NORTHERN CAPE DEPARTMENT OF HEALTH

2015/16 – 2019/2020

TABLE OF CONTENT

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ANC	Antenatal Client
ANC	Antenatal Clinics
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-Retrovirals
ASSA	Actuarial Society of South Africa
BUR	Bed Utilisation Rate
C-Section	Caesarean Section
CCTV	Closed-Circuit Television
CDC	Communicable Disease Control
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CFR	Case Fatality Rate
CHC	Community Health Centres
CHE	Council of Higher Education
CHW	Community Health Workers
CPIX	Consumer Price Index
DCST	District Clinical Specialist Teams
DHIS	District Health Information System
DHMIS	District Health Management Information System
DHS	District Health Services
DR-TB	Drug Resistant Tuberculosis
DTap IPV	Diphtheria, Tetanus, Pertussis and Polio Vaccine
EDR	Electronic Drug Resistance
EPI	Extended Programme on Immunisation
EML	Essential Medicine List
EMS	Emergency Medical Services
EPMDS	Employee Performance Management Development Programme
ETR	Electronic TB Register
FDC	Fixed Dose Combination
GIAMA	Government Infrastructure Asset Management Act
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPV	Human Papilloma Virus
HR	Human Resources
HRP	Hospital Revitalisation Programme
HTA	High Transmission Area
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
ISHP	Integrated School Health Program
IYM	In-Year Financial Monitoring
JTG	John Taolo Gaetsewe
KbPS	Kilobits Per Second
LOGIS	Local Government Information System
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
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
MTT	Ministerial Task Team
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
No.	Number
NSP	National Strategic Plan
OD	Organisational Development
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
PEP	Post Exposure Prophylaxis
PERSAL	Personnel and Salary Administration System
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PTB	Pulmonary Tuberculosis
QA	Quality Assurance
SACTWU	Southern African Clothing and Textile Workers' Union
SADHS	South African Demographic and Health Survey
SCD	Step Down Care
SCM	Supply Chain Management
SLA	Service Level Agreements
SOP	Service Operating Procedures
SRH	Sexual and Reproductive Health
STATS SA	Statistics South Africa
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
TB	Tuberculosis
THS	Tertiary Hospital Services
U5MR	Under Five Mortality Rate
UNAIDS	United Nations Programme on HIV and AIDS
VIZ	Videlicet
WBPHCOTs	Ward Based Primary Health Care Outreach Teams
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Norms
XDR	Extensive Drug Resistant
ZF MGCAWU	Zwelentlanga Fatman Mgcawu

FOREWORD BY THE EXECUTIVE AUTHORITY (HEALTH MEC)

Vision

It is my pleasure to present the 5 year Strategic Plan of the Provincial Department of Health for the Northern Cape. This plan reflects on the Departmental intentions to continue to improve the lives of the people of the Northern Cape.

The past 5 years has experienced major policy shifts and key interventions in responding to the health issues and provision of better health care. As we move forward on our transformation agenda, we are continuing to provide "Health Service Excellence for All". This is a vision that the department is prepared to achieve in the next five years and we believe that it is still relevant to realise the vision of the country which is "A long and healthy life to all South Africans" through excellent service to our people.

Strategic Direction

The province will put more effort and channel most of the resources to Primary Health Care (PHC) in order to ensure universal access, health promotion and disease prevention. The fight against HIV and AIDS remains top of our agenda; clearly despite the dropping to the lowest incident rate in the country, the province is still faced with a mammoth task to encourage behavioural change. The triple burden of disease presents new challenges of TB XDR which necessitates a new approach and redoubling of efforts to improve on adherence to treatment and reduce mother to child transmission.

The department is still committed to reduce the incidence of non-communicable diseases and ensure that they are reduced to a manageable level in the next five years. This can be done through promoting healthy diets and encourage physical activities through intersectoral collaboration. Mental health should also find expression at the NHI pilot sites, this should be done through developing district based mental health services that are incorporated in Primary Health Care Re-engineering.

Strategies and activities to implement recommendations from Operation Phakisa

The President of South Africa announced in his State of the Nation Address (SONA) post elections that "we will launch an adaptation of the Big Fast Results methodology that we have been discussing with the government of Malaysia. The methodology involves setting clear targets, following up with on-going monitoring of progress and making the results public. Using this implementation methodology, the Government of Malaysia was able to register impressive results within a short period. In South Africa, we have renamed the Malaysian approach Operation Phakisa, to emphasise its critical role in fast-tracking delivery on the priorities included in the National Development Plan 2030. We will also pilot this methodology to improve service delivery in our clinics nationwide, promoting Minister Motsoaledi's Ideal Clinic Initiative".

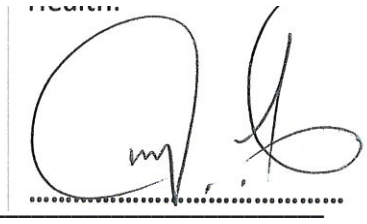
Commitment

In the coming five years we are committed within the infrastructure plan to improve and maintain our infrastructure and allocate funding in an effective and efficient manner to achieve better health outcomes for all.

The Department will strengthen leadership in all facilities and ensure that community based structures are established and thoroughly empowered in order to exercise leadership roles in our communities. We commit to strengthen our emergency medical services, by ensuring that we finalise the two person crew system and procure obstetric ambulances in order to improve quality of care services in the EMS.

Conclusion

As we look forward in the future, this strategic plan will focus entirely in ensuring that we provide better health care that is client based and informed by the needs of the communities in the Northern Cape Province. We believe that we will see better health outcomes in the next five years.



MR N.M.JACK
MEC FOR HEALTH
DATE: 04 MARCH 2015

STATEMENT BY THE HEAD OF DEPARTMENT (HOD)

Vision

Our 5 year strategic plan, premise on continuing to provide "Health Service Excellence for all", and provides a solid foundation of work ahead. As postulated in the plan we will continue to keep up to the expectation in the next 5 years. Over the past period, the Department of Health in the Northern Cape has ensured that almost all commitments that were made were fulfilled.

Key Focus

In general, we shall ensure that the reforms as pronounced by National Department find expression in the Province without fail. The Medium Term Strategic Framework (MTSF) which is anchored to the National Development Plan (NDP) remain the guiding document of government to ensure that we stick to our commitment for the coming 5 years. Our key priority is to ensure that we accelerate the implementation of Primary Health Care (PHC) Re-Engineering in all the Districts, within a context of an effective and efficient District Health System.

The Primary Health Re-engineering will unfold in line with the vision and mission of the department. In this regard we will ensure we comply with all standards as set out by the Office of the Health Standards Compliance throughout all our facilities in the province. Our focus will be to ensure that we have a responsive health management information system to inform our decision making. This will be done through strengthening the use of information for planning and monitoring system and improving our ICT infrastructure, costing our health service packages and ensuring an effective and efficient supply of medicine throughout the province.

We will improve our Emergency Medical System to reach the expectation of our communities and ensure that the service is of a good standard. We will also improve our forensic services to respond to all the districts needs and strengthen capacity across the entire Province in the next five years.

Strengthening Financial Management

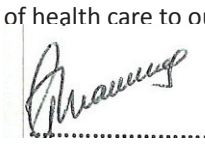
Over the past five years health sector underwent radical reforms. These changes put the financial baseline under pressure, notwithstanding the inefficiencies and pilferage. We will improve the Supply Chain Management (SCM) through the management of contracts and implementation the SCM reforms. Financial delegations to hospital Chief Executive Officers (CEO's) and the District Managers will be implemented to improve the turn- around strategy and respond to the immediate commitments of the facilities.

Strengthening Human Resources Management

We will ensure that there is a productive workforce within our Department through improving the Infrastructure of all colleges and ensure that training and development is effective and efficient in those facilities. Through the implementation of Workload Indicators of Staffing Needs (WISN), we will ensure that we have appropriate workforce, at the right positions, with the right skills. The workforce of the Department will respond to the service delivery platform in the next 5 years.

Conclusion

Through all the commitments that the Department undertook, we believe that our vision of "Health Service Excellence for All "will be our pillar for the next five years. We are therefore presenting the Strategic Plan for the Department of Health in the Northern Cape Province with confidence that our commitments will become a reality and we will provide a quality of health care to our people,



Ms G.E. MATLAOPANE
HEAD OF DEPARTMENT
DATE: 04 MARCH 2015

OFFICIAL SIGN-OFF OF THE 5 YEAR STRATEGIC PLAN

It is hereby certified that this 5 Year Strategic Plan:

- Was developed by the Northern Cape Provincial Department of Health with leadership from the MEC for Health and Head of Department
- Complies with the Framework for 5 Year- Strategic Plans of Provincial Departments of Health **2015/16 – 2019/20**, the Medium Term Strategic Framework 2014-2019 and Negotiated Service Delivery Agreement for Health, National Development Plan and other relevant planning documents.

.....	2015/3/11
Mr. Mxolisi Mlatha **Director: Policy & Planning**	**Date**
.....	11/03/2015
Mr. Daniel Gaborone **Acting Chief Finance Officer**	**Date**
.....	11/03/2015
Ms. Gugulethu E. Matlaopane **Head of Department**	**Date**
APPROVED BY	
.....	11.03.2015
Mr. Ntsikelelo McCollen Jack **Executive Authority**	**Date**

PART A

STRATEGIC OVERVIEW

1. VISION

Health Service Excellence for All

2. MISSION

Working together, we are committed to provide quality health care services and promote a healthy society. Our caring, multi-skilled professionals will integrate comprehensive services using evidence-based care strategies and partnerships to maximize efficiencies for the benefit of all.

3. VALUES

- **Respect** (towards colleagues and clients, rule of law and cultural diversity)
- **Integrity** (Honesty, Discipline, and Ethics)
- **Excellence** through effectiveness, efficiency, innovation and quality health care
- **Ubuntu** (Caring Institution, Facility and Community)

4. LEGISLATIVE AND OTHER MANDATES

(a) Constitutional Mandates

Section 27 of the Constitution of the Republic of South Africa, Act 108 of 1996, provides for right of access to health care services, including reproductive health care.

The Department provides access to health care services, including reproductive health care by making sure that hospitals and clinics are built closer to communities and emergency vehicle are provided, promotion of primary health care, etc.

