The PPP allows children to have vast opportunity to have alternative in seeking care which improves health seeking behaviour of the community. The Non-Polio AFP rate was achieved against the target of 13 cases per year.

Northern Cape has improved tremendously in EPI surveillance on case findings and reporting. As a province, we have also contributed to the country's achievement on being certified Polio-Free. The African Regional Certification Commission (ARCC) has accepted the South Africa national documentation of polio-free status. This was announced during the recent meeting in Lusaka on the 19th September 2019.

The Sanofi Pasteur EPI Immunization Indaba was successfully executed from 10th to 11th September 2019 at the Kimberley Garden court.

The Head of Department also awarded the best Performing District for FY 18/19, Frances Baard with a "Best performing district" certificate.

Integrated School Health Programme (ISHP)

The MCYWH&N Directorate managed to sign a memorandum of understanding (MOU) with Scatec Solar in the ZFM and INNOVO in JTG and PKS districts to support the School Health programme which commenced from April to October 2019. The main objective was to increase the coverage of screening amongst Grade 1 and 8 learners which led to achievement of target for Grade 8 learners. The limited resources such as transport and shortage of staff remain a challenge in the implementation of ISHP effectively.

The HPV campaign during February and March 2020, being referred to as the transition period was implemented in four districts, excluding John Taolo Gaetsewe due to challenges of resources e.g. transport. This is where the immunisation of learners was changed from Grade 4 to Grade 5. This therefore, resulted in opportunity to catch up learners who were not previously immunised due to no consent form or being missed or absent was provided with the HPV vaccination. The performance of 2019/2020 could not be reported due to unavailability of capturing system which is the responsibility of National Department Health.

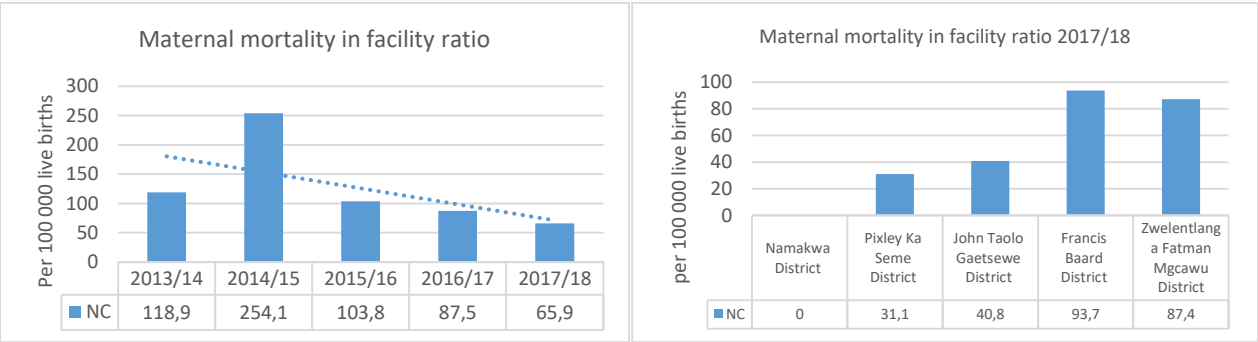
Adolescent and Youth Friendly Services

The teenage pregnancy in 10 to 19 years remain a challenge as presented by adolescents accessing facilities in high numbers. The AYFS programme appointed three coordinators (FB, JTG and ZFM) to support the AYFS programme, two districts are outstanding due to Human Resource processes. The performance for 2017/2018 is 17, 6%, increased to 18.4% in 2018/19 and 2019/2020. The NDoH has renewed and signed the memorandum of understanding with Love Life in FB (Sol Plaatje, Dikgatlong), ZFM (Dawid Kruiper) and JTG (Gasegonyana) and Soul City in (Gasegonyana) to assist in addressing the teenage pregnancy challenges.

Maternal Death

Maternal death is a death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric). The maternal mortality ratio (MMR) is a measure of maternal mortality and is defined as the number of maternal deaths per 100 000 live births. The numerator is the number of maternal deaths, while the denominator includes the number of live births and is expressed per 100 000 live births. This Maternal mortality in facility ratio by province, 2017/18 per 100 000 live births [Source: DHIS] FS EC MP NW LP GP KZN NC WC 50 100 150 200 132.9 55.1 128.3 109.2 108.5 65.9 117.5 101.9 120.0 SA: 105.7 Provinces EC FS GP KZN LP MP NC NW WC 68 Section A: Delivery ratio is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys.

Figure 6: Maternal mortality in facility ratio by province, 2013/14 – 2017/18 (per 100 000 live births)



Source: District Health Barometer 2017/18

The figure above clearly depicts the provincial reduction in maternal mortality in facility ratio since 2013/14. The ratio of 254.1 per 100 000 in 2014/15 was due to poor data quality when 28 maternal deaths were reported in February 2015 at Dr Harry Surtie Hospital in Upington (ZF Mgcawu District). In 2017/18 Namakwa District reported zero maternal deaths.

Table 1: District with an increase in maternal mortality in facility ratio and number of maternal deaths, 2016/17 – 2017/18

District	Maternal mortality in facility ratio		Number of maternal deaths		Increase in the number of maternal deaths between 2016/17 and 2017/18
	2016/17	2017/18	2016/17	2017/18	
Zwelentlanga Fatman Mgcawu (ZFM) District	46,6	87,4	2	4	2

Source: District Health Barometer 2017/18

The table shows the district with an increase in the maternal mortality in facility ratio between 2016/17 and 2017/18 as well as the increase in the number of maternal deaths in facility for the same period. Zwelentlanga Fatman Mgcawu (ZFM) District had the greatest increase in the number of maternal deaths in facility (2 maternal deaths).

Table 2: Maternal and Women's Health

Indicator	Type of Indicator	Period	South Africa	Northern Cape	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
Maternal mortality in facility ratio(per 100k)	Impact	2018/19	105.9	**71.3**	**62.7**	**94.5**	**73.2**	**44.8**	**106.5**
Maternal death in facility (Number)		2018/19	1 065	**17**	**1**	**3**	**4**	**4**	**5**
Live birth in facility (Number)		2018/19	959 720	**21794**	**1507**	**2848**	**4715**	**8393**	**4331**
Delivery in 10 to 19 years in facility rate	Outcome	2018/19	12.9	**18.4**	**17.7**	**19.9**	**21.1**	**16.6**	**18.3**
Delivery in 10 to 19 years in facility (Number)		2018/19	124 628	**4041**	**268**	**550**	**1014**	**1406**	**803**
Delivery in facility-total (Number)		2018/19	964 209	**21928**	**1515**	**2762**	**4800**	**8467**	**4384**
Antenatal client initiated on ART rate	Outcome	2018/19	95.8	**96.3**	**96.6**	**98**	**96.7**	**97.8**	**92.1**
Antenatal client start on ART (Number)		2018/19	109 900	**1786**	**56**	**242**	**607**	**567**	**314**
Antenatal client known HIV positive but NOT on ART		2018/19	18 005	**428**	**21**	**78**	**93**	**155**	**81**
Mother postnatal visit within 6 days rate	Output	2018/19	75.3	**65.3**	**50.8**	**73.5**	**91**	**55.7**	**55.8**
Mother postnatal		2018/19	725 586	**14 329**	**769**	**2030**	**4368**	**4716**	**2446**

Indicator	Type of Indicator	Period	South Africa	Northern Cape	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
visit within 6 days after delivery									
Antenatal 1st visit before 20 weeks rate	Output	2018/19	68.1	**63.1**	**72.5**	**68.5**	**60.8**	**59.6**	**65.1**
Antenatal 1st visit before 20 weeks (Number)		2018/19	729 259	**15 915**	**`1221**	**2459**	**3635**	**5233**	**3367**
Antenatal 1st visit- total		2018/19	1 071 081	**25 210**	**1685**	**3589**	**5980**	**8780**	**5176**
Couple year protection rate	Output	2018/19	61	**60.8**	**63**	**58.4**	**53**	**71.8**	**54.6**
Contraceptive years dispensed (Number)		2018/19	7 247 868	**265 373**	**35 601**	**38172**	**61359**	**78539**	**51702**
Cervical cancer screening coverage	Output	2018/19	65.1	**46**	**37.7**	**47.3**	**48.7**	**41.7**	**53.4**
Cervical cancer screening 30 years and older (Number)		2018/19	861 893	**13058**	**1089**	**2262**	**2395**	**3990**	**3322**

The performance of the **Northern Cape is 71.3/100 000** and **SA is 105/100 000**.

The following are the districts that are significantly contributing to the number of maternal deaths. (note: the mortality data in districts with referral hospitals, are included in their respective district):

- ZFM 106/100 000 with 5 MD live birth 4331
- PKS: 94.5/100 000 with 3 MD live birth -2848
- JTG: 73.2/100 000 with 4 maternal deaths live births :- 4715
- Namakwa: 71.3/100 000 with 1 maternal death , live birth- 1507
- Frances Baard : 44.8/100 000 with 4 maternal deaths , live births -8393

Table 3: Child Health

Indicator	Type of Indicator	Period	South Africa	Northern Cape	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
Death in facility under 1 year rate	Impact	2018/19	7.5	**6.6**	**3.6**	**4.8**	**9.4**	**8.7**	**4**
Death in facility under 1 year (Number)		2018/19	14 841	**322**	**19**	**29**	**49**	**178**	**47**
Death in facility under 5 years rate	Impact	2018/19	4.8	**4.5**	**2**	**2.7**	**6.5**	**6.6**	**2.5**
Death in facility under 5 years (Number)		2018/19	16 844	**378**	**19**	**33**	**58**	**216**	**52**
Diarrhoea case fatality under 5 years rate	Impact	2018/19	1.9	**2.4**	**0**	**0**	**4**	**3**	**0.47**
Diarrhoea case fatality under 5 years (Number)		2018/19	679	**24**	**0**	**0**	**8**	**15**	**1**
Diarrhoea separation under 5 years (Number)		2018/19	36 009	**1010**	**53**	**44**	**201**	**497**	**215**
Early neonatal death in facility rate (per 1K)	Impact	2018/19	9.8	**10**	**10.6**	**6.3**	**7**	**13.1**	**9.5**
Death in facility (0-7 days) – Number		2018/19	9 431	**218**	**16**	**18**	**33**	**110**	**41**
Live birth in facility (Number)		2018/19	959 720	**21794**	**1507**	**2848**	**4715**	**8393**	**4331**
Neonatal death in facility rate (per 1K)	Impact	2018/19	12.1	**11.7**	**11.9**	**8.1**	**7.2**	**16.4**	**9.7**
Death in facility 8-18 days (Number)		2018/19	2 212	**37**	**2**	**5**	**1**	**28**	**1**
Pneumonia case fatality under 5 years rate	Impact	2018/19	1.9	**2.3**	**0**	**2.1**	**2.9**	**2.7**	**0**
Pneumonia case fatality under 5 years (Number)		2018/19	962	**24**	**0**	**1**	**5**	**18**	**0**
Pneumonia separation under 5 years (Number)		2018/19	50 212	**1045**	**77**	**48**	**172**	**675**	**73**
Severe acute malnutrition case fatality under 5 years rate	Impact	2018/19	7.1	**4.3**	**4**	**1.8**	**7.7**	**4.6**	**3**
Severe acute malnutrition case fatality under 5 years (Number)		2018/19	806	**28**	**1**	**1**	**6**	**15**	**5**
Severe acute malnutrition inpatient under 5 years (Number)		2018/19	11 280	**648**	**25**	**55**	**78**	**325**	**165**
Infant PCR test positive around 10 weeks rate	Outcome		0.74	**1.4**	**0**	**1.3**	**2.9**	**0.77**	**1.1**
Infant PCR test positive around 10 weeks (Number)			1 371	**32**	**0**	**4**	**17**	**7**	**4**