(b) Legal Mandates

The legislative mandates are derived from the National Health Act 61 of 2003

Chapter 4

Section 25 provides for Provincial health services and general functions of provincial departments;

Section 26 provides for Establishment and composition of Provincial Health Council;

Section 27 provides for Functions of Provincial Health Council and

Section 28 provides for Provincial consultative bodies

Chapter 5

Section 29 provides for the Establishment of district health system;

Section 30 provides for division of health districts into sub-districts;

Section 31 provides for establishment of district health councils;

Section 32 provides for health services to be provided by municipalities and

Section 33 provides for preparation of district health plans

(c) Policy Mandates

- Basic Conditions of Employment (Act 75 0f 1975)
- Broad Based Black Economic Empowerment (Act 53 of 2003)
- Child Care Act, 1983
- Child Care Amendment (Act 96 of 1996)
- Choice on Termination of Pregnancy (Act 92 of 1996)
- Constitution of the Republic of South Africa (Act 106 of 1996)
- Control of Access to Public Premise and Vehicles (Act 53 of 1985)
- Convention of the Rights of the Child, 1997 (Chapters 5 and 7)
- Division of Revenue (Act 7 of 2007)
- Electronic Communication and Transaction (Act 25 of 2002)
- Electronic Communications Security (Pty) Ltd (Act 68 of 2002)
- Employment Equity (Act 55 of 1998)
- Environment Conservation (Act 73 of 1989)
- Fire-arms Control (Act 60 of 2000)
- Foodstuffs, Cosmetics and Disinfectants (Act 54 of 1972)
- Hazardous Substances Control (Act 15 of 1973)
- Health Professions (Act 56 of 1974)
- Higher Education (Act 101 of 1997)
- Income Tax Act, 1962
- Inquest (Act 58 of 1959)
- Intimidation (Act 72 of 1982)
- Labour Relations (Act 66 of 1995)
- Maternal Death (Act 63 of 1977)
- Medicine and Related Substance Control (Act 101 of 1965)
- Mental Health Care (Act 17 of 2002)
- National Building Regulations and Building Standards (Act 103 of 1997)
- National Environmental Management (Act 107 of 1998)
- National Health (Act 63 of 1977)
- National Health (Act 61 of 2003)
- National Youth Commission Amendment (Act 19 of 2001)
- Nursing (Act 50 of 1978 and Related Regulations)
- Nursing (Act 33 of 2005)
- Occupational Health and Safety (Act 85 of 1993)
- Preferential Procurement Policy Framework (Act 5 of 2000)
- Prevention and Combating of Corrupt Activities (Act 12 of 2004)
- Prevention and Treatment of Drug Dependency (Act 20 of 1992)
- Promotion of Access to Information (Act 2 of 2000)
- Promotion of Administrative Justice (Act 3 of 2000)
- Promotion of Equality and Prevention of Unfair Discrimination (Act 4 of 2000)
- Protected Disclosures (Act 26 of 2000)
- Protection of Information (Act 84 of 1982)
- Public Finance Management (Act 1 of 1999 and Treasury Regulations)
- Public Service (Act 103 of 1994 and regulations)
- South African Qualifications Authority (Act 58 of 1995)
- Sexual Offences (Act 32 of 2007)
- Skills Development (Act 97 of 1998)
- South African Schools Act, 1996
- State Information Technology (Act 88 of 1998)
- Sterilization (Act 44 of 2005)
- The International Health Regulations (Act 28 of 1974)
- Tobacco Control Amendment (Act 23 of 2007)
- Tobacco Products Control Amendment (Act 12 of 1999)
- White Paper on Transformation of Health Service

5. SITUATIONAL ANALYSIS

5.1. DEMOGRAPHICS

The Northern Cape population as revealed by Statistics SA Mid-Year Population Estimates 2014; outlines that the population has increased from 1 162 914 to 1 166 680. Just over 48% of the population is aged younger than 24 years and approximately 9.8% is 60 years and older. A great proportion of the population is either young or children, with the latter being beneficiaries of free health services, resulting in health expenditure being high in accordance to the population health needs of persons in that age cohort.

Table 1: Total population by age group and sex

Age Group	Female	Male
	Number	Number
0-4 yrs.	53 000	54 071
5-9 yrs.	51 838	52 486
10-14 yrs.	56 649	57 587
15-19 yrs.	59 110	61 466
20-24 yrs.	54 492	58 796
25-29 yrs.	49 730	55 580
30-34 yrs.	40 822	44 676
35-39 yrs.	35 125	36 830
40-44 yrs.	34 501	32 344
45-49 yrs.	32 796	29 207
50-54 yrs.	28 559	25 182
55-59 yrs.	25 440	22 219
60-64 yrs.	21 185	17 680
65-69 yrs.	17 161	12 436
70-74 yrs.	13 140	8 704
75-79 yrs.	7 507	5 167
80+ yrs.	7 513	3 678
Total	**588 570**	**578 111**

Source: Mid-Year Population Estimates, 2014 (Statistics SA) **Due to rounding numbers do not necessary add up to totals.**

PROVINCIAL SHARE OF TOTAL POPULATION IN SA

Although there is a slight change in the population figures, the province continues to have the smallest population which is 2.2% of the total population of South Africa. It further covers a total area of 372 889 square kilometers which is 30.5% of the country's land area. This implies that services rendered at vast and rural areas will be affected negatively and will continue to increase expenditure in transportation costs due to distances.

5.2. SOCIO-ECONOMIC ISSUES

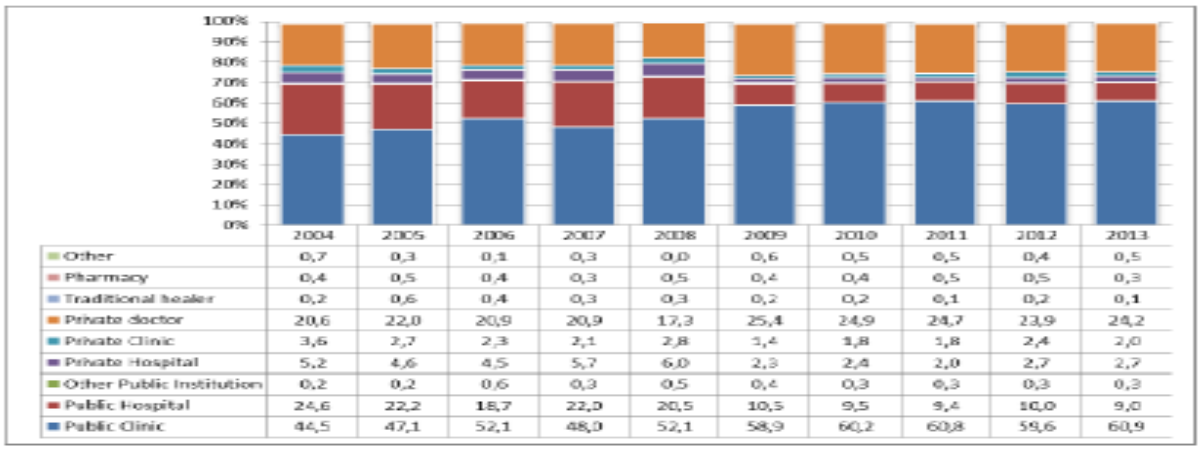
Figure 1: Trends in key labour market indicators in Northern Cape, 2008–2014

	2008	2009	2010	2011	2012	2013	2014
	Youth 15-34 years (Thousand)						
Population	383	386	390	394	399	404	409
Labour force	216	204	197	203	203	211	219
Employed	143	126	120	119	130	126	126
Unemployed	73	78	77	84	74	85	93
Not economically active	166	182	193	191	196	193	190
Rates (%)							
Unemployment rate	33,8	38,4	39,3	41,5	36,2	40,4	42,4
Employed/population ratio (Absorption)	37,4	32,6	30,7	30,2	32,5	31,1	30,9
Labour force participation rate	56,5	52,9	50,6	51,6	50,9	52,3	53,6
	Adults 35-64 years (Thousand)						
Population	315	320	325	330	335	340	345
Labour force	195	187	185	186	191	206	215
Employed	168	160	159	149	165	169	182
Unemployed	27	27	26	37	26	37	33
Not economically active	119	133	140	144	144	134	129
Rates (%)							
Unemployment rate	13,9	14,3	14,2	19,8	13,6	17,8	15,4
Employed/population ratio (Absorption)	53,4	50,1	48,8	45,2	49,2	49,8	52,8
Labour force participation rate	62,1	58,4	56,9	56,4	56,9	60,5	62,5

Source: National and Provincial labour market: Youth Quarter 1 (2008) – Quarter 1 (2014) (Statistics SA)

Between 2008 and 2014, the number of employed youth in the province decreased from 143 000 to 126 000, while at the same time the number of the unemployed also increased, resulting in a rise in the youth unemployment rate from 33.8% in 2008 to 42.4% in 2014. Therefore as we plan our health care services, we need to recognise the fact that young people will not be having medical aids and relying on public health care services.

Figure 2: Percentage of distribution of type of health-Care facility consulted first by the households when members fall ill or get injured, 2004 - 2013



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Other	0,7	0,3	0,1	0,3	0,0	0,6	0,5	0,5	0,4	0,5
Pharmacy	0,4	0,5	0,4	0,3	0,5	0,4	0,4	0,5	0,5	0,3
Traditional healer	0,2	0,6	0,4	0,3	0,3	0,2	0,2	0,1	0,2	0,1
Private doctor	20,6	22,0	20,9	20,9	17,3	25,4	24,9	24,7	23,9	24,2
Private Clinic	3,6	2,7	2,3	2,1	2,8	1,4	1,8	1,8	2,4	2,0
Private Hospital	5,2	4,6	4,5	5,7	6,0	2,3	2,4	2,0	2,7	2,7
Other Public Institution	0,2	0,2	0,6	0,3	0,5	0,4	0,3	0,3	0,3	0,3
Public Hospital	24,6	22,2	18,7	22,0	20,5	10,5	9,5	9,4	10,0	9,0
Public Clinic	44,5	47,1	52,1	48,0	52,1	58,9	60,2	60,8	59,6	60,9

Source: General Household Survey, 2014 (Statistics SA)

Figure 2 shows that approximately 69.9% of households indicated that they would first go to public clinics and hospitals, whilst 28.9% of households said that they would first consult a private doctor, or private clinic or hospital with the rest consulting traditional healers.

According to the General Household Survey (2014), in 2010, there were 14.2% of people residing in Northern Cape with medical aid coverage. The figure declined to 13.3% (2011), increased to 18.9% (2012) and 20.2% (2013). This is indicative that the vast majority of people are still relying on public health facilities. With this great number of people relying on the public health care system means that greater pressure continues to bear on the potentially diminishing resources to provide health care services.

5.3. EPIDEMIOLOGICAL PROFILE / BURDEN OF DISEASE

Table 2: Mortality and Causes of death: Leading causes of death

Causes of death	Number	%
Human Immunodeficiency Virus (HIV) disease	1 187	8.7
Tuberculosis	1 061	7.7
Cerebrovascular Diseases	636	4.6
Hypertensive diseases	621	4.5
Influenza and pneumonia	600	4.4
Chronic lower respiratory diseases	546	4.0
Diabetes mellitus	522	3.8
Other forms of heart disease	446	3.3
Ischaemic heart diseases	423	3.1
Intestinal infectious diseases	378	2.8
Other natural causes	5 742	41.9
Non-natural causes	1 537	11.2
Total	**13 699**	**100**

Source: Mortality and causes of death in Northern Cape, 2013: Findings from death notification (Statistics SA)

In the province, Human Immunodeficiency Virus (8.7%) is the leading cause of death, followed by Tuberculosis (7.7%), Cerebrovascular Diseases (4.6%), Hypertensive Diseases (4.5%) and Influenza and Pneumonia (4.4%). These five leading causes contribute to more than a quarter (29.9%) to the mortality and causes of death in the Northern Cape Province. It means in terms of planning, we must focus on these diseases profile.

Maternal and Child Mortality

Millennium Development Goal 4 and 5 is about the reduction of child mortality by 2/3 and maternal mortality by 3/4 by 2015. In an effort to reduce maternal and child morbidity and mortality District Clinical Specialist Teams have been introduced throughout the country at district level

- To strengthen the clinical governance of maternal child and neonatal services at all levels
- To mentor doctors and nurses working in district facilities to improve clinical outcomes
- To ensure that the correct treatment guidelines and protocols are adhered to and
- Essential equipment is available and properly used

The common causes contributing to the high under 5 child mortality rates in the province are diarrhoea, pneumonia and malnutrition with HIV and AIDS as an underlying factor. The conditions that contribute to neonatal deaths are mainly prematurity and asphyxia. In support of the neonatal survival strategy, the National Department of Health Child Health Cluster is in the process of developing a national plan called “HAPPI-NeSS road map for healthy babies in South Africa” to operationalize recommendations from the National Perinatal Morbidity and Mortality Committee. This will ensure that all levels of care are assigned roles and responsibilities that will have targets and reviewed regularly to support the care of sick children. District Specialist Teams have started to review children’s data to develop improvement plans to improve maternal and child care outcomes.

Prevention of Mother to Child Transmission (PMTCT)

HIV is transmitted to approximately one third of babies of HIV positive mothers if there is no medical intervention. Use of antiretroviral drugs, obstetric practices including caesarean delivery and safe infant feeding practices can reduce transmission to very low levels. The main aim of the programme is to prevent transmission of HIV to unborn babies during pregnancy, labour, delivery, post-delivery and to ensure that more HIV positive mothers have access to medicines, to information and counselling about HIV, which will result in fewer babies being born with HIV. The rate of mother to child transmission of HIV (MTCT) in the Province continues to decrease from 3.0 (2012/13) to 2.5 (2013/14).

The success of this programme can be attributed to social mobilization campaign integrated with the new PMTCT guidelines workshop conducted to promote early booking of pregnant women before 20 weeks. The province is currently re-training Health Care Practitioners in the Integrated Management of Childhood illnesses (IMCI). Early Childhood Centre Personnel

and the Ward Based Outreach Teams are also being trained in Community IMCI to strengthen positive household practises.

Fourteen neo-natalies were also donated by the NDOH to assist nurses and doctors working in neonatal units or managing sick children to conduct fire-drills in neonatal resuscitation. Essential Steps in Obstetric Emergencies (ESMOE) training and fire-drills is being conducted regularly at facility level. There has been a steady decline in maternal deaths over the past years from 167/100 000 live births (2011/12) to 127/100 000 live births (2013/14). Few of these reported deaths were HIV related meaning that more women during pregnancy opt to be tested and prioritised for antiretroviral treatment. The province is faced with challenges related to specialised care or emergencies due to distance between Primary Health Care Services, the Level 1, Regional and the Tertiary hospitals. This also impacts on referral routes for services of a higher level.

Surgical services are non-functional in most of the level 1 hospitals due to inadequate theatres, under skilled doctors and insufficient nurses. The Tertiary Hospital in Kimberley then becomes the only specialised health care facility that renders services for complicated maternity cases small, sick neonates and children. Despite the fact that Antenatal care is offered free of charge in public facilities, this is not the case in rural areas as transport costs to access services are expensive leading to infrequent or non-attendance of antenatal services. Emergency transport for pregnant women and sick children with complications is an ongoing challenge throughout the province. Only one district John Taolo Gaetsewe has dedicated obstetric ambulances donated by the mining sector in the area. Ten obstetric ambulances were donated to the district and placed at strategic points for easy referral of patients.

A cell phone technology called **MomConnect** was introduced in May 2014 to improve interaction between pregnant women and Health Care Practitioners. MomConnect is an initiative by the National Department of Health of using cell phones to register pregnant women to improve maternal and child health outcomes. Once registered each pregnant mother will receive stage based messages of the pregnancy. The mothers will also be given an opportunity to provide feedback to the health system on services received. This will help create awareness, improve knowledge and monitor the health status of mother and unborn baby. These messages will be disseminated to the mother for a period of one year, after the birth of the baby.

HIV / AIDS and STI's

The Northern Cape Province has made great strides in the management of HIV and TB and has made significant progress to reduce HIV prevalence and reduce deaths due to TB. The role of the Provincial Council on AIDS (PCA) encompasses civil society, private, business, mining sector has contributed to the successes of the HIV, AIDS and STI Programme and therefore must be acknowledged. Chaired by the Premier, the PCA has the ultimate political authority for the AIDS response and it is through combining the resources, skills and experiences of all sectors of society that the goals and objectives of the Programme can be achieved. The PCA is responsible for monitoring sectoral response towards the goal of the Provincial Strategic Plan on HIV, TB and STIs (2012 – 2016) and also for harnessing collective planning by different stakeholders.

Recent developments in the area of prevention and treatment mean that more people are living longer with HIV and fewer incidents of AIDS are seen as new treatment options seem to improve health outcomes significantly. However, challenges are still encountered with adherence to treatment and patients defaulting.

HIV Counselling and Testing (HCT)

Between 2012/13 and 2013/14, a total of 291 471 people were tested for HIV in public health facilities across the province. Year on year, there was a slight improvement with about 158 469 people tested in 2013/14 financial year compared to 133 002 in 2012/13. The HIV positivity rate in 2013/14 was lower at 6.9% (11 009 of 158 469) compared to 8.9% (11 947 of 133 002) in 2012/13.

The reduction in the HIV positivity rate as recorded in the District Health Information System (DHIS) is similar to the observed stabilisation of HIV prevalence in the Province as indicated by the National Antenatal HIV Prevalence Survey. The HIV and AIDS Programme continues to strengthen efforts in reduction of new infections and by ensuring HIV negative people remain negative. The programme has put into place HIV Counselling and Testing (HCT) targeted interventions to address the scourge of HIV and AIDS among key population (e.g. men having sex with men, truck drivers, casual sex workers, inmates, etc.), among women and youths.

TB/HIV Collaboration

The vision of the Northern Cape Provincial Strategic Plan (2012 - 2016) is aligned to that of the National Strategic Plan (2012 - 2016) and the long-term vision for South Africa with respect to the HIV and TB epidemics. United Nations Programme on HIV and AIDS (UNAIDS) has advocated the Three Zeros; zero new infection, deaths and discimination. To suit its local context, South Africa has included a 4th zero. The new South African vision, which the province adopts, now advocates for:

1. Zero new infections
2. Zero deaths from HIV and TB
3. Zero new infections due to vertical transmission
4. Zero discrimination related to HIV and TB

The Provicial Strategic Plan (PSP) is due to be revised in 2016 , this may impact on the current focus, targets and indicators as tabulated in this strategic plan. Necessary changes may require an amendment of the strategic plan of the Department.

Antiretroviral Treatment

The Minister of Health, Dr. Aaron Motsoaledi announced that as from 1 April 2013, eligible HIV positive patients receiving ARVs in the public sector will be treated with one tablet of a fixed dose combination (FDC) drug (Tenofovir, Efavirenz and Emtricitabine). Initially, only Priority Group 1 patients (adults, adolescents, pregnant women and breast feeding women) were commenced on 1 April 2013, largely attributed to the rollout of the ART FDC.

However, from October 2013, all facilities started implementing Fixed Dose Combination (FDC) as per mandate for all categories of patients hence the number of patients switched from old single dose regimens has improved. The number of registered ART patients in the Province, increased from 31 286 (2012/13) to 39 158 at the end of the financial year 2013/14. This represents a 20% year-on-year increase which is very significant and can be largely attributed to the implementation of FDC. However, the roll out of FDC to patients who were already in the ART program (switching) has been slow.

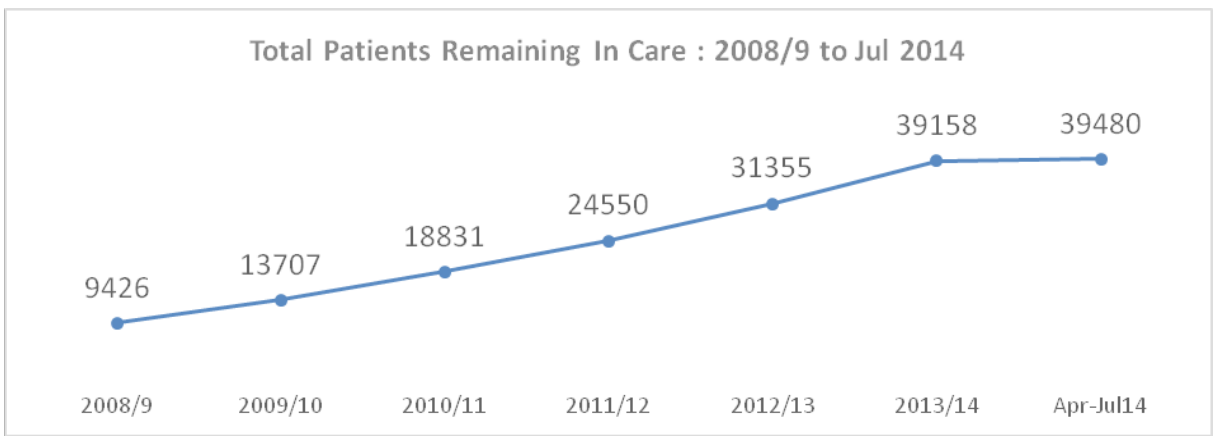


Figure 3: Total number of eligible enrolled into Antiretroviral Treatment Program per financial year, Northern Cape 2008/09 – July 2014
Source: District Health Information System (DHIS)

The National Department of Health (NDOH) has implemented the Central Chronic Management Dispensing and Distribution (CCMDD) system in the Pixley-Ka-Seme District to improve treatment adherence and reduce waiting times at clinics. Qualifying patients will receive 6 month supply of chronic medication including Fixed Dose Combination ARVs. To date only 3 498 patients have been registered on the programme. The Province is targeting to have at least 10 000 patients with chronic diseases on the CCMDD system by the end of the financial year.