Indicator	Type of Indicator	Period	South Africa	Northern Cape	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
Infant PCR test around 10 weeks (Number)			185 318	**2254**	**98**	**320**	**579**	**907**	**350**
Immunisation under 1 year coverage	Output		81.9	**87.8**	**85.5**	**73.4**	**89.4**	**92.6**	**92.2**
Immunisation fully under 1 year new (Number)			944 650	**17877**	**1492**	**2646**	**4290**	**5779**	**3670**
Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose	Output		49.5	**55.3**	**56.3**	**61.3**	**39.8**	**58.1**	**64.5**
Infant exclusively breastfed at DTaP-IPV-Hib-HBV			477 984	**11252**	**871**	**2024**	**1960**	**3793**	**2604**
DTaP-IPV-Hib-HBV (Hezavalent) 3rd dose			966 387	**20344**	**1548**	**3303**	**4920**	**6533**	**4040**
Measles 2nd dose coverage			76.5	**86.2**	**76.9**	**84.6**	**86.1**	**89.3**	**87.2**
Measles 2nd dose (Number)			890 235	**17728**	**1362**	**3042**	**4167**	**5646**	**3511**

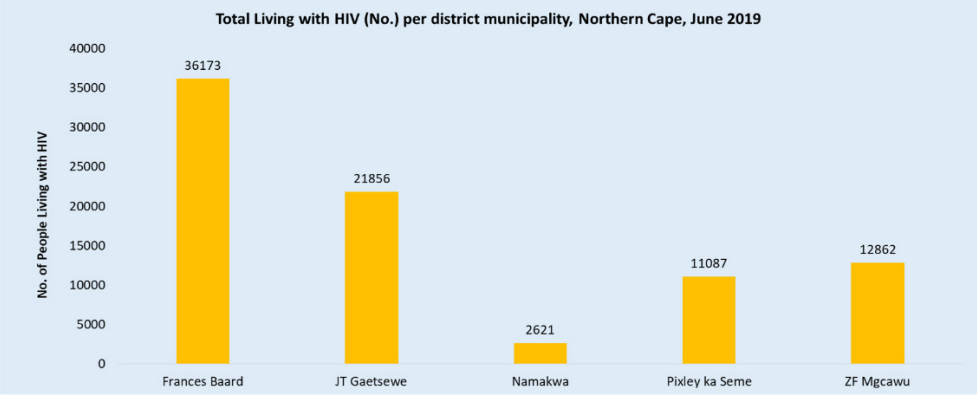
Source: webDHIS (2018/19)

8.3.4. HIV and AIDS

HIV & AIDS Burden

The number of people living with HIV in the Province is estimated to 84 599 (as on December 2019, Source: Thembisa Model), with Frances Baard contributing 43% followed by JT Gaetsewe at 26% while Namakwa had the least number of people living with HIV (see illustration below).

Figure 7: Total number of people living with HIV per district, Northern Cape, 2019



Source: Thembisa HIV Estimates

In terms of HIV positivity rate, the Province rate has been relatively stable around four percent (4%) in the past three financial years (WebDHIS, 2018/'19). However, the prevalence rate among pregnant women attending antenatal care was also stable at 17% (Source: National HIV Prevalence Survey, 2017).

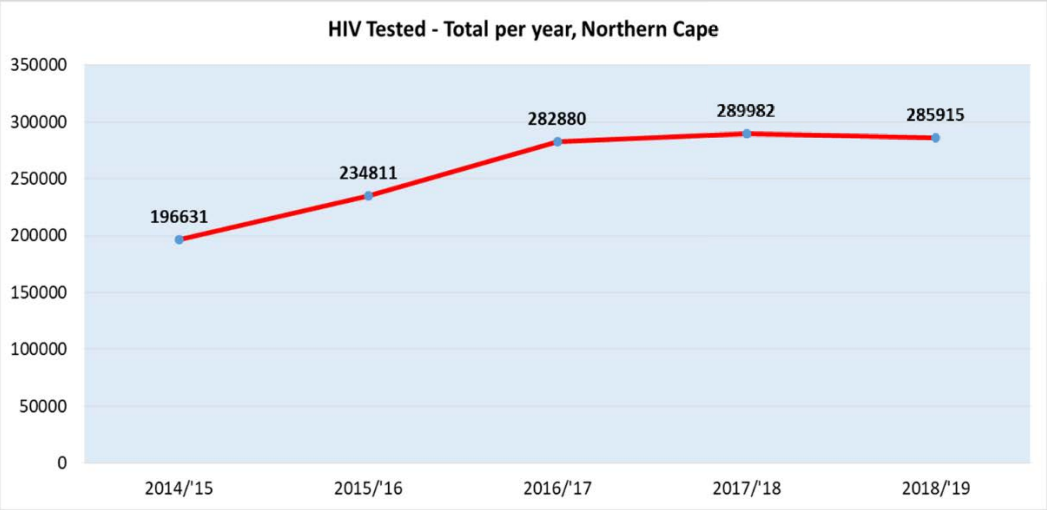
HIV & AIDS Prevention Programmes

In order to address the scourge of HIV and other sexually transmitted infections (STIs), the Directorate has key programmes with specific interventions.

HIV Testing Services (HTS)

The HIV Testing Services (HTS) has been a key intervention for both prevention and diagnosis. This programme has seen substantial improvement, with 1.3 million people tested in the past five years (i.e. 2014/'15 – 2018/'19). There's been a notable improvement, despite a slight drop in 2018/'19 due to the exiting of one of the key partners, HST, which contracted private doctors to provide HIV testing to uninsured population at no cost.

Figure 8: Number of people HIV tested per district, Northern Cape, 2014/'15 – 2018/'19 FY



Source: WebDHIS, Northern Cape Department of Health

Medical Male Circumcision

The implementation of medical male circumcision (MMC) in the Northern Cape has been largely hampered by shortages of medical officers in our public health facilities. The Province has identified 19 MMC sites, however, not all of them are fully operational because of the reason given. To address this problem, with support from National Department of Health NDoH), the Province has been working with CHAPS for the past three years. This partnership came to an end on 31st October 2019, however, the partnership is still continuing on month-to-month contract until the new tender has been concluded. This is the most important partnership with CHAPS managing to support the Province in achieving its target in 2018/'19, the since 2015/'16. In 2018/'19, CHAPS managed to contract seven (7) private doctors to provide MMC in Frances Baard and JT Gaetsewe districts. This initiative is focused on addressing shortages of clinicians in public health facilities which has negatively affected access to MMC services.

In the past five-year period (i.e. 2014 – 2018), the Province has provided voluntary medical male circumcision to 36 350 men (10 years & older). Though, there's been a notable improvement in 2018/'19, access in Namakwa remains to be very low. The MMC Programme has been embarking on demand creation but more importantly, the Programme has undertaken to introduce CircumQ for task shifting, where professional nurses will be trained to perform MMC with mentoring from experienced doctors. Training has commenced with seventeen clinicians trained in February 2020 and followed by practicals on which 171 clients were circumcised through this intervention. CircumQ is very critical for the setting in the Province as this will have positive long-term effects in improving MMC access.

Condom Distribution and Promotion

Condom distribution and promotion is the cornerstone of HIV and STI prevention generally, this also includes preventing unwanted pregnancies. In 2018/'19, the Province improved distribution of condoms, with close to 14 million male condoms distributed in the financial year. Compared to 2017/'18 financial year, the male condom distribution in 2018/'19 showed an increase of 4.9%. This improvement can be attributed to the development of district condom scale-up plans including dedication from districts to avail dedicated transport. However, there's a need to make provision of adequate transportation of condoms and creating more storage

space at sub-district level. The programme also collaborated with certain mines and NGOs for increasing access to condoms among key populations.

Antiretroviral Treatment and Care

The Treatment Programme has worked hard to strengthen implementation of Universal Test & Treat (UTT) which requires that more people being tested for HIV and those who are diagnosed with HIV are started on treatment on the same day. The Regional Training Centre continues to train more nurses on Nurse Initiated Management of Antiretroviral Treatment (NIMART) and all health facilities have NIMART trained nurses to ensure that UTT is implemented successfully. This is coupled with provision of clinical mentoring and support to NIMART trained nurses by district clinical mentors and doctors. Through these interventions, the Province has managed to increase the number of clients on antiretroviral treatment (ART) from 57 429 (2017/'18) to 59 347 (2018/'19), which represents an increase of 3.3%.

Despite these positive efforts, ART continues to be negatively hampered by non-adherence to treatment which result in high levels of lost to follow-up rate. The Programme has established Adherence Clubs at facility level in order to address poor treatment adherence.

Community Outreach Services (COS)

In 2018, the National Department of Health reached an agreement with labour unions on the Community Outreach Services Resolution of 2018. This Resolution required that all Community Health Workers (CHWs) will no longer be appointed by NGOs but will enter into a contract with Department of Health on an annual basis to provide community health care services. The Province implemented the Resolution in November 2018, where 1 965 CHWs signed a contract with the Department of Health and also monthly stipends increasing from R2500 to R3500. Stipends for CHWs is currently being paid through Persal and job descriptions of CHWs were also revised to ensure good returns in terms of services provided. Supervision of CHWs is handled by Facility Managers since the Province do not have appropriate Outreach Team Leaders (OTL) for Ward Based Teams.

90-90-90 HIV Cascades

The country has adopted UNAIDS 90-90-90 targets for both HIV and TB programmes with the timeline of achieving these targets by December 2020. All 9 provinces in the country have developed the Accelerated Surge Plans for Achieving 90-90-90 aimed at overcoming existing bottlenecks and fast tracking progress toward the 90-90-90 HIV and TB targets.

Northern Cape is currently at 90-87-83 in terms of performance against 90-90-90 across its total population. Results for each of the sub-populations vary, with adult females at 94-91-92, adult males at 91-76-77, and children at 79-121-52. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care.

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

To achieve 90-90-90 targets, the province must increase the number of adult men on ART by 3 728, the number of adult women on ART by 2 298 by December 2020; and the target for number of children on ART has been exceeded. Across the province, Namakwa and Pixley ka Seme are the closest to attaining 90-90-90 based on preliminary data collected. All districts are performing poorly on viral load completion and this is also resulting in poor viral load suppression

8.3.5. TUBERCULOSIS SITUATIONAL ANALYSIS

The Provincial TB annual incidence rate (per 100 000) has increased slightly in 2018 (687 per 100 000) compared to 2017 (525 per 100 000), illustration shown in Table below. Despite this slight increase, countrywide, the number of TB cases recorded have been shown to be under-estimated. The same goes for the Northern Cape, where it is estimated that around 4000 TB cases are missed on an annual basis.