Home Based Care

The Primary Health Care (PHC) re-engineering approach to providing health services proposes a community based approach for the delivery of PHC outreach service to the uninsured population of South Africa, which represents 79.8% of the total population.

The Department of Health will deploy PHC outreach teams in rural areas, informal urban settlements and in townships. The PHC re-engineering model will include for the first time Community Health Workers (CHW's) as part of the formal organisation of the health service workforce.

These outreach teams comprise of six Community Health Workers (CHW's) and one professional nurse as a team leader. Training on the re-engineering of Primary Health Care for Ward Based Teams has commenced in the second quarter of 2012/13 with 408 community health workers bringing total CHWs trained to 1 299 and 35 professional nurses trained as team leaders as at end of March 2013. In addition, the Department of Health as part of the Expanded Public Works Programme for the Social sector created 831 jobs against the target of 750 000 jobs from 1st April 2009 until 31st March 2014.

Medical Male Circumcision (MMC)

Research studies have shown that Medical Male Circumcision (MMC) decreases the risk of female- to-male HIV transmission by approximately 60% in males (at individual level). Since 2007, World Health Organization (WHO) and UNAIDS have recommended voluntary medical male circumcision as an additional important strategy for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision, where the public health benefits will be maximized. In South Africa, the MMC Programme is primarily targeting males aged between 15-49 years due to the level of risk shown in this age group. The Medical Male Circumcision introduction in the Province has started at a slow pace, mainly due to diverse cultural beliefs and the low acceptance of the programme by the community.

Since the start of the programme in 2010 the programme has managed to perform 20 544 circumcisions. This represents only 45% of the number of men who should have been circumcised to date (45 959) as the planned target between 2010/11 and 2012/13. Through a partnership forged with external stakeholders, particularly the South African Clothing and Textile Union (SACTWU), two private doctors were contracted to provide MMC services in John Taolo Gaetsewe and Frances Baard districts as a strategy to increase access and improve programme performance towards planned targets.

Overview of the performance of the Provincial TB Control during 2004-2013

Tuberculosis remains one of the drivers of morbidity and mortality in the country, including the Northern Cape Province. With a population of 51 million, South Africa is currently estimated to have a TB incident rate of between 900 and 1000 (per 100 000). Therefore, more intervention strategies must be put to aid the TB control programme in reducing the impact of the disease on the community. The following interventions are important for the TB programme:

- Reduce transmission of infection in the communities
- Early diagnosis and treatment initiation
- Retaining patients in care until completion of treatment
- Address identified social determinants of health

Implementation of all these strategies will not only assist the Province but also contribute to the national effort towards achieving the Millennium Development Goals. The escalation of Multi-Drug Resistance (MDR) TB and emergence of Extensive Drug Resistant (XDR) TB has further warranted the strengthening of the programme and a call for new initiatives. Poor socio-economic conditions, geographical barriers (long distances to health facilities due to the vastness) and stigma including lack of knowledge further exacerbates the situation.

Milestones over the past two years include new rapid diagnostics' tests for drug susceptible and drug resistant TB including new medicines for treating MDR and XDR TB. Scaling up community based outreach teams as part of PHC re-engineering; to provide care and support for patients at household level. Promoting healthy lifestyle has been another notable achievement. Public-Private Partnership is an effective solution to challenges on access to TB care and support services in the Northern Cape, hence the partnership with the mines and the correctional services. During the commemoration of the World TB Day (24 March 2014), the Provincial Department of Health and four of the big mines (i.e. AfriSam, Khumani, Beeshoek and Black Rock) entered into a memorandum of understanding which will see the department providing health care services to employees in these mines including their immediate families.

Case finding

A stabilisation in the number of TB cases has been observed in the last two years.

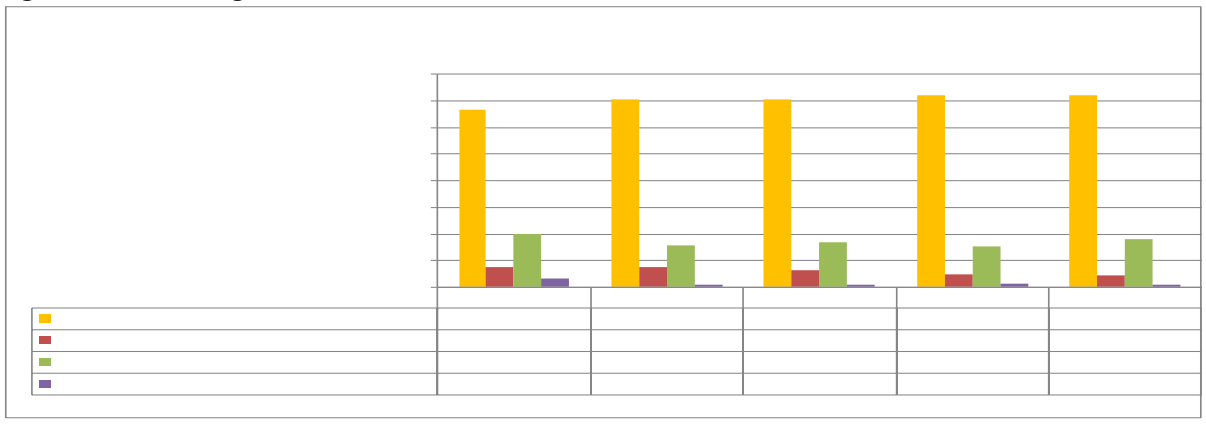
Table 3: Northern Cape TB Incidence per 100 000 Population 2004 – 2013

Year	Pulmonary TB				Extra Pulmonary TB		All TB cases	
	Smear + PTB		All PTB cases					
	N	Incidence per 100 000	N	Incidence per 100 000	N	Incidence per 100 000	N	Incidence per 100 000
2004	3 631	327	5 699	514	458	41	6 127	552
2006	4 155	375	6 757	609	620	56	7 377	665
2008	4 054	365	7 629	688	563	51	8 192	738
2010	4 280	399	9 435	881	817	76	10 252	956
2012	4 693	438	9 444	881	717	67	10 191	951
2013	4707	388	8 687	716	563	49	8 821	727

Source: ETR.Net, 2014

Although the number of TB cases over the years has stabilised, a high proportion of smear positives at an average of approximately 48% of total TB cases is observed for the last 3 years. The TB incidence (per 100 000) for all TB cases in 2013 was the lowest since 2008. The success of the tracer team project may account for the trend shown in Table 3.

Figure 4: Case holding, 2009 – 2013



Source: ETR.Net, 2014

A slight improvement in the smear conversion and remaining smear positive over last 3years is observed at an average of 72% for smear conversion and smear positive at 5% respectively. Smear conversion in Namakwa has declined from 81% (2012) to 67% (2013) this can be attributed to high proportion at 8% (2013) of patients remaining smear positive at end of two months. The improvement in the smear conversion is attributable to improved patient management and patient adherence to treatment. Albeit the smear conversion improvement, late or no sputum collection at 2 months still remains a challenge i.e. some patients not having sputum at 2 months due to either poor recording and reporting of sputa results, late collection of sputa which require ongoing support and seasonal migration to farms.

A strategy was put in place to address seasonal migration in farming communities and it thus involves forging partnerships with the farming unions, throughout some farms. Partnerships are currently in place with the farms in different parts of Pixley-ka-Seme (Siyancuma, Siyathemba and Ubuntu) and ZF Mgcawu districts, where the District TB Coordinators periodically meet with the farmers, to address TB related challenges. This partnership is envisaged to improve patient retention by reducing defaulters among seasonal workers who move between geographical areas thus becoming difficult to track.

Multi-Drug Resistant (MDR) TB

In response to the National Policy Framework on Decentralized and De-institutionalized Management of MDR-TB, the Northern Cape Province identified Nababeep CHC and De Aar Hospital as decentralized MDR-TB sites. Although each facility admits 4 patients each, plans are underway to increase the bed capacity of each facility to 20 and 40 DR-TB beds respectively. The refurbishment of Nababeep has been prioritized for 2014/15. Access to DR-TB care is currently improving by allowing patients to be treated at health facilities nearest to their homes.

Improved TB diagnostics, poor living conditions and high TB defaulter rate are the main drivers of increased number of DR-TB patients. The province reported 279 MDR-TB patients and 30 XDR-TB patients during 2013; a decrease of 3.5% and 3% respectively**.**

Extensive Drug Resistant TB (XDR)

Albeit the number of XDR TB patients diagnosed has remained consistent over the years, this can be attributed to patients refusing to be initiated on XDR TB regimen as laboratory is diagnosing more patients than the actual patients that presents themselves at facilities due to some dying before treatment started or lost to follow up.