In addressing this problem of missed cases, the National Department of Health has come with the Finding TB Missing Cases Initiative to ensure all exposed people are screened for TB, diagnosed and put into treatment. The Finding TB Missing Cases Initiative is linked to South Africa's End TB Strategy (2030). All these strategies are also aligned to the 90-90-90 Strategy with specific targets that should be realized by end of December 2020.

Table 4: TB incidence rate (per 100 000), Northern Cape, 2016 - 2018

District	2016		2017		2018	
	New TB	Incidence Rate (per 100 000 pop)	New TB	Incidence Rate (per 100 000 pop)	New TB	Incidence Rate (per 100 000 pop)
Frances Baard	1811	467	1549	405	1966	605.3
JTG	1556	642	1186	528	1449	819.1
Namakwa	700	606	504	435	587	542.9
Pixley ka Seme	1604	820	1524	818	1701	912.8
Z.F. Mgcawu	1875	742	1251	528	1398	590.4
NC	7546	632	6014	525	7101	687.4

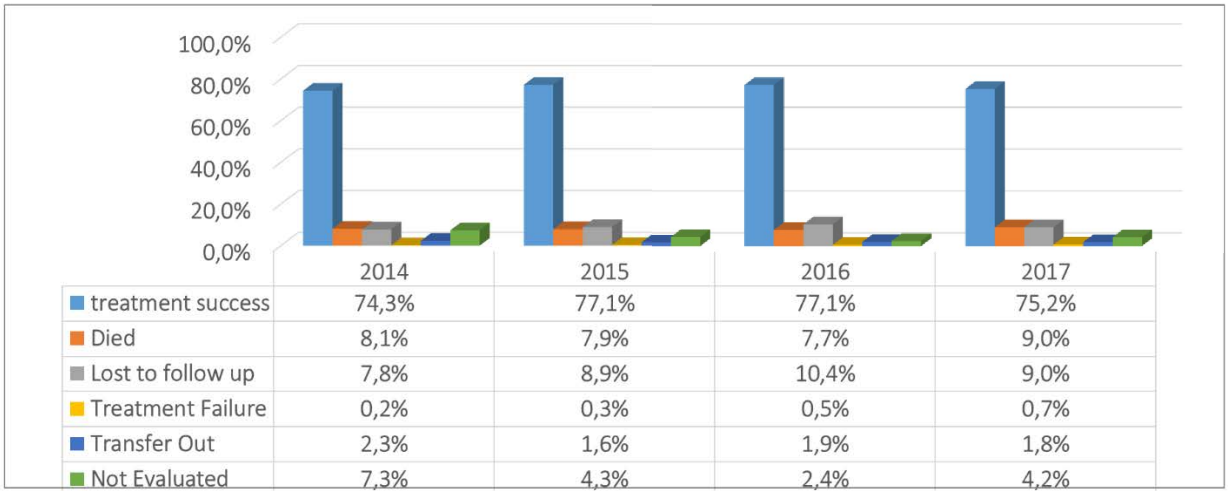
Source: Electronic TB Register (ETR), Northern Cape, 2019

Treatment Outcomes – Drug Susceptible TB

Between 2015 and 2016, the TB treatment success rate among patients with drug – susceptible TB (DS-TB) remain stable at 77% before dropping slightly in 2017 to 75%. It has been difficult for the Province to breach the 80% annual target of treatment success. The main factors associated with this poor performance are poor treatment adherence, higher death rates and poor socio-economic conditions such as high unemployment rate, poverty, lack of food security, etc. Both lost to follow-up and death rates were reported to be 9% in 2017, showing a marginal decrease against the annual target of 7.5% for both indicators.

TB disease remain to be the leading underlying cause of death for the Province as reported by Statistics South Africa

Figure 9: TB treatment outcomes (DS-TB, Northern Cape, 2016 - 2018



	2014	2015	2016	2017
treatment success	74,3%	77,1%	77,1%	75,2%
Died	8,1%	7,9%	7,7%	9,0%
Lost to follow up	7,8%	8,9%	10,4%	9,0%
Treatment Failure	0,2%	0,3%	0,5%	0,7%
Transfer Out	2,3%	1,6%	1,9%	1,8%
Not Evaluated	7,3%	4,3%	2,4%	4,2%

Source: Electronic TB Register (ETR), Northern Cape, 2019

Drug – Resistant TB

The World Health Organization introduced the use of new and repurposed drugs in order to improve treatment outcomes and patient management. These drugs are, Bedaquiline, Delaminid, Linezolid and Short Regimen for the management of drug-resistant TB (DR-TB). This intervention has greatly contributed to improved treatment outcomes, with treatment success rate among DR-TB patients improving from 42% (2016) to 44% in 2018. The total number of DR-TB patients increased substantially from 225 in 2017 to 352 in 2018. Apart from the benefits on health outcomes, these interventions have resulted in price reduction, namely, Bedaquiline unit price decreased from R10 000 to R5 400, that resulted in a massive savings of R2,2 million for the Provinc

Table 5: TB

Indicator		Type of Indicator	Perio d	South Africa	Northern Cap e	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
TB DS Death rate		outcome	2017	6.5	7.8	6.9	7.8	7.6	8.3	7.8
DS TB patients who died (Number)		Output/proceSs	2017	16 133	680	53	149	133	197	149
All DS TB patients in cohort (Number)		Output /process	2018	225 553	8732	768	1913	1750	2379	1922
TB DS client lost to follow up rate		outcome	2017	8	9.8	7.4	6.2	8	11.8	11.7
DS TB patients who were lost to follow up (Number)		Output /process	2017	19 761	849	56	118	140	280	224
TB DS treatment success rate		Outcome	2017	76.3	74	75.7	75.0	73.0	72.6	77.6
DS TB patients who completed treatment or were cured		outcome	2017	188 352	6462	581	1434	1277	1727	1491

Indicator		Type of Indicator	Perio	South Africa	Northern Cape	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
TB MDR death rate	Long regimen	Impact	2016	20.8	16.4	--	--	--	--	--
	Short regimen	Impact	2017	17.3	20.3	--	--	--	--	--
TB MDR client loss to follow up rate	Long regimen	Outcome	2016	19.6	33.8	--	--	--	--	--
	Short regimen	Outcome	2017	14.6	11	--	--	--	--	--
TB MDR treatment success rate	Long regimen	Outcome	2017	53.9	42.0	--	--	--	--	--
	Short regimen	Outcome	2017	49.6	61.9	--	--	--	--	--
TB XDR clientdeath rate	Long regimen	Impact	2016	21.3	39.7	--	--	--	--	--
	Short regimen	Impact	2017	20.7						
TB XDR client lost to follow up rate	Long regimen	Outcome	2016	11.3	11					
	Short regimen	Outcome	2017	7.7	-					
TB XDR client success rate	Long regimen	Outcome	2016	58.1	38.0					
	Short regimen	Outcome	2017	31.3	-					
TB symptoms 5 years and older screened in facility rate		Output /process	2018	83.7	62.8	69.5	60.9	52.5	50.0	88.0
Screen for TB symptoms 5 years and older		Output /process	2018	82 929 115	2514 931	387 152	473 736	404 949	555 988	692 106
PHC headcount 5 years and older (Number)		Output /process	2018 /19	99 082 287	2266943	323534	441377	424000	639131	438901
TB symptom child under 5 years screened in facility rate		Output/process	2018 /19	81.7	53.5	73.7	51.6	31.9	49.1	82.0
Screen for TB symptoms under 5 years		Output/process	2018 /19	16 547 063	424317	55279	69779	66361	111142	121756
PHC headcount under 5 years (Number)		Output/process	2018 /19	20 26 739	792811	75055	135122	208011	226220	148403
TB/HIV co-infected client on ART rate (ETR.net)		Output/process	2017	89.1	96.3%	74.4%	97.2%	98.3%	98.9%	95.1%
HIV positive TB cases who are on ART (Number)		Output/process	2018	108 481	3713	199	684	923	1178	729

Indicator		Type of Indicator	Perio	South Africa	Northern Cape	Namakwa District	Pixley Ka Seme District	John Taolo Gaetsewe District	Francis Baard District	Zwelentlanga Fatman Mgcawu District
HIV positive TB cases (Number)		Output/process	2018	125 222	3778	218	690	935	1189	746

*NB: implementation of Short regimen using Bedaquiline was implemented during 2017, hence we have short regimen outcomes dating back to 2017.

*The MDR TB outcomes reported in the above are disaggregated by Short(SR) and/or Long Regimen(LR) , however the figure is not same as the AR because the outcomes are aggregated (both SR +LR) differ from the AR 2018/19 thus gives a slightly variance of -1%.

*MDR TB outcomes reported on the EDRweb system are limited to province ie. does not include district level.

9. MTEF BUDGETS

OVERVIEW OF 2020/2021 BUDGET AND MTEF ESTIMATES

MTEF BASELINE PRELIMINARY FOR 2019/20-2021/22

Financial Year 2020/2021 - R 5 593

Financial Year 2021/2022 – R 5 968

Financial Year 2022/2023 – R6 254

Key Assumptions

The following broad key assumptions were made while preparing the budget of the Department of Health for the 2020 MTEF:

- The assumption for the general CPIX used for the current budget is based on the inflationary projections estimated at 4.8 per cent for 2020/21, 4.8 per cent for 2021/22 and 4.7 per cent for 2022/23 MTEF years;
- The assumptions for the provision of Improvement on Conditions of Service (ICS) in the baseline for the 2020 MTEF is linked to the estimated inflationary projections for the period;
- Additional funds were allocated during the 2018 MTEF as a baseline adjustment to ease the budget pressure on the historical shortfall of personnel costs not sufficiently budgeted and cover the improvement of conditions of service and further provide for the pressures on goods and services;
- As part of the revitalisation and capacitation of the health sector a new grant, namely Statutory Human Resource and Training Development Grant has been introduced in order to directly deal with appointments of critical staff in health facilities with an amount of R21.431 million and R104.034 previously known as Health Professionals Training Development Grant was incorporated to the said grant;
- The Malaria, TB and Community Outreach Services components are funded within the HIV, TB, HPV, Malaria and Community Outreach Grant in order to harmonise and standardise the work of ward-based primary health care outreach teams, optimise TB screening and provide efficient contact tracing of index cases as well as find TB cases and place them on appropriate treatment with an allocation of R33.358 million for TB and R90.661 million for Community Outreach Services.

An amount of R26.405 million is included in the financial year, 2021/22 cater for the appointment of returning Medical Officers returning from Cuban training

Aligning departmental budgets to achieve government's prescribed outcomes

In line with the National Development Plan (NDP) 2030 and the Medium Term Strategic Framework (MTSF) 2019-2024, the department will flag key achievements to support the realisation of priority 3: Education, Skills and Health in the MTSF. The health action plan will be estimated on annual basis using evidence-based Annual Performance Planning and priority areas resources allocation methods.

Social determinants of health

Approximately 30% of the population are unemployed and 10% of households live with an annual income below R4,800 or less than R400 per month. All this adds to the deprivation index of the district.

The income status impacts on revenue collection at hospital services as patients are not being able to pay for services rendered.

Epidemiological (disease) profile of the District

In the district the majority of deaths amongst people from 25 - 65+ are caused by Non-communicable diseases with HIV & TB the highest amongst the 15 – 24 years age group.
Due to the absence of private facilities not only the uninsured population is dependent on the health care facilities but also the insured population. These facilities serve a population of 193 195 people.
Service packages implemented in these facilities sometimes also cover elements in the next level of care due to the vastness and challenges with referral paths. This however assists to bring services closer to the communities.

Universal Health Coverage (NHI Initiatives)

The department is committed to implementing the plan of government in improving the provisioning of health care in Primary Health Care facilities through Operation Phakisa in the health sector, namely the ideal clinic initiative. This came with interventions such as Health Patient Registration System which enables the department of health to register the particulars of a patient electronically and have such records available at each health service point across the system. To date, all facilities are implementing the Health Patient Registration System and 37 182 patients have registered on the system and on the other hand, the intervention of Central Chronic Medication Distribution and Dispensing has seen 3 365 Patients receiving their medicine at a Private Pick up points.

This has led to improved availability of chronic medicine to stable patients, decongestion of facilities and improved patient satisfaction. The department has introduced the Central Chronic Medication Distribution and Dispensing (CCMDD), and its significance is to decant and reduce queues at health facilities. Patients receiving chronic medication are able to receive their medication at alternative delivery sites through a partnership with the private sector.

WBPCHOT

WBPCHOT strategy is a National model that was implemented in SA 2011 with the aim of rendering Health care services at the door step of our communities and zooming into HH registering and profiling HH information to determine a type of service needed
This programme has employed 330 CHW's across the District in a bid to fight the new HIV infections, retaining in care those already on treatment and conduct structured screenings in communities Including HTS services and Health campaigns.
This cadres of community based Health workers are strategically placed at all Health Care facilities and other small settlements with satellite/mobile points to support all clients on medication.

Towards the surge of 90-90-90 targets this programme is mostly looking at the followings:

90% of people on treatment with suppressed viral loads (RIC adherent) and this would be reached through establishment of Adherence clubs, CCMDD run by a trained lay persons with the support of clinicians
90% of vulnerable groups screened (this would be done through community based screenings by CHW's)
90% treatment success (through direct dotting of TB patients by CHW's and implementing I – ACT programme which is designed to support newly diagnosed clients in facilities and ensure that they become stable on their treatment.

Establishment of Governance Structures

With the decentralisation of Mental Health services, it has become necessary to establish district based mental health boards. These structures will provide the leverage to participate in the governance of the mental health sector and promote the observance of the human rights of the most vulnerable in our society. It also gives effect to the statutory intent of the National Health Act to create a partnership for the health of our people between the state and society.
We implore the man and women with the requisite ability and commitment to put their skills and expertise at the service of the people of our province through the hospital and mental health boards.

Training and appointment of Health Professionals

In July 2018, Twenty-one (21) Northern Cape RSA-Cuban trained final year medical students will return to South Africa to undertake the last phase of their medical training. Plans are underway to receive and integrate these students in Kimberley Hospital through the departmental collaboration with the University of Free State and Stellenbosch University.

With this cohort of medical personnel, plans are afoot to strengthen the decentralisation of medical services where from 2019 onwards, the district hospitals will be utilised as training platforms for the medical students and some allied programmes such as physiotherapy and occupational therapy. This is in line with the National Development Plan that emphasises the provision of primary health care and provides that health care should be focussed on a more decentralised, area-based, people-centred approach of the primary health care system.

Improved quality of health care

This period has been marked by so many challenges especially those that are related to Human Resources and fleet, the department lost quite a few Emergency Care Personnel to accidents and others leaving the service. Procurement challenges have contributed to our program being unable to boost our operational status with regards to ambulances. Despite these challenges the program is achieving two thirds of its targets as stipulated in the Annual performance plan. We have seen a gradual improvement in the response time on priority call in the Urban areas across the province, however this is still not good enough as we would love to see 100% achievement on all our targets.

Our college has since been producing impressive results. Since the inception of the college over 100 employees have been trained to the Intermediate Life Support Qualified Emergency Care Practitioners. We have also seen 36 students being upskilled from Basic Ambulance Assistance to intermediate Life Support qualification. This is a direction towards improving quality of service to the people of the Northern Cape.

REVIEW OF THE CURRENT FINANCIAL YEAR (2019/20)

The department has filled clinical funded positions in all facilities in various districts. More health professionals were also appointed for the operationalisation of both new Mental Health Hospital and De Aar Hospital. There is a need to look into all facilities and prioritise the appointment of health professionals across the province

Pixley ka Seme District has 400 CHW's placed through the primary health sector. Officials are trained in Phase 1 and Phase 2 which enabled them to do screening for Hypertension, Diabetes, Pregnancy, TB and Mental Health illnesses. The services rendered by CHW's are integrated with the PHC services and overseen by a Professional Nurse from the clinic to which they are allocated.

Primary Health Care Re-engineering has always been the cornerstone of rendering quality health care services to our people. The department has implemented Phase 1 of the National Health Insurance at Pixley Ka Seme as a pilot districts. The phase 2 of the project is underway and the department is ready to implement it and ensure that all initiatives like Ideal Clinics and Hospitals are operational.

Furthermore, the implementation of Health Patient Registration and Central Chronic Medication Distribution and Dispensing systems are implemented in all facilities to decongest the Regional and Tertiary Hospitals. To date, all facilities are implementing the Health Patient Registration System and 37 182 patients have registered on the system and on the other hand, the intervention of Central Chronic Medication Distribution and Dispensing has seen 3 365 Patients receiving their medicine at a Private Pick up points.

The Cuban programme is nearing completion of which students are expected to start returning in 2021/22 MTEF of which plans to absorb them are beginning in the 2020/21 financial year. The new De Aar hospital only operates in the old hospital's human capacity and funding has not been sourced to incrementally expand the services package.

The Emergency Medical Services programme is having capacity challenges coupled with old vehicles been used or exceeded 120000 in terms of mileage. The department managed to put systems in place, 53 new vehicles were procured of which 38 were ordinary ambulances as was promised in the previous financial year. This number has improved our operational status to just about 100 vehicles in the province. Inter-facility transfers continue to be on the rise due to low levels of skills capacity and low level of service packages available in certain facilities.

Procurement challenges have contributed to our program being unable to boost our operational status with regards to ambulances. Emergency Medical Services program has achieved two thirds of its targets as stipulated in the Annual performance plan.

Our college has since been producing impressive results. Since the inception of the college over 100 employees have been trained to the Intermediate Life Support Qualified Emergency Care Practitioners. We have also seen 36 students being upskilled from Basic Ambulance Assistance to intermediate Life Support qualification. This is a direction towards improving quality of service to the people of the Northern Cape.

The Department spent 100 percent of its maintenance budget on maintenance of facilities and firefighting equipment as planned.

OUTLOOK FOR THE COMING FINANCIAL YEAR (2020/21)

The department has planned to perform the following activities:

- Improving Health Management and Leadership
- Increase the workforce by filling critical clinical funded posts in the health facilities.
- Improve access to community based primary care services through the Ward Based Primary Health Care Outreach teams (WBPHCOTs)
- Manage TB and improve quality of HIV/Aids related services including access to HIV counseling and testing, Antiretroviral Treatment (ART) to cater for new infections and prevention of mother to child transmission.
- Advocacy and implementation of the second phase of National Health Insurance
- Reduction of Maternal and Child Mortality
- Ensure the implementation of the HPRS and CCMDD in all facilities
- Procurement of Ambulances and appointment of personnel to ensure the two-person crew

- Early detection and treatment of Non-Communicable Diseases
- Revitalisation and refurbishment of health facilities to respond to NHI initiatives
- Improve the implementation of School Health Programme
- Improve advocacy through community Dialogues and Imbizos

Reprioritisation

The budget of the department was reprioritized to make provision for the permanent recruitment of Community Health Care Workers under the community outreach services component within the HIV, TB, HPV, Malaria and Community Outreach Services Grant. The budget of infrastructure delivery caters mainly for the rehabilitation and maintenance of existing facilities within the Health Facility Revitalisation Grant.

An additional amount of R6 million per MTEF year allocated under the Statutory Human Resource and Training development grant for the appointment of critical clinical staff at the new Kimberley Mental Health Hospital.

Procurement

The department will procure and replace medical equipment for health facilities having old once as well as take part in the RT contract for maintenance and repairs in that regard. There are no major or bulk procurement is envisaged other than the normal replacement of emergency vehicles and their conversion thereof. The completion of the Nurses College is expected to be in the current 2020/21 MTEF year.

Programme summary

Summary of payments and estimates by programme.

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2016/17	2017/18	2018/19		2019/20		2020/21	2021/22	2022/23
1. Administration	219 343	230 612	222 316	219 255	221 283	271 053	231 354	244 079	255 802
2. District Health Services	1 915 040	1 989 019	2 186 459	2 406 496	2 416 470	2 420 648	2 594 145	2 777 168	2 910 098
3. Emergency Medical Services	291 112	302 654	330 835	362 085	372 085	385 820	386 634	407 900	426 610
4. Provincial Hospital Services	390 460	338 932	386 212	408 835	417 026	426 148	457 678	482 576	505 738
5. Central Hospital Services	945 261	953 819	1 080 233	1 147 240	1 147 583	1 147 583	1 232 998	1 294 887	1 357 041
6. Health Sciences And Training	123 985	98 734	129 235	140 029	142 373	159 735	146 237	180 763	189 439
7. Health Care Support Services	108 599	91 782	122 511	123 415	123 415	217 867	131 751	139 000	145 670
8. Health Facilities Management	375 338	561 800	420 065	389 956	389 956	415 549	412 562	442 398	463 632
Total payments and estimates	**4 369 138**	**4 567 352**	**4 877 866**	**5 197 311**	**5 230 191**	**5 444 403**	**5 593 359**	**5 968 771**	**6 254 030**

The department's budget baseline for 2020/21 shows a significant growth of 7 per cent from the adjusted budget of 2019/20 and growth with 6.7 per cent in 2021/22 and 4.8 per cent in 2022/23. The positive growth over the 2020 MTEF is above the projected CPI and this is attributable to the additional funds allocated as baseline adjustment to ease the budget pressure on the historical shortfall of improvement of conditions of service and contractual obligations.

The key objectives of the department to be achieved include among others: the acceleration of ideal clinic initiative; re-engineering of primary health care; rolling out of the CCMDD in all districts, National Health Insurance (NHI), emergency medical services, medical equipment, the prevention and successful management of HIV/AIDS and TB; maintenance of infrastructure and rendering of tertiary health services.