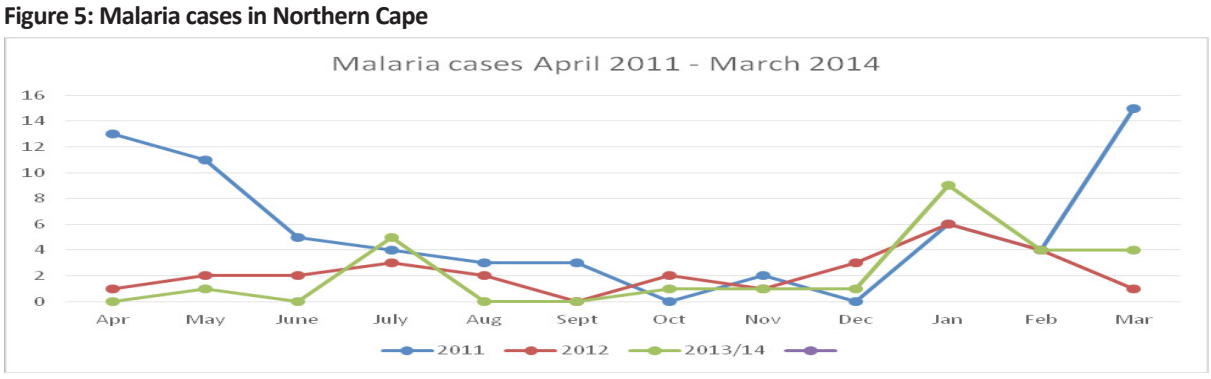
Meningococcal Meningitis

Meningococcal disease is a serious and even life-threatening disease and most of the cases are reported in winter and spring. The disease has a rapid progression and is managed as a medical emergency in order to reduce morbidity and mortality. The overall incidences of meningococcal disease are decreasing although the case fatality is increasing. The case fatality rate (CFR) for the 4th quarter of 2013/14 financial year was 100%. The CFR represents the measure of the outcome of management of the case. It may reflect quality of care, public health response and good clinical practice.

Malaria

Malaria in the Northern Cape is not caused by vectors but is prevalent in a population with a travel history to Malaria endemic areas. Although the province is not endemic for local transmission it should be noted that by the end of March 2014, 18 malaria cases were reported compared to the 8 patients in 2013. The increase was most likely caused by the movement of people from outside malaria endemic areas as all these cases were travel related. Communicable diseases often spread throughout districts, provinces and country borders.

Figure 5: Malaria cases in Northern Cape



Source: Communicable Disease Control unit line lists

Endemic Conditions

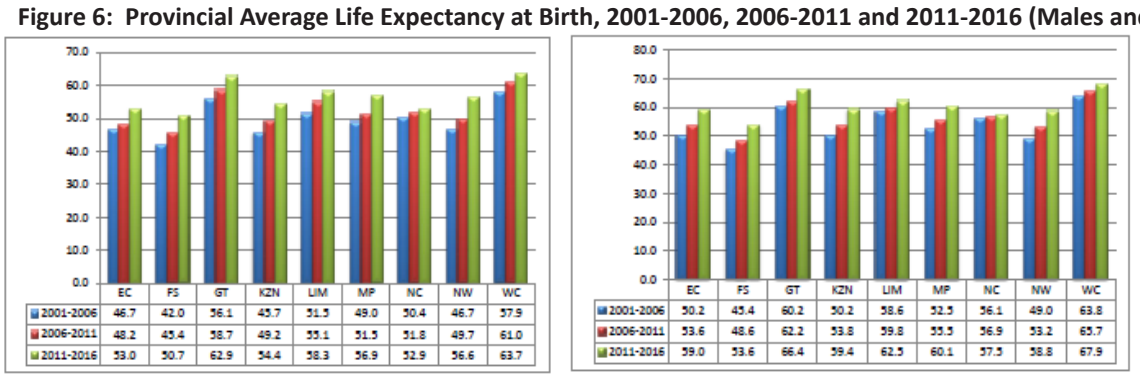
The table below depicts priority conditions reported from the period April 2013 – March 2014. Diarrhoeal diseases rank as the highest condition (5206 cases) in the Northern Cape Province. The data presented serves as a risk indicator and early warning system as it reflects the extent and effectiveness of interventions e.g. health promotion, vaccination programs. Nosocomial infections are a concern with 72 patients reported dead out of 423 cases (case fatality rate = 17%) in 2013/14.

Table 4: Number of endemic conditions during April 2013 – May 2014 (Northern Cape)

Condition	Cases	Deaths	CFR
Meningococcal Meningitis	1	1	100%
Food Poisoning	33	0	0%
Shigella/Bacillary Dysentery	5	0	0%
Rubella	10	0	0%
Acute Flaccid Paralysis (AFP)	6	0	0%
Malaria	18	0	0%
Bilhazia (Schistosomiasis)	6	0	0%
Varicella	470	0	0%
Hepatitis	Hep A =35	0	0%
	Hep B = 16	1	6.3%
	Hep C = 2	1	50%
Nosocomial or Hospital acquired Infections (HAI)	423	72	17.02%
Animal Bites	947	0	0%
Diarrheal disease	5206 (2343 cases are < 5 years)	29	0.6%

Source: Communicable Disease Weekly reports of outbreak data (2013-2014-Northern Cape)

Figure 6: Provincial Average Life Expectancy at Birth, 2001-2006, 2006-2011 and 2011-2016 (Males and Females)



Source: Mid-year population estimates, Statistics SA (2014)

According to the Mid-year population estimates 2014, the average provincial life expectancy at birth has increased for both males and females in the Northern Cape and will increase further to 52.9 years and 57.5 years for males and females respectively for the period 2011-2016 which will be measured against the National Development Plan target of 70 years for the country.

Table 5: Population suffering from chronic health conditions as diagnosed by a medical practitioner or nurse, by sex

Chronic health conditions		Thousands
Tuberculosis	Male	4
	Female	4
	Total	**9**
Heart attack / Myocardial infarction	Male	3
	Female	7
	Total	**9**
Stroke	Male	*
	Female	2
	Total	**3**
Asthma	Male	11
	Female	16
	Total	**27**
Diabetes	Male	12
	Female	25
	Total	**37**
Cancer	Male	1
	Female	1
	Total	**2**
HIV and AIDS	Male	8
	Female	10
	Total	**18**
Hypertension / High blood pressure	Male	48
	Female	95
	Total	**143**
Arthritis	Male	6
	Female	20
	Total	**25**
Other	Male	11
	Female	17
	Total	**28**
Total Population	Male	566
	Female	596
	Total	**1163**

Source: General Household Survey, Statistics SA (2013) Due to rounding numbers do not necessary add up to totals.

N.B.Values based on three of less unweighted cases are considered too small to provide accurate estimates, and values are therefore replaced by asterisks

According to General Household Survey (2013), 25.8% of the total population in the Northern Cape suffers from chronic disease and 27% of the population age five and over have some form of disability. Provision therefore needs to be made within the budget to accommodate the poorest of the poor to attain medication for their chronic illness and people living with disability to also get assistive devices.

Disabilities

Table 6: Population aged 5 years and older that have some difficulty or unable to do basic activities, by province, 2013

Degree of difficulty with which basic activities are carried out		Thousands
Seeing	Some difficulty	95
	A lot of difficulty	9
	Unable to do	4
	Total	**107**
Hearing	Some difficulty	26
	A lot of difficulty	5
	Unable to do	2
	Total	**34**
Walking	Some difficulty	27
	A lot of difficulty	9
	Unable to do	7
	Total	**43**
Remembering and concentrating	Some difficulty	21
	A lot of difficulty	7
	Unable to do	2
	Total	**30**
Self-Care	Some difficulty	25
	A lot of difficulty	9
	Unable to do	22
	Total	**57**
Communication	Some difficulty	8
	A lot of difficulty	1
	Unable to do	3
	Total	**12**
Total aged 5 years and older		**1040**

Source: General Household Survey, Statistics SA (2013) Due to rounding numbers do not necessary add up to totals.
Totals exclude the 'don't know' and 'no difficulty' options as well as unspecified.

6. OVERVIEW OF THE PERFORMANCE OF THE PROVINCIAL DOH DURING 2010/11-2014/15-

The Strategic Plan of the Department (2010/11- 2014/15) offered an opportunity to reflect on the past and shape the future and has been part of a holistic process within which it has looked at growing the service package of health services. The Key Strategic Goals, which were revised in 2011/12, aimed at addressing the manner in which the people are served and the achievement of the targets of the Health System Priorities. They were about intensifying the on-going work towards the meeting of the targets as set out in the Provincial Growth and Development Strategy which in itself has an important role to play in contextualising national imperatives and grounding them within realities and specificities of the Province.

Usable bed utilisation measures the occupancy of district hospital beds, namely the proportion of usable beds occupied over the year, and therefore measures how efficiently a hospital is using its available capacity. Bed utilisation rate (BUR) should be read in conjunction with the average length of stay (ALOS). If a high ALOS occurs in conjunction with a high bed utilisation rate (>90%), this suggests that the hospital has a high demand for beds.

An acceptable norm for Bed Utilisation Rate (BUR) is 70%, nationally. A very high bed utilisation rate (BUR) suggests that the hospital is very busy and that the quality of care provided to the patients may be compromised due to insufficient staff to provide optimal care to patients or patients might get discharged before optimal recovery due to the high demand for beds. A very low BUR may suggest that the hospital is under-utilised either because there is no need for the service in the area, or because patients choose not to use the hospital.

The BUR rates for most of the hospitals in all the districts in the Northern Cape, except Z.F Mgcawu district were not within acceptable range from the national averages for 2012/13. The re-engineering of Primary Health Care is expected to remedy this situation.

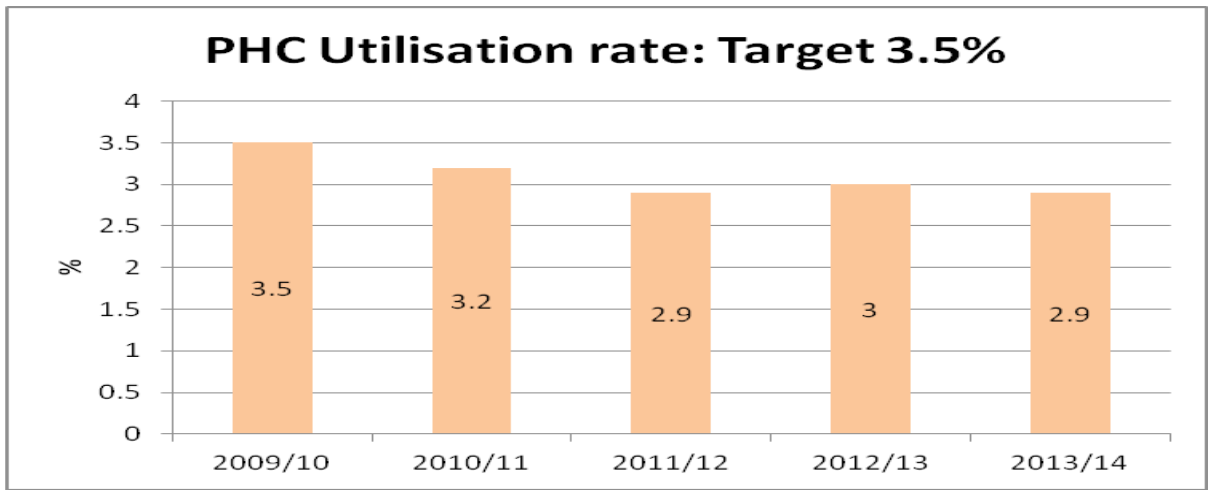
The average length of stay (ALOS) indicator measures how many days (on average) each patient spends in hospital. It measures aspects of the quality of care and efficiency of the hospital. If the ALOS is persistently high it suggests that patients spend too much time in hospital either because they are not timeously discharged or not appropriately treated resulting in longer recovery times, or they are not discharged when they should be often due to shortage of doctors in a hospital. Admission, treatment and discharge procedures should therefore be reviewed. If the ALOS is persistently low (less than 1.5 days), it could mean that patients are discharged earlier than they should be, or referral rates to other hospitals are high.