R thousand	Outcome 2016/17	2017/18	2018/19	Main appropriation	Adjusted appropriation 2019/20	Revised estimate	Medium-term estimates 2020/21	2021/22	2022/23
Current payments	**3 806 289**	**3 934 088**	**4 465 052**	**4 834 604**	**4 902 484**	**5 110 034**	**5 268 311**	**5 626 698**	**5 895 541**
Compensation of employees	2 322 039	2 572 131	2 863 924	3 136 829	3 156 709	3 156 709	3 375 329	3 598 068	3 770 782
Goods and services	1 479 782	1 358 050	1 598 535	1 697 775	1 745 775	1 949 420	1 892 982	2 028 630	2 124 759
Interest and rent on land	4 468	3 907	2 593	–	–	3 905	–	–	–
Transfers and subsidies to:	**167 559**	**165 677**	**52 617**	**42 125**	**42 125**	**58 025**	**38 437**	**40 629**	**42 577**
Provinces and municipalities	1 532	651	3 355	13 290	6 290	4 167	14 033	14 804	15 515
Departmental agencies and accounts	6	–	–	–	–	-145	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	4	–	–	–
Non-profit institutions	106 738	118 423	929	4 344	–	1 083	–	–	–
Households	59 283	46 603	48 333	24 491	35 835	52 916	24 404	25 825	27 062
Payments for capital assets	**395 290**	**467 587**	**360 197**	**320 582**	**285 582**	**276 344**	**286 611**	**301 444**	**315 912**
Buildings and other fixed structures	318 208	397 420	243 014	155 434	155 434	169 512	111 597	116 734	122 337
Machinery and equipment	77 082	69 881	116 837	165 148	130 148	106 832	175 014	184 710	193 575
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	286	346	–	–	–	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**4 369 138**	**4 567 352**	**4 877 866**	**5 197 311**	**5 230 191**	**5 444 403**	**5 593 359**	**5 968 771**	**6 254 030**

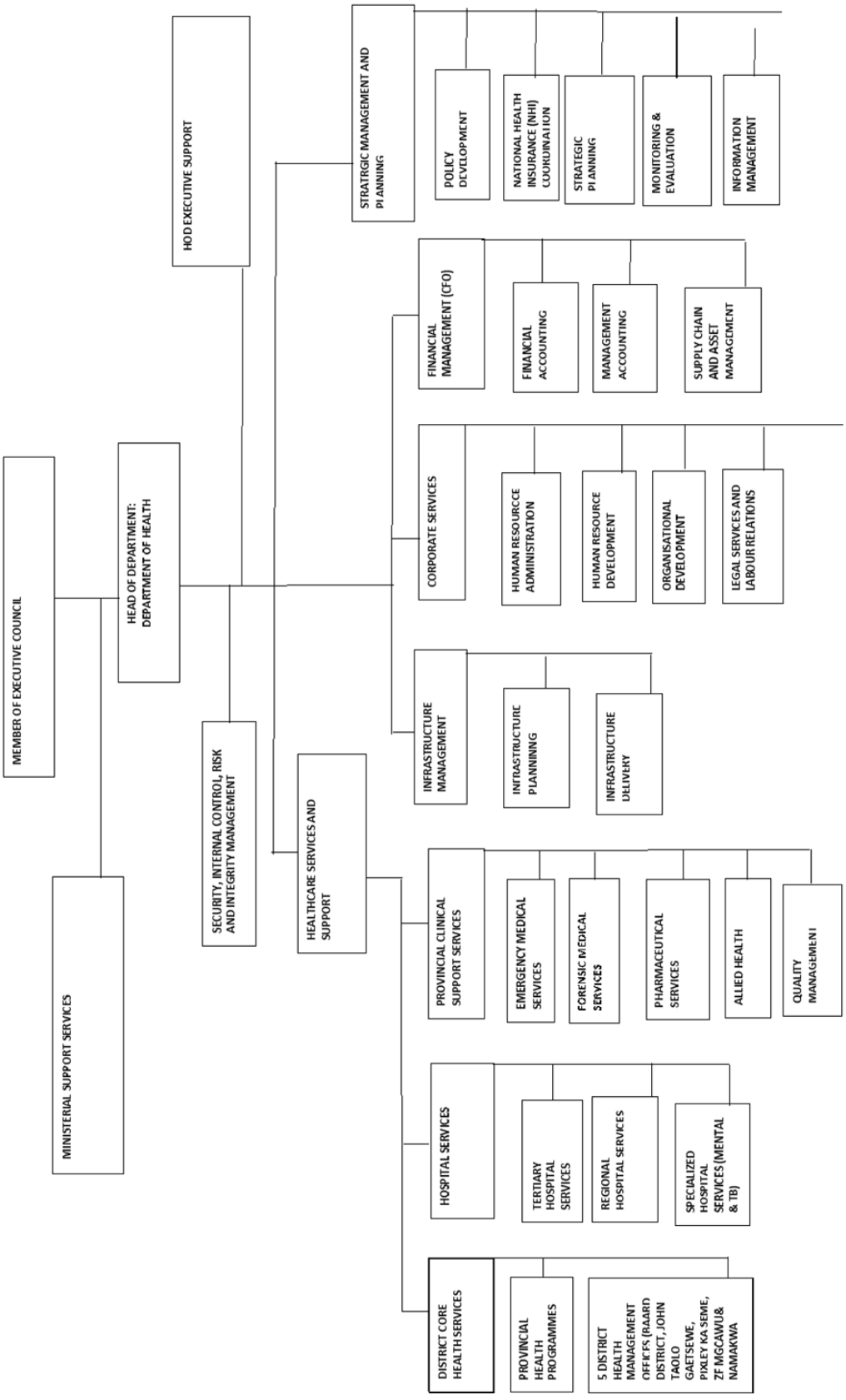
Compensation of employees grows by 6.9 per cent when compared with the adjusted budget of R3.157 billion in 2019/20. This growth makes provision for the carry through costs on the permanent recruitment of Community Health Care Workers within the Comprehensive HIV/Aids component of grant. Personnel costs remains the main cost driver of the department, hence constitutes 60 per cent of the budget allocated for 2020/21 financial year. The compensation of employee's budget shows an increase by 7.1 per cent and 4.7 per cent in 2021/22 and 2022/23 respectively.

The goods and services budget show a growth of 8 per cent in 2020/21 when compared to the R1.746 billion of adjusted budget of 2019/20. This is attributable to baseline adjustment to ease the budget pressure on goods and services. On the outer years of the MTEF the budget shows a real growth of 7.1 per cent in 2021/22 and 4.7 per cent in 2022/23 respectively.

Transfers and subsidies show a growth of 8 per cent when compared to the adjusted budget of 2019/20. The budget for transfers shows the growth of 5 per cent and 4.8 per cent for 2021/22 and 2022/23 MTEF year respectively.

The budget for payments of capital assets shows a growth of 0.3 per cent compared to the R285.582 million of the adjusted budget of 2019/20. This significant reduction is mainly due to reprioritisation within the Health Facility Revitalisation Grant to scale down on the construction of new facilities and prioritising maintenance and repairs of existing health facilities.

10. INTERNAL ENVIRONMENTAL ANALYSIS: DRAFT ORGANISATIONAL STRUCTURE



The implementation of the National Development Plan 2030, the Medium Strategic Goal and the implementation of the National Health Insurance are key factors that influenced the review of the Organizational structure. Department has been operating with an obsolete organizational structure, that was not assisting the full implementation of the strategic plan. A number of challenges has been observed, were we have experienced instability in many management positions. Key position for decision making was filled through acting that also took a long time in having the posts filled.

An Organizational Capacity Assessment was done under the leadership of the DPSA and the Office of the Premier (Efficiency Services), the outcomes of the assessment revealed key findings that impacted on service delivery. With the review of the organizational structure all the key findings have been taken into consideration in order to improve the departments performance. A lot of attention was focused on the top structure, as were key decision are to be taken. The National Department of Health developed a generic top structure to serve as a guide to provincial Health departments. This generic structure focusses on the core business of the department and mostly given consideration to the Service Delivery Model (SDM) the department is utilizing to render services to the broader community.

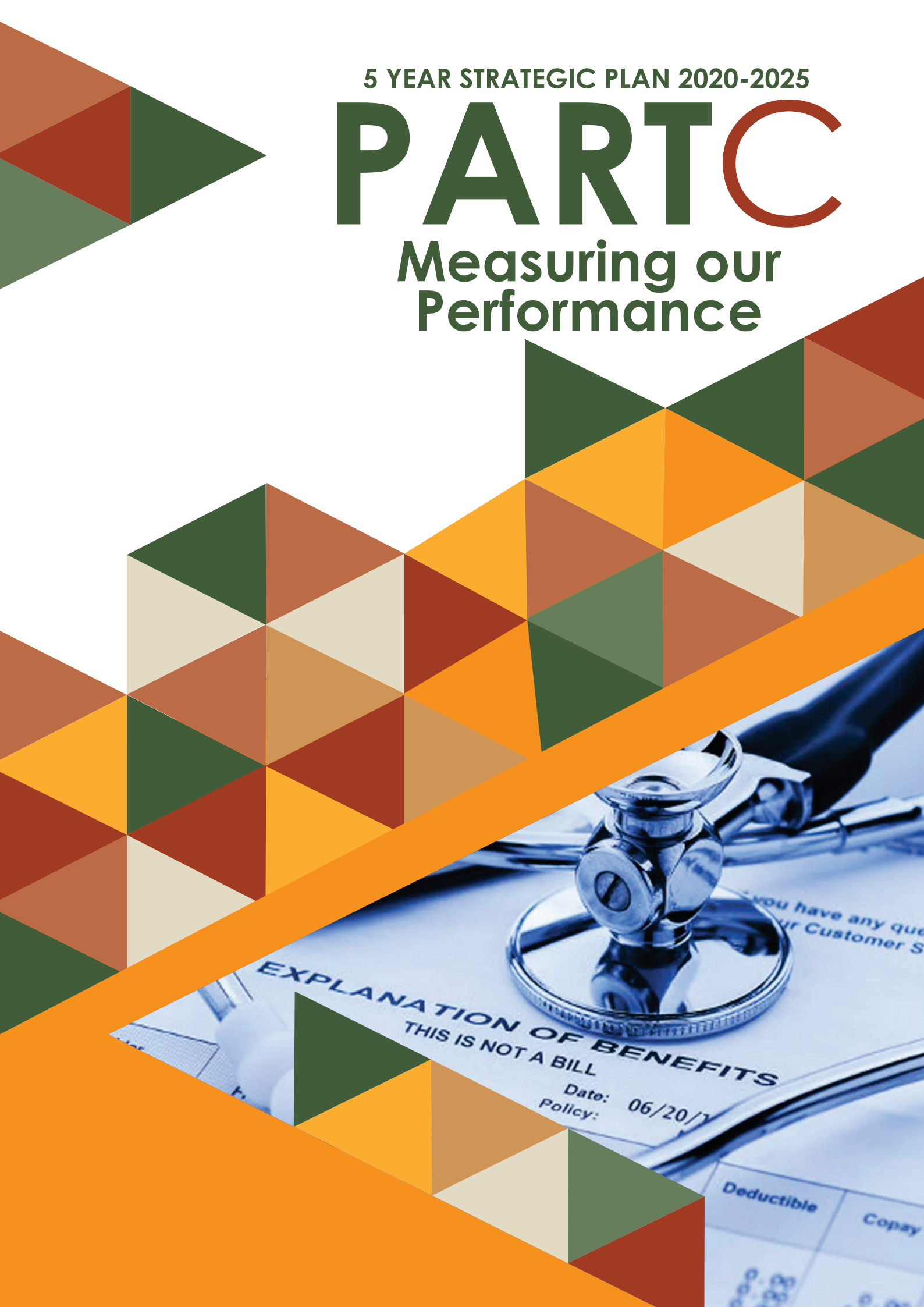
The model focusses on the hierarchy of services, giving attention to the element of strategic leadership within the department. The propose structure allows for the Core business to be directed from executive level, where we see District Health Services as the service delivery vehicle, tertiary and specialized hospitals and Health Programmes are put at a strategic level. This will improve decision making and better advice the Accounting Officer. Not under-looking the role of line functions that are key as support to the core. Having this proposed structure approved will have a direct impact on departmental performance. The span of control of control for Executive managers have been standardized, in order for them to focus on strategic matters and be able to keep control of operations at a lower level. Middle management given responsibility to oversee operations and unit and senior managers tasked with decision making responsibilities.

In short, this proposed structure focus on decision making, accountability and responsibility.

5 YEAR STRATEGIC PLAN 2020-2025

PART C

Measuring our Performance



PART C: MEASURING OUR PERFORMANCE

11. INSTITUTIONAL PROGRAMME PERFORMANCE INFORMATION

MEASURING IMPACT

MTSF Priority 3: Education, Skills and Health	
Impact statement A	**Life expectancy of the Northern Cape improved to 66.6 years by 2024, and 70 years by 2030**
Impact statement B	**Universal Health Coverage for all South Africans progressively achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030**

MEASURING OUR OUTCOME

MTSF INTERVENTION	**OUTCOME**	**OUTCOME INDICATOR**	**BUDGET PROGRAMME**	**DATA SOURCE**	**PROVINCIAL**	
					BASELINE 2018/19	**FIVE YEAR TARGET (2020/2025)**
Develop a comprehensive policy and legislative framework to mitigate the risks related to medical litigation	Management of Medico-legal cases in the health system strengthened	Contingent liability of current medico-legal cases	1	Medico-legal case management system	R1.6 billion	R320 million
Improve financial management	Unqualified audit opinion achieved	Audit opinion of Provincial DoH	1	Auditor General Report and Annual Reports	Qualified audit opinion	Unqualified audit opinion
Establish provincial nursing colleges with satellite campuses in all 9 provinces	Staff equitably distributed and have right skills and attitudes	Number of public Nursing colleges accredited and registered to offer quality basic and specialist nursing programmes	6	Accreditation certificate	1	3
Develop and implement a comprehensive HRH strategy 2030 and a HRH plan 2020/21-2024/25 to address		HRH Plan for 2020/21 – 2024/25 Developed	1	Signed off Human Resource Plan	1	HRH Plan for 2020/21 – 2024/25 Developed

MTSF INTERVENTION	OUTCOME	OUTCOME INDICATOR	BUDGET PROGRAMME	DATA SOURCE	PROVINCIAL	
					BASELINE 2018/19	FIVE YEAR TARGET (2020/2025)
the human resources requirements, including filling critical vacant posts						
Enabling legal framework created for the implementation of NHI Bill	Package of services available to the population is expanded on the basis of cost-effectiveness and equity	UHC service Index [5+]	2	South African Health Review	-	60%
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for NHI; Improved quality of primary healthcare services through expansion of the Ideal Clinic Programme	Robust and effective health information systems to automate business processes and improve evidence based decision making	Percentage of health facilities electronically recording clinical codes for their patients visits	1	-	-	50%
	Quality and safety of care improved	Percentage of public health facilities certified by OHSC	1	Ideal Health Facility software	-	100%
		Ideal Clinic Status Obtained rate	2	Ideal Health Facility software	63%	90%
		Patient experience of care satisfaction	2,4,5	Patient surveys	41.1%	80%
	Management of patient safety incidents improved to reduce new medicolegal cases	Patient Safety Incident (PSI) case closure rate	2,4,5	PSI Software	58% (11/19)	80%
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and	Leadership and governance in the health sector enhanced to improve quality of care	Number of Districts with Quality Improvement; monitoring and Response Forums formalized and convened quarterly	2	Terms of Reference of Monitoring and Response Forums	5	5

MTSF INTERVENTION	OUTCOME	OUTCOME INDICATOR	BUDGET PROGRAMME	DATA SOURCE	PROVINCIAL	
					BASELINE 2018/19	FIVE YEAR TARGET (2020/2025)
accreditation for NHI;		Percentage of PHC facilities with functional Clinic committees	2	Attendance registers of meetings of clinic committees	50%	99%
		Percentage of Hospitals with functional hospital boards	2,4,5	Attendance registers of meetings of hospital boards	45%	100%
Improve access to maternal health services; Improve the Integrated Management of Childhood Diseases services Protect children against vaccine preventable diseases	Maternal, Neonatal, Infant and Child Mortality reduced	Maternal Mortality in facility Ratio	2,4,5	DHIS	71/100 000 live births	120/100 000 live births
		Neonatal death in facility rate	2	DHIS	11.7/1000 live births	14/1000 live births
		Death in facility under 5 years rate	2,4,5	DHIS	3.6/1000	4.7/1000
	Stunting among children reduced	Children <5 who are stunted	2	SADHS	28.7%	27%
Provide prompt treatment of HIV and other sexually transmitted infections	HIV incidence among youth reduced	HIV positive 15-24 years (excl ANC))	2	Survey (Health Sciences Research Council)	4.4%	3.9%
	90:90:90 targets for HIV AIDS achieved by 2020 and 95:95:95 targets by 2024/25 Reduce HIV & AIDS related mortality by 25% by 2025	ART client remain on ART at end of month	2	Tier.net, WebDHIS	59 347	86 478
		AIDS related deaths as a proportion of total population	2	Thembisa HIV Estimates Model, Statistics South Africa, Causes of Mortality Report	0.07%	0.05%
Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health	Significant progress made towards ending TB by 2035 through improving prevention and treatment strategies Reduce TB related related mortality by 25% by 2025	All DS-TB treatment success rate	2	Tier.net, WebDHIS	74%	90%
		TB related deaths as a proportion of total population	2	Thembisa HIV Estimates Model, Statistics South Africa	0.08%	0.06%
		All DS-TB client death rate	2	DHIS, Tier.net	7,8%	6%

MTSF INTERVENTION	OUTCOME	OUTCOME INDICATOR	BUDGET PROGRAMME	DATA SOURCE	PROVINCIAL	
					BASELINE 2018/19	FIVE YEAR TARGET (2020/2025)
	Malaria eliminated by 2023	Malaria case fatality rate	2	DHIS	0%	0%
	Hypertension and diabetes prevalence managed	Hypertension client treatment new 18-44 years	2	DHIS	-	175 948
		Diabetes client treatment new 18-44 years	2	DHIS	-	175 948
Improve Emergency Medical Services and Access to Medication	Render an effective and efficient Emergency Medical Service	EMS P1 urban response under 30 minutes rate	3	DHIS	-	40%
		EMS P1 rural response under 60 minutes rate	3	DHIS	-	50%
	Improve availability and access of medicine	Percentage availability of medication (EML and STG) in the health facilities and institutions	7	Stock management reports	83.3%	90%
Implement the costed infrastructure plan to improve efficiency and effectiveness of health services delivery	Health facilities refurbished and adequately maintained to ensure effective service delivery	Percentage of public health facilities refurbished, repaired and maintained	8	Project management information systems (PMIS)	Baselines not available	80% of public health facilities refurbished, repaired and maintained

12. KEY RISKS

Outcomes	Risks	Mitigation
Ensure sound management of finances to achieve unqualified audit outcome	Inadequate resources for health Accruals and limited cash flow Slow Supply Chain process	Bid for adequate funding Strengthen management of Accruals and Commitments Continue to implement stringent measures on supply chain and financial management
Management of Medico-legal cases in the health system strengthened	Financial loss due to interest on charged legal costs	Enforcement of penalty clauses on non-compliance with the delivery terms and strengthen management of medico legal cases
Staff equitably distributed and have right skills and attitudes	Non-alignment between departmental establishment & organogram	Finalization & approval of departmental organogram
Robust and effective health information systems to automate business processes and improve evidence based decision making	Inability to render efficient and effective ICT services throughout the province	Incorporate transfer of skills in SLA with service providers;
Management of patient safety incidents improved to reduce new medicolegal cases	Unreliable & inaccurate performance information for decision making	Establishment of internal controls pertaining to financial governance matters; Consequence management for non-compliance with the DHMIS Policy
90:90:90 targets for HIV AIDS achieved by 2020 and 95:95:95 targets by 2024/25 Reduce HIV & AIDS related mortality by 25% by 2025 Reduce TB related related mortality by 25% by 2025	Increase in HIV incidences Decrease in patients remaining on ART Increased incidence rate of new drug susceptible TB and DR-TB patients	Strengthen combination preventative approach Intensify quarterly support visits by province Improve collaboration with other stakeholders DCS, mines, ECD centres & WBOT
Maternal, neonatal, infant and child Mortality reduced Stunting among Children reduced Hypertension and diabetes prevalence managed	Increase in Neonatal, child and maternal morbidity & mortality Risk of vaccine preventable disease outbreaks e.g. polio, measles, pneumonia etc	Strengthen implementation of policies and the Road to Health Booklet Involvement of Ward Based Outreach Team(WBOT) on social mobilisation and tracing of patients

Render an effective and efficient Emergency Medical Service	Transgression of EMS norms & standards Misuse & abuse of ambulances & other non-emergency vehicles (e.g. used as taxi, fuel theft & tyres)	Appoint more staff to fully comply with two crew legislation Strengthen the monitoring and regular inspections of facilities & ambulances by EMS inspectors
Improve availability and access of medicine	Inefficient stock management at facility level	Roll-out of stock management systems at facilities Support visits by pharmacy personnel to facilities
Health facilities refurbished and adequately maintained to ensure effective service delivery	Loss of funding due to non-compliance	Ensure compliance to table B5 commitments

13. PUBLIC ENTITIES

The department does not have Public Entities

PUBLIC-PRIVATE PARTNERSHIPS (PPPS)
The department does not have Public-Private Partnerships

CONCLUSION
The focus of the department is to improve service delivery, with the ultimate aim of improving the quality of life of our poor and unemployed community

14. TECHNICAL INDICATOR DESCRIPTION (TID) FOR STRATEGIC PLAN

1.	Indicator title	Contingent liability of medico-legal cases
	Definition	Total rand value of the medico-legal claims for all backlog cases that were on the case register as at 31 March 2019
	Source of data	Medico-legal case management system
	Method of calculation/Assessment	**Numerator:** Total rand value of the medico-legal claims for all backlog cases that were on the case register as at 31 March 2019
	Means of verification	Medico-legal case management system
	Assumptions	Accuracy dependent on reporting of data into the system
	Disaggregation of Beneficiaries	Women, Youth and persons living with disabilities
	Spatial transformation	None
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower number of cases reported
	Indicator responsibility	**Manager: Legal Services**