The ALOS in all the hospitals in four districts i.e. Namakwa, John Taolo Gaetsewe, Z.F Mgcawu and Pixley-Ka-Seme in the Northern Cape Province have been within acceptable range of 3.2 days from the national averages of 3.5 days for 2013/14.

The Caesarean section (C-section) rate is an important indicator of access to essential (and emergency) obstetric care and is one of the key maternal health indicators. It measures the quality of maternal and neonatal care and was within acceptable range from national averages for 2012/13, for all of the Provincial hospitals except for Prof. ZK Matthews, Manne Dipico (Colesberg), Kakamas and Postmasburg hospitals.

Key Service Delivery Issues (Including Social Determinants of Health)

Figure 7: PHC Utilisation Rate

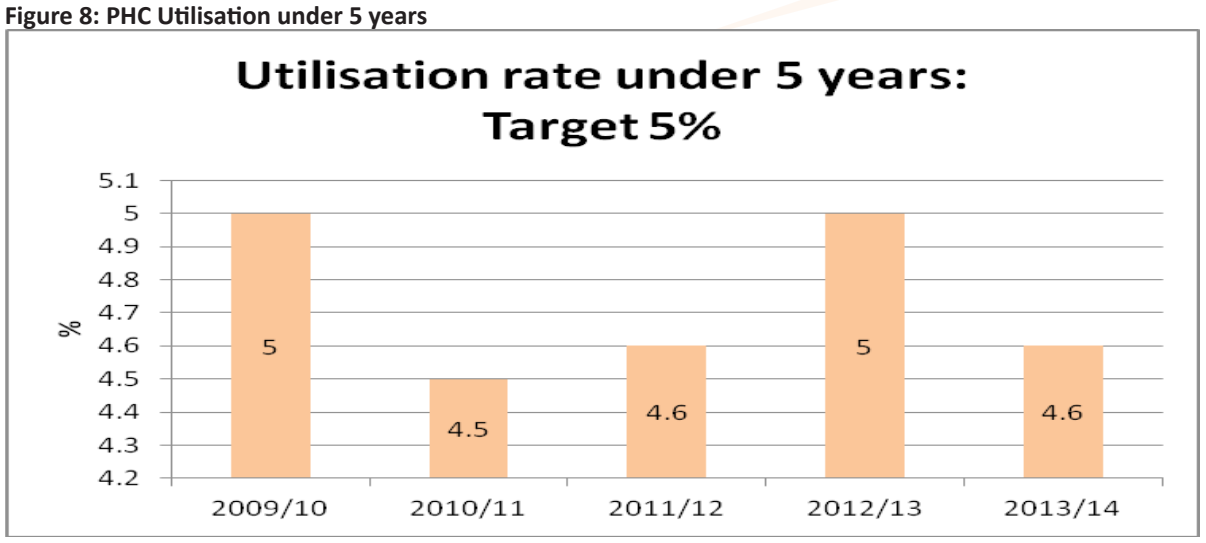


Source: Annual Reports (2009/10- 2013/14)

The primary health care (PHC) utilisation rate indicators measures the average number of PHC visits per person per year to a public PHC facility. It is calculated by dividing the PHC total annual headcount by the total catchment population. The target for the South African public health sector is 3.5 PHC visits per person per year.

Facilities have been well utilised in Northern Cape over the years at around 3.1 visits per person per year. Although this shows a good sign in the current Primary Health Re-Engineering set up, it poses a problem as the department should ensure that PHC's should be utilised more in order to reduce the referrals to other levels of care.

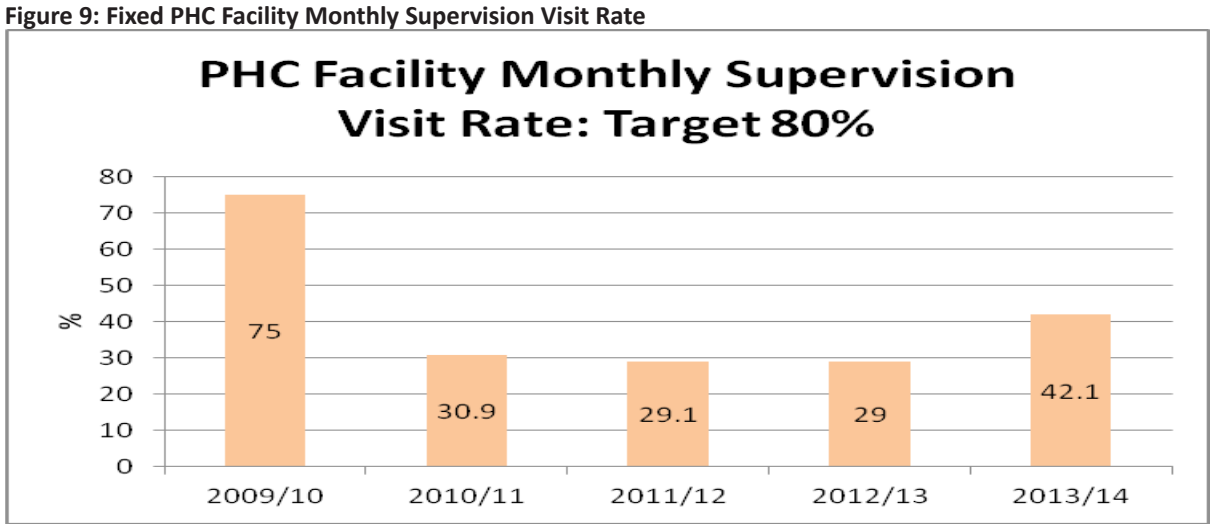
Figure 8: PHC Utilisation under 5 years



Source: Annual Reports (2009/10- 2013/14)

The PHC under 5 utilisation rate in Northern Cape has remained constant over the past four financial years. This suggests that the department is doing well and children under 5 years are utilising our PHC facilities.

Figure 9: Fixed PHC Facility Monthly Supervision Visit Rate



Source: Annual Reports (2009/10- 2013/14)

Supervisory visits provide a system for identifying and addressing problems at facility level. The supervision rate is the number of fixed PHC facilities visited by a clinical supervisor at least once a month, as a proportion of the total number of fixed PHC facilities in the district.

The Northern Cape has had the lowest supervisory visit rates in the country with 75% (2009/10), 30.9% (2010/11), 29.1% (2011/12), 29% (2012/13) and 42.1% (2013/14). This was a result of the absence of area managers and properly constituted sub-district structures. Since 2013/14 the department has started to attend to these structural deficiencies hence we experience an improvement of 42.1% although the target of 80% is not yet reached.

KEY SERVICE DELIVERY ISSUES – (INCLUDING SOCIAL DETERMINANTS OF HEALTH)

Table 7: Social Determinants of Health

Household Access to Basic Services	CENSUS 2011
Percentage of traditional and informal dwellings, shacks and squatter settlements	16.4%
Percentage of households with no access to piped (tap) water	2.6%
Percentage of households with no access to improved sanitation	22.7%
Percentage households with no access to electricity for lighting	14.6%
Percentage households with no access to refuse removal by local authority or private company	33.7%

Source: CENSUS (2011), Statistics SA

As far as access to basic services are concerned, less than three per cent (2.6%) of households in the Northern Cape Province do not have access to piped water and 22.7% are without access to improved sanitation. This implies that they are still using the bucket system, pit latrines without ventilation or have no toilet facility. These are fundamentals of health for the poor.

According to Census 2011, in terms housing, 16.4% of the population lives in traditional, informal dwellings or squatter settlements. A fairly high percentage (14.6%) of households does not have access to electricity for lighting purposes. More than a third (33.7%) of households does not have formal refuse removal by a local authority or private company. A lot of progress has been made in this regard, but more should be done to achieve some of the goals of the National Development Plan relevant to this.

Table 8: Review of progress towards the health-related Millennium Development Goals (MDGs)

MDG Goal	Target	Indicator	Source Of Data	Baseline (2009)	Progress In 2014	Target 2015/16
Goal 1: Eradicate Extreme Poverty And Hunger	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children (under five years)	DHIS	0.9/ 1000	Not more than 14 582 children presenting to health facilities with severe malnutrition	5.1/1000
Goal 4: Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate	DHIS ASSA, 2010 – Aids Committee of Actuarial Society of South Africa	6.4/ 1000 live birth	5.3/1 000 live births	5/ 1000 live births
		Infant mortality rate	ASSA, 2010 – AIDS Committee of Actuarial Society of South Africa SADHS 2003	6.8/ 1000 live births	8.1/1 000 live births	8/ 1000 live births
		Proportion of one-year-old children immunised against measles	DHIS	95.6%	92%	95%
Goal 5: Improve Maternal Health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio	Maternal Deaths Surveillance system	244/100 000	127/100 000 live births	135/ 100 000
		Proportion of births attended by skilled health personnel	DHIS	100%	100%	100%
Goal 6: Combat HIV and AIDS, Malaria and other diseases	Have halted by 2015, and begin to reverse the incidence of HIV/ AIDS, Malaria and other major diseases	HIV prevalence among 15- to 24-year-old pregnant women	National HIV and Syphilis Prevalence Survey of South Africa 2007	17.2	17.8	17.5
		Contraceptive prevalence rate	DHIS	33.2%	31.3%	45%
		Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS)	DHIS	85%	85%	85%
		Malaria case fatality	DHIS	0%	0%	0%

Table 9: Review of progress towards the Negotiated Service Delivery Agreement (NSDA) 2010- 2014