2.	Indicator title	Audit opinion of Provincial DoH
	Definition	Audit opinion for Provincial Departments of Health for financial performance
	Source of data	Auditor General's report, Annual Report
	Method of calculation/Assessment	**Numerator:** Audit outcome for regulatory audit expressed by AGSA for 2019/20 financial year
	Means of verification	Auditor General's report, Annual Report
	Assumptions	The departmental financial statements are true and fair in accordance with the financial reporting framework
	Disaggregation of Beneficiaries	None
	Spatial transformation	None
	Reporting cycle	Annual progress against the five year target
	Desired performance	Unqualified Audit Opinion from the Auditor General
	Indicator responsibility	**Senior Manager Finance**

3.	Indicator title	Number of public Nursing colleges accredited and registered to offer quality basic and specialist nursing programmes
	Definition	Total number of public nursing colleges accredited and registered to offer quality basic and specialist nursing programmes
	Source of data	Accredited and registered certificates of all nursing colleges to offer quality basic and specialist nursing programmes
	Method of calculation/Assessment	**Numerator:** Sum of public nursing colleges accredited and registered to offer basic and specialist nursing programmes
	Means of verification	Accredited and registered certificates of all nursing colleges to offer quality basic and specialist nursing programmes
	Assumptions	Accuracy is depended on the reliability of the accreditation
	Disaggregation of Beneficiaries	None

	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher
	Indicator responsibility	Chief nursing Officer

4.	**Indicator title**	**Human Resources Plan Developed**
	Definition	The plan sets out what a department plans to achieve in terms of Human Resources over a 3-year period
	Source of data	Signed off Human Resource Plan
	Method of calculation/Assessment	Numerator: One Human Resources Plan developed
	Means of verification	Signed off Human Resource Plan
	Assumptions	The departmental plans are not integrated
	Disaggregation of Beneficiaries	Women, Youth and persons living with disabilities
	Spatial transformation	All districts
	Calculation type	Non-cumulative
	Reporting cycle	Annual progress against the five year target
	Desired performance	1 Developed Human Resource Plan
	Indicator responsibility	**Senior Manager Human Resources Management**

5.	**Indicator title**	**UHC service Index** [5+]
	Definition	UHC Service Coverage Index is a measurement of coverage of essential health services and is calculated as the product of Reproductive, maternal, newborn and child health coverage; infectious disease control; non-communicable diseases and service capacity and access
	Source of data	South African Health Review (SAHR 2018)
	Method of calculation/Assessment	Not applicable
	Means of verification	South African Health Review (SAHR 2018)
	Assumptions	South African Health Review 2018, based on: world Health Organisational Bank for Reconstruction and Development/ The World Bank
	Disaggregation of Beneficiaries	None
	Spatial transformation	All Districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher performance
	Indicator responsibility	**Manager: District Health Services**

6.	**Indicator title**	**Percentage of health facilities electronically recording clinical codes for their patients visits**
	Definition	The number of health facilities electronically recording clinical codes for their patients visits as a proportion of the number of health facilities
	Source of data	Facility records
	Method of calculation/Assessment	Numerator: Sum of health facilities electronically recording clinical codes for their patients visits Denominator: Total number of health facilities
	Means of verification	Facility records
	Assumptions	There is a low number of health facilities electronically recording clinical codes for their patients visits

	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All Districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Good performance
	Indicator responsibility	**Manager: District Health Services**

7.	**Indicator title**	**Percentage of public health facilities certified by OHSC**
	Definition	Percentage of Public Health Facilities certified by the Office of Health Standards Compliance against the regulated norms and standards
	Source of data	Annual Report OHSC
	Method of calculation/Assessment	Numerator: Total number of public health faciliti
	Means of verification	Annual Report OHSC
	Assumptions	OHSH would have the capacity to assess and certify health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All Districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher
	Indicator responsibility	Chief Director: District Health services

8.	**Indicator title**	**Ideal Clinic Status obtained rate**
	Definition	Fixed PHC health facilities that obtained Ideal Clinic Status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs/CDCs
	Source of data	Ideal Health Facility Software
	Method of calculation/Assessment	**Numerato**r: Fixed PHC facilities have obtained Ideal Clinic Status **Denominator:** Fixed PHC clinics or fixed CHCs and or CDCs
	Means of verification	Ideal Health Facility Software
	Assumptions	Accuracy dependent on reporting of data into the system
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher ideal status rate reflects good performance
	Indicator responsibility	**Manager: District Health Services; Manager: Quality Assurance**

9.	**Indicator title**	**Patient Experience of Care satisfaction rate**
	Definition	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires
	Source of data	Patient surveys
	Method of calculation/Assessment	**Numerator:** Patient Experience of Care satisfied responses **Denominator:** Patient Experience of Care survey total responses
	Means of verification	Patient surveys
	Assumptions	Patients are not satisfied with health care services in PHC facilities
	Disaggregation of Beneficiaries	Women, Youth and people with disabilities

	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher rate of patients satisfied reflects good performance
	Indicator responsibility	**Manager: Quality Assurance**

10.	**Indicator title**	**Patient Safety Incident (PSI) case closure rate**
	Definition	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month
	Source of data	Patient Safety Incident Software
	Method of calculation/Assessment	Numerator: Patient Safety Incident (PSI) case closed Denominator: Patient Safety Incident reported
	Means of verification	Patient Safety Incident Software
	Assumptions	Accuracy dependent on quality of data from health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher rate of Patient Safety Incident (PSI) case closed reflects good perforamance
	Indicator responsibility	**Regional Hospital Manager**

11.	**Indicator title**	**Number of districts with quality improvement; monitoring and response forums convened quarterly**
	Definition	Districts with Quality Improvement; monitoring and Response Forums formalized that convene quarterly with clinical governance responsibility
	Source of data	Terms of reference of response forums
	Method of calculation/Assessment	**Numerator:** Number of Districts with Quality Improvement; monitoring and Response Forums convened quarterly
	Means of verification	Terms of reference of response forums
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Maximum number of districts with forums convened quarterly
	Indicator responsibility	**Manager**: District Health Services

12.	**Indicator title**	**Percentage of PHC facilities with functional clinic committees**
	Definition	Total number of PHC facilities with functional clinic committees as a proportion of the Total number of fixed PHC clinics
	Source of data	Attendance registers of meetings of clinic committees
	Method of calculation/Assessment	**Numerator:** Total number of PHC facilities with functional clinic committees **Denominator:** Total number of fixed PHC clinics
	Means of verification	Attendance registers of meetings of Clinic committees
	Assumptions	Attendance registers are accurately kept
	Disaggregation of Beneficiaries	Women, Youth and persons with disability

	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher percentage of functional clinic committees reflects good performance
	Indicator responsibility	DHS Manager

13.	**Indicator title**	**Percentage of hospitals with functional hospital boards**
	Definition	Total number of hospitals with functional hospital boards as a proportion of the Total number of district hospitals
	Source of data	Attendance registers of meetings of hospital boards
	Method of calculation/Assessment	**Numerator:** Total number of hospitals with functional hospital boards **Denominator:** Total number of district hospitals
	Means of verification	Attendance registers of meetings of hospital boards
	Assumptions	Attendance registers are accurately kept
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher percentage of functional hospital boards reflects good performance
	Indicator responsibility	DHS Manager

14.	**Indicator title**	**Maternal Mortality in facility ratio**
	Definition	Maternal death is death occurring during pregnancy, child birth, and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100000 live births in facility
	Source of data	Maternal death register, Birth registers (Combined, labour and Postnatal registers), Tick register ward/OPD/casualty
	Method of calculation/Assessment	**Numerator:** Maternal death in facility **Denominator:** Live births known to facility (Live births in facility plus Born alive before arrival at facility)
	Means of verification	Maternal death register, Birth registers (Combined, labour and Postnatal registers), Tick register ward/OPD/casualty DHIS
	Assumptions	Accuracy dependent on quality of data submitted by the health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

15.	Indicator title	Neonatal death in facility rate
	Definition	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility
	Source of data	Midnight report, Birth registers (Combined, labour and Postnatal registers) PHC Comprehensive Tick Register, DHIS
	Method of calculation/Assessment	**Numerator:** Neonatal deaths (under 28 days) in facility **Denominator:** Live birth in facility
	Means of verification	Midnight report, Birth registers (Combined, labour and Postnatal registers) PHC Comprehensive Tick Register, DHIS
	Assumptions	Accuracy dependent on quality data submitted by health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower death rate in facilities indicate better obstetric management practices and antenatal and care.
	Indicator responsibility	**Director: MCYWH & Nutrition; Chief Director- Health Programmes**

16.	Indicator title	Death in facility under 5 years rate
	Definition	Children under 5 years who died during their stay in the facility as a proportion of all live births
	Source of data	Paediatric admission register, Midnight report, DHIS
	Method of calculation/Assessment	**Numerator:** Death in facility under 5 years total **Denominator:** Live birth in facility
	Means of verification	Paediatric admission register, Midnight report, DHIS
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower rate of deaths
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

17.	Indicator title	Children <5 who are stunted
	Definition	Percentage of stunted (moderate or severe) children aged 0-59 months (moderate= height for age below- 2 standard deviations from the WHO Child Growth Standards median Severe- = height for age below – 3 standard deviations from the WHO Child Growth Standards median)
	Source of data	South African Demographic and Health Survey 2016
	Method of calculation/Assessment	Not applicable
	Means of verification	Not required for Strategic Plan 2020-2025

	Assumptions	The main limitation of this indicator is that the length or height can be difficult to obtain, thus leading to problems of validity
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All Districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower rate
	Indicator responsibility	**Manager: MCYWH & Nutrition; Chief Director- Health Programmes**

18.	**Indicator title**	**HIV positive 15-24 years (excl ANC rate)**
	Definition	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of those who were tested for HIV in this age group
	Source of data	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net, DHIS
	Method of calculation/Assessment	**Numerator:** SUM[HIV positive 15-24 years female (excl ANC) + HIV positive 15-24 years male] **Denominator: SUM[**HIV test 15-24 years female (excl ANC) + HIV test 15-24 years male]
	Means of verification	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net, DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Youth
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower positivity rate reflects good performance
	Indicator responsibility	Manager: HAST

19.	**Indicator title**	**ART client remain on ART at end of period**
	Definition	Total clients remaining on ART (TROA) at the end of the period
	Source of data	TIER.Net System
	Method of calculation/Assessment	**Numerator:** ART adult and child under 15 years remaining on ART end of month
	Means of verification	ART Register; TIER.Net; DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All District
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher
	Indicator responsibility	Manager: HAST

20.	Indicator title	AIDS related deaths as a proportion of total population
	Definition	Total number of deaths due to AIDS
	Source of data	TIER.Net System
	Method of calculation/Assessment	**Numerator:** Total number of AIDS related deaths Denominator: Total population
	Means of verification	ART Register; TIER.Net; DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All District
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower rate reflects good performance
	Indicator responsibility	Manager: HAST

21.	Indicator title	ALL DS-TB Client Treatment Success rate
	Definition	TB Clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently successfully complted treatment as a proportion of all those in the treatment outcome cohort
	Source of data	TB Register; ETR.Net
	Method of calculation/Assessment	**Numerator:** All DS-TB client successfully completed treatment **Denominator:** All DS-TB patients in treatment outcome cohort
	Means of verification	TB Register; ETR.Net
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher treatment success rate reflects good performance
	Indicator responsibility	Manager: HAST

22.	Indicator title	TB related deaths as a proportion of total population
	Definition	The total number of TB related deaths as a proportion of the total population
	Source of data	Thembisa HIV Estimates Model, Statistics South Africa
	Method of calculation/Assessment	**Numerator:** Sum of TB related deaths **Denominator:** Total Population
	Means of verification	TB Register; ETR.Net
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	Not applicable
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher
	Indicator responsibility	Manager: HAST

23.	Indicator title	All DS-TB Client Death Rate
	Definition	TB Clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently died as a proportion of all those in the treatment outcome cohort
	Source of data	TB Register; ETR.Net
	Method of calculation/Assessment	**Numerator:** All DS-TB client died **Denominator:** All DS-TB patients in treatment outcome cohort
	Means of verification	TB Register; ETR.Net
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower death rate reflects good performance
	Indicator responsibility	Manager: HAST

24.	Indicator title	Malaria case fatality rate
	Definition	Malaria deaths reported in South Africa. The death resulting from primary malaria diagnosis at the time of death
	Source of data	Malaria Information System
	Method of calculation/Assessment	**Numerator**: Malaria deaths reported **Denominator**: Malaria new case reported
	Means of verification	Malaria information System
	Assumptions	Accuracy dependant on quality of data from health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Lower percentage indicates a decreasing burden of malaria
	Indicator responsibility	Manager: NCD

25.	Indicator title	Hypertension client treatment new 18 – 44 years
	Definition	Total number of new hypertension clients 18 - 44 years put on treatment
	Source of data	DHIS
	Method of calculation/Assessment	**Numerator:** SUM of hypertension client treatment new 18 - 44 years
	Means of verification	DHIS
	Assumptions	Accuracy dependant on quality of data from health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher number reflects good performance
	Indicator responsibility	Senior Manager –NCD; Chief Director-Health Programmes

26.	Indicator title	Diabetes client treatment new 18 – 44 years
	Definition	Total number of new diabetes clients 18 - 44 years put on treatment
	Source of data	DHIS
	Method of calculation/Assessment	**Numerator:** Diabetic client treatment new 18-44 years
	Means of verification	DHIS
	Assumptions	Accuracy dependant on quality of data from health facilities
	Disaggregation of Beneficiaries	Not applicable
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher number reflects good performance
	Indicator responsibility	Senior Manager –NCD; Chief Director-Health Programmes

27.	Indicator title	EMS P1 urban response under 30 minutes rate
	Definition	Emergency P1 calls in urban locations with response times under 30 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time that the first dispatched medical resource arrives on scene
	Source of data	DHIS, institutional EMS registers OR patient and vehicle report.
	Method of calculation/Assessment	**Numerator:** SUM([EMS P1 urban response under 30 minutes]) **Denominator:** SUM([EMS P1 urban calls])
	Means of verification	DHIS, institutional EMS registers OR patient and vehicle report.
	Assumptions	Accuracy dependant on quality of data from health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons living with disabilities
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher percentage indicate better response times in the urban areas
	Indicator responsibility	**Senior Manager Emergency Medical Services**

28.	Indicator title	EMS P1 rural response under 60 minutes rate
	Definition	Emergency P1 calls in rural locations with response times under 60 minutes as a proportion of EMS P1 rural call
	Source of data	DHIS, institutional EMS registers Patient and vehicle report.
	Method of calculation/Assessment	**Numerator:** SUM([EMS P1 rural response under 60 minutes]) **Denominator:** SUM([EMS P1 rural calls])
	Means of verification	DHIS, institutional EMS registers Patient and vehicle report.
	Assumptions	Accuracy dependant on quality of data from health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons living with disabilities
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target

	Desired performance	Higher percentage indicate better response times in the rural areas
	Indicator responsibility	Senior Manager Emergency Medical Services

29.	**Indicator title**	**Percentage availability of medication (EML and STG) in the health facilities and institutions.**
	Definition	Percentage of medication that were requested *versus* medication that were replaced.
	Source of data	Stock management reports.
	Method of calculation/Assessment	**Numerator:** Number of medication replaced **Denominator:** Number of medication requested by facilities and institutions
	Means of verification	Stock management reports.
	Assumptions	Unavailability of medication in facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	100% of medication must be available in all health facilities
	Indicator responsibility	**Manager: Pharmaceutical Services**

30.	**Indicator title**	**Percentage of health facilities with major refurbishment or rebuild**
	Definition	Number of existing health facilities where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management contract projects only) have been completed (excluding new and replacement facilities) as a proportion of total number of health facilities Rebuild is considered where refurbishment cost is >70% of estimated replacement value
	Source of data	Project management Information Systems (PMIS)
	Method of calculation/Assessment	**Numerator:** Total number of health facilities with completed refurbishment **Denominator:** Total number of health facilities on the 10 year infrastructure plan that needed major refurbishment or replacement
	Means of verification	Project management Information Systems (PMIS)
	Assumptions	Health facilities are dilapidated
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Reporting cycle	Annual progress against the five year target
	Desired performance	Higher percentage reflects good performance
	Indicator responsibility	Manager: Infrastructure and Technical Management

15. ACRONYMS

ADMIN	Administration
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Client
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immuno Deficiency Syndrome
APP	Annual Performance Plan
ART	Antiretroviral Therapy
ARV	Anti-Retroviral
BAS	Basic Accounting System
BANC	Basic Antenatal Care
CCMDD	Central Chronic Management Dispensing and Distribution
CCTV	Closed-Circuit Television
CDC	Communicable Disease Control
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CFR	Case Fatality Rate
CHC	Community Health Centres
CHS	Community Health Services
CHW	Community Health Workers
CPIX	Consumer Price Index
DBE	Department of Basic Education
DBSA	Development of SA
DCST	District Clinical Specialist Teams
DHIS	District Health Information System
DHS	District Health Services
DIP	District Implementation Plan
DOH	Department of Health
DRG	Diagnosis Related Grouper

DRPW	Department of Roads and Public Works
DR-TB	Drug Resistant Tuberculosis
DSD	Department of Social Development
DTap IPV	Diphtheria, Tetanus, Pertussis and Polio Vaccine
EDR	Electronic Drug Resistance
EML	Essential Medicine List
EMS	Emergency Medical Services
EPI	Extended Programme Immunisation
EPMDS	Employee Performance Management Development System
ESMOE	Essential Steps in Obstetric Emergencies
ETR	Electronic TB Register
FDC	Fixed Dose Combination
GCCN	Government Central Core Network
GDP	Gross Domestic Product
GIAMA	Government Infrastructure Asset Management Act
HAI	Hospital Acquired Infections
HAST	HIV & AIDS, STI
HBB	Help Babies Breathe
HCSS	Health Care Support Services
HCT	HIV Counselling & Testing
HEP	Hepatitis
HFM	Health Facilities Management
HFRG	Health Facility Revitalisation Grant
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPCSA	Health Professions Council of South Africa
HPV	Human Papilloma Virus
HR	Human Resources

HRP	Hospital Revitalisation Programme
HRP	Human Resource Plan
HST	Health Science and Training
HVAC	Heating, Ventilation, Air-Conditioning and Cooling
ICT	Information Communication and Technology
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPC	Infection Prevention Control
IPT	Isoniazid Preventative Therapy
IRM	Infrastructure Reporting Model
ISHP	Iintegrated School Health Programme
IYM	In-Year Financial Monitoring
JTG	John Taolo Gaetsewe
KbPS	Kilobits Per Second
LOGIS	Local Government Information System
LP	Liquid Petroleum (Domestic Gas)
LTF	Lost to Follow-up
MbPS	Megabits Per Second
MCWH / N	Maternal, Child, and Women's Health / Nutrition
MDG	Millennium Development Goals
MDR	Multi Drug Resistant TB
MEC	Member of the Executive Council
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
MTT	Ministerial Task Team
N	Number
N/A	Not Applicable

NCD	Non-Communicable Disease
NCDOH	Northern Cape Department of Health
NCS	National Core Standards
NDOH	National Department of Health
NDP	National Development Plan
NET	Network
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NICD	National Institute Communicable Disease
NIHE	National Institute of Higher Education
No.	Number
OHH	Outreach Household
OHS	Occupational Health and Safety
OPD	Out Patients Department
OSD	Occupational Special Dispensation
P1	Priority One
PCA	Provincial Council on AIDS
PCR	Polymerase chain reaction
PDE	Patient Day Equivalent
PDP	Personal Development Plan
PEP	Post Exposure Prophylaxis
PERSAL	Personnel and Salary Administration System
PHC	Primary Health Care
PHS	Primary Healthcare Services
PHS	Provincial Hospital Services
PMDS	Performance Management and Development System
PMTCT	Prevention of Mother to Child Transmission
PSP	Provincial Strategic Plan
PSS	Patient Satisfaction Survey

PT	Provincial Treasury
PTB	Pulmonary Tuberculosis
QA	Quality Assurance
R254	One Year Nursing Programme
R425	Two Year Nursing Programme
R683	Four Year Nursing Programme
R	Rand
R	Rate
RV	Rota Virus
SA	South Africa
SACTWU	Southern African Clothing and Textile Workers' Union
SAPS	South African Police Service
SLA	Service Level Agreements
SMS	Senior Management Structure
SONA	State of the Nation Address
SOP	Service Operating Procedures
SRH	Sexual and Reproductive Health
STATS SA	Statistics South Africa
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
STP	Service Transformation Plan
TB	Tuberculosis
TFI	Transfer in
TFO	Transfer out
THS	Tertiary Hospital Services
TIER	Three Integrated Electronic Registers
TROA	Total Client Remaining on ART
U5MR	Under Five Mortality Rate
U-AMP	User Asset Management Plan

UNAIDS	United Nations Programme on HIV and AIDS
VIZ	Videlicet
VS	Versus
VMMC	Voluntary Medical Male Circumcision
WBPHCOTs	Ward Based Primary Health Care Outreach Teams
WEH	West End Hospital
WHO	World Health Organisation
XDR	Extensive Drug Resistant

NORTHERN CAPE DEPARTMENT OF HEALTH

5 YEARS STRATEGIC PLAN

2020/2021- 2024/2025

Published by the Northern Cape Department of Health
Private Bag x 5049
Kimberley
8300
South Africa

Tel: 053 830 2148
Fax: 053 833 4394
Email: dion.theys@gmail.com

PR99/2020

ISBN: 978-0-621-48354-3

NOTES

NORTHERN CAPE DEPARTMENT OF HEALTH
5YEARS STRATEGIC PLAN
2020/21 - 2024/2025

Published by the Northern Cape Department of Health
Private Bag x 5049
Kimberley
8300
South Africa

Tel: 053 830 2148
Fax: 053 833 4394
Email: dion.theys@gmail.com

PR99/2020
isbn: 978-0-621-48354-3

Printed by: Wolfram Communications