OUTPUT 1: INCREASING LIFE EXPECTANCY		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Improve Life expectancy at birth	Ensure improvement in life expectancy at birth in males (58) and females (60)	58 years for males 60 years for females

OUTPUT 2: DECREASING CHILD AND MATERNAL MORTALITY		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Decrease child and maternal mortality	Under 5 Mortality Rate (U5MR) Infant Mortality Rate Maternal Mortality Ratio Neonatal Mortality Rate (<28 days) Prevalence of underweight among children ≤59 months	5 per 1000 live births 8 per 1000 live births 135/100 000 live births 12.4 /1 000 9.5%

OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Reduce the HIV, AIDS and TB Prevention	Estimated prevalence of HIV in 15 – 49 year old women Mother to Child Transmission Rate of HIV, within 2 months of age Proportion of eligible HIV positive pregnant women initiated on ART Total number of patients (adults and children) on ART Medical Male Circumcisions Proportion of TB Treatment Success among all TB cases TB Defaulter rate at the end of TB treatment among all TB cases Percentage of HIV-TB co-infected patients who are on ART on completion of TB treatment Percentage of diagnosed MDR-TB patients who are enrolled in a TB treatment programme	7.8% <3% 95% 52 639 52 186 90% 4% 100% 100%

OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVESS		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Revitalisation of Primary Health Care	Intensify clinic supervision Improve patient satisfaction rate	80% 80%

OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVESS Health Care Financing and Management		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Costing delivery of Health Care services to prioritise and adequately finance Health system to maximise health outcome	One approved manual for costing activities at lower level to assign monetary value for delivery of health services and consequently reduce the under and over expenditure Determine appropriate and adequate baseline funding for Health care system Ensure more equitable and sustainable health care financing importantly at the Districts and Health care facilities	Unit cost data at 50% of health facilities in the Province and use of data in decision making 100% funding of Annual Performance Plan Targets 75% of health facilities will function within the allocated fund, as patient statistics and performances are used to inform resources allocation.
Maximising revenue generation and collection with emphasis on private and insured patients	Reengineer revenue generation and collection processes Ensure proper billing of services provided and effective debt collection for private and insured patients	100% Standard Operating Procedures will be implementation in all facilities to expand revenue sources 90% of revenue target collection through re-engineering of business process flows at Kimberley Hospital
Provide strategic guidance and monitoring for optimal resources use	Ensure competitive bidding processes and use of approved price index and transversal contracts to attain value for money Proper implementation of PFMA, PPPA, Treasury Regulations other laws and prescripts for sound financial management Reducing wastage and inefficiencies in the use of resources through reinforcing accountability in the use of resources.	100% compliance in terms of SCM procurement policies and principles Less than 5% of total funds in incidence of non-compliance through quarterly monitoring of output against Annual Performance Plan 2% wastage through controlling expenditure
Assets management	Strengthening of capacity of assets management unit to optimally manage the assets	100% assets record keeping

OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVESS Human Resource for Health		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Development of Scarce and Critical Skills	Provide training and bursary opportunities for Scarce and Critical Medical and Allied Health professions	50 Bursary opportunities towards Medical and allied Health professions)
Implementation of the Human Resource Plan	Review and align the Provincial Human Resource Plan with the service delivery platform	Implementing Human Resource Plan

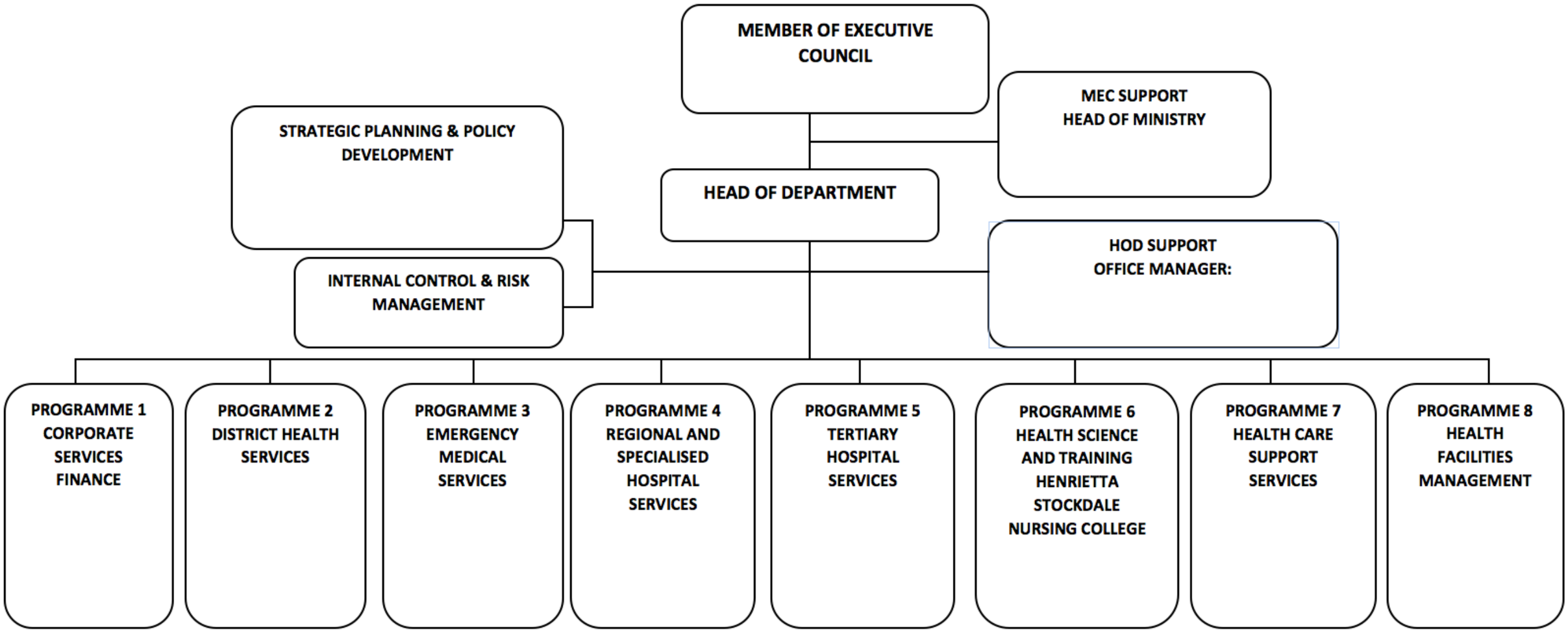
OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVESS Quality of Health and the Accreditation of Health Establishments		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Improve Quality of care in our facilities	Patient satisfaction rate Acknowledgement of Complaints within 5 days Complaints resolved within 25 working days Facilities which have been assessed for compliance with the National Core Standards Facilities compliant against the 6 priority areas of the National Core Standards (NCS) Facilities with Quality Improvement Plans Facilities with monthly Clinical audit meetings Facilities who have conducted Staff Satisfaction Survey	80% 80% of complaints received must be acknowledged 80% of complaints received must be resolved within 25 working days 100% all facilities to be assessed 100% of facilities to be complaint against the 6 Priority areas of the NCS 100% of facilities must have Quality Improvement Plans 70% of facilities 70% of facilities to participate in the Staff Satisfaction Survey

OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVESS Health Infrastructure		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Implementation of Hospital Revitalisation Programme Implementation of Infrastructure Grant for Province Implementation of Capital Infrastructure Maintenance Programme	New replacement Hospital New Clinics and Community Health Centres (CHC) Upgraded and refurbished facilities	2 New Hospitals (De Aar and Mental Health) in construction and 1 hospital in Kuruman at planning stage 1 CHC and 2 Clinics in construction Upgrades as per priority needs as defined in User Asset Management Plan and agreed by District Health Services
Implementation of Clinical Engineering Maintenance Programme	Repaired and replaced clinical equipment	Maintenance agreements for all newly purchased equipment is standard practice

OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVESS Information, Communication and Technology and Health Information Systems		
Provincial Priorities	**Planned Provincial Strategies and activities 2014/15**	**Target (Required provincial performance by 2015/16**
Improve audit outcomes on DHIS data	Appoint Performance Information Audit Improvement team Regular audits on DHMIS policy implementation Data Quality Assessments	Achieve 100% clean audit on DHIS data audit

(b) Organisational Environment

Figure 10: Senior Management Organizational Structure



Leadership and management

To improve health care services to communities and patients, the department has embarked in a process of capacitating Human Resource Management to be the one that is responsive to the people of the Northern Cape. The department structure has been reviewed to ensure that services are geared towards the Primary Health Care Model.

Between 2015 and 2020, we need to move towards a department that is more capable, more professional and more responsive to the needs of the Patient. Our Human Resource Strategy must be able to deal with areas where the department is currently at its weakest.

In transforming the quality of health care service, the department faces several challenges, some of them are external, and some of them are as a result of the limited resource capacity. Even where these challenges are external, the department can and must plan for the external drivers, such as technological change, high exit of scarce and critical skills.

We need to focus on:

- Strengthening the human resource at district level and resourcing all health facilities
- Promote quality and measuring actual performance against performance standards
- Provide and improve effective Employee Performance Management System (EPMDS)
- Responding to the human resource needs of re-engineering of Primary Health Care and NHI

In conclusion, we have put up strategies to unlock the weakest areas, tackle major problems, put the department on the right path and promote health care service excellence.

(c) Description of the Strategic Planning Process

Every five (5) years, after the election of a new government, departments have a responsibility to convert the Manifesto of the ruling party or coalition into a Programme of Action of Government. This is done through the compilation of a 5 year strategic plan by the Department with the process unfolding as follows:

- The Department hosts a Strategic Planning Session after the establishment of a new government where its Programme of Action is outlined to particularly the Senior Managers.
- All the Chief Directorates and Directorates thereafter compile their Strategic Plans aligned to the Programme of Action and priorities of the newly elected government.
- The respective Senior Managers sign their Strategic Plans off and forward to Policy and Planning Directorate that compiles a composed Draft Departmental Strategic Plan.
- The latter becomes a basis for directorates to communicate and consult each other on their respective plans and further interact with Policy and Planning to ensure that the document complies with the directives of National Treasury and the National Department of Health.
- The Draft Five Year Strategic Plan may, where it is deemed necessary or appropriate be referred to Provincial Treasury for their inputs as part of providing support to the Department of Health. The latter is also applicable to the National Department of Health.
- The Draft Five Year Strategic Plan is then tabled at a Senior Management Meeting for endorsement. Thereafter the Director for Policy and Planning, Chief Financial Officer and Accounting Officer signs the draft and forwards it to the Executive Authority for approval.
- The Executive Authority has the mandate and power to alter the draft in order that it responds adequately to the new Government mandate and or Manifesto; if or upon acceptance of the Draft Five Year Strategic Plan the Executive Authority may assent to it becoming the Five Year Strategic Plan of the Department by signature.
- The Strategic Plan is then tabled to the Provincial Legislature ten (10) days before the Executive Authority presents his/ her budget vote in the Provincial Legislature.
- Changes to the Five Year Strategic Plan can only be effected if there are major policy shifts in the course of the five year period in which it is applicable or if there are significant changes in the environment in which it was intended to be applied.
- The changes to the Five Year Strategic Plan are effected in the form of an annexure to the Annual Performance Plan (APP) of the department. They only become effective once the Annual Performance Plan is approved by both Accounting Officer and Executive Authority and tabled in the house (Legislature).
- In the subsequent years the aforementioned changes are reflected as part of the APP and not in an annexure.

Table 10: Alignment between NDP Goals 2030, Priority interventions proposed by NDP 2030 and Sub-outcomes of MTSF 2014-2019

NDP Goals 2030	NDP Priorities 2030	Sub-Outcomes 2014-2019 (MTSF)
Average male and female life expectancy at birth increased to 70 years	(a) Address the social determinants that affect health and diseases (d) Prevent and reduce the disease burden and promote health	HIV & AIDS and Tuberculosis prevented and successfully Managed
Tuberculosis (TB) prevention and cure progressively improved		
Maternal, infant and child mortality reduced		
Prevalence of Non-Communicable Diseases reduced by 28%		Maternal, infant and child mortality reduced
Injury, accidents and violence reduced by 50% from 2010 levels		
Health systems reforms completed	(b) Strengthen the health system	Improved health facility planning and infrastructure delivery
		Health care costs reduced
	(c) Improve health information systems	Efficient Health Management Information System for improved decision making
	(h) Improve quality by using evidence	Improved quality of health care
Primary health care teams deployed to provide care to families and communities		Re-engineering of Primary Health Care
Universal health coverage achieved	(e) Financing universal healthcare coverage	Universal Health coverage achieved through implementation of National Health Insurance
Posts filled with skilled, committed and competent individuals	(f) Improve human resources in the health sector	Improved human resources for health
	(g) Review management positions and appointments and strengthen accountability mechanisms	Improved health management and leadership

IMPACT INDICATORS AND TARGETS

Table 11: Key Activities that contribute towards the Medium Term Strategic Framework (MTSF) 2014 – 2019

Impact Indicator	Baseline (2009)	Baseline (2012)	2019 Targets (South Africa)	2012 Baseline (Province)	2019 Target (Province)
Life expectancy at birth: Total	56.5 years	60 years (increase of 3.5years)	63 years by March 2019 (increase of 3 years)	60 Years	60 Years
Life expectancy at birth: Male	54 years	57.2 years (increase of 3.2 years)	60.2 years by March 2019 (increase of 3 years)	58 years	58 years
Life expectancy at birth: Female	59 years	62.8 years (increase of 3.8 years)	65.8 years by March 2019 (increase of 3 years)	60 years	60 years
Under-5 Mortality Rate (U5MR)	56 per 1000 live-births	41 / 1000 live-births (25% decrease)	23 / 1000 live-births by March 2019 (20% decrease)	5.2 / 1000 live-births	4.5 / 1000 live- births
Neonatal Mortality Rate	-	14 / 1000 live-births	6 / 1000 live-births	14.8 / 1000	12 / 1000
Infant Mortality Rate (IMR)	39 per 1000 live-births	27 / 1000 live-births (25% decrease)	18 / 1000 live-births	9.9 / 1000 live-births	7.3 / 1000 live-births
Child under 5 years diarrhoea case fatality rate	-	4.2%	<2%	2.8/ 1000	1.5/ 1000
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	10.5%	11.2%
Maternal Mortality Ratio	304 per 100 000 live-births	269 per 100 000 live-births	Downward trend <100 per 100 000 live-births by March 2019	151 /100 000 live-births	120/100 000 live-births

Table 12: Strategic Goals and objectives based on the new MTSF 2014-2019

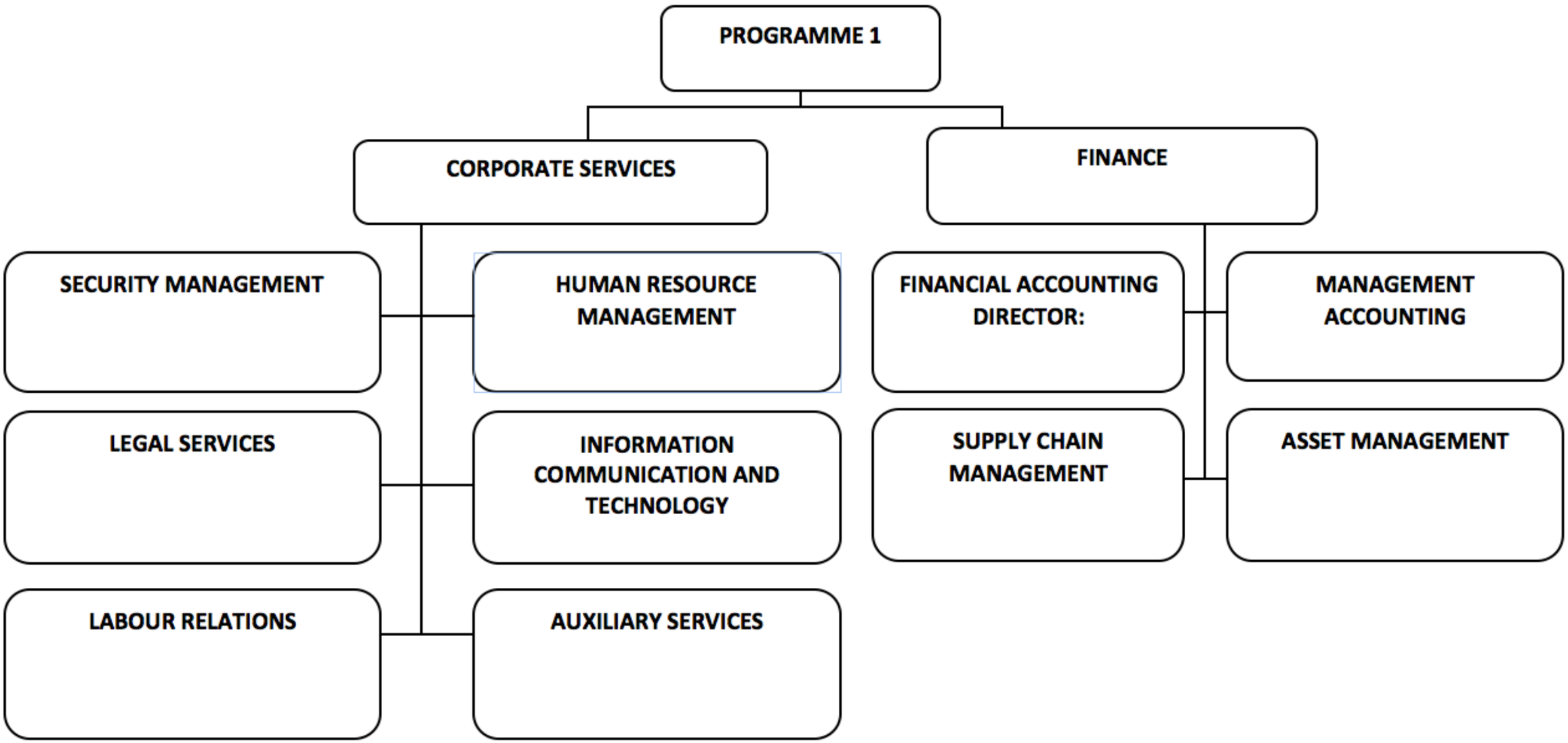
Strategic Goal	Goal Statement	Expected Outcomes (Objective Statement)
1. Universal health coverage achieved through implementation of National Health Insurance	Achieve the full implementation of NHI through the establishment of NHI fora and strengthen inputs from patients on their experience of health care services.	Expanded NHI implementation
2. Improved quality of health care	Ensure that all necessary resources are in place to render the mental health care services	Full package of psychiatric hospital services by providing 143 hospital beds
	Introduce a patient centred approach in a regional hospital	Quality health care services at regional hospital
	Ensure that all necessary resources are in place to render tertiary hospital services	Quality health care services at tertiary hospital
	Ensure that there is an improvement on pathological and clinical services in all facilities	Efficient forensic pathological services and expanded proportion of facilities offering PEP services
	Improve patient waiting times in all facilities	Improved availability and rational use of medicine
	Improving availability and management of emergency care services In all facilities	Quality ambulance services, special operations, air ambulance services, planned patient transport, obstetric ambulance services and disaster management
3. Implement the re-engineering of Primary Health Care	To expand coverage of ward based outreach teams, strengthen school health programmes and accelerate appointment of District Clinical Specialist teams within all districts	Quality primary health care services
	Improve compliance with the national core standards	Increased patient satisfaction and functional governance structures
	Introduce a patient centred approach in all district hospitals	Quality health care services in District hospitals
4. Reduced health care costs	To strengthen capacity on financial management and enhance accountability	Achieve an unqualified audit opinion from the Auditor General
5. Improved human resources for health	To develop a responsive health workforce by ensuring adequate training and accountability measures	Approved human resource for health plan that will address shortage and retention of health professionals
6. Improved health management and leadership	Strengthening leadership and governance in the department and ensuring that there is collaborative planning at all levels	Have an efficient and effective planning, good governance, stable health management and leadership across the province
7. Improved health facility planning and infrastructure delivery	Construction of new facilities, major and minor refurbishment and strengthening relationships with public works to accelerate infrastructure delivery.	Health facilities that are in accordance with national norms and standards Adequate health technology according to different levels of care
8. HIV & AIDS and Tuberculosis prevented and successfully managed	Increase access to a preventative package of sexual and reproductive health including medical circumcision and implement essential interventions to reduce HIV,TB and NCD mortality	Strengthened integration of health programmes e.g.HIV, TB , PMTCT, MCWH/N and NCD Reduced burden of diseases
9. Maternal, infant and child mortality reduced	To improve the health of mothers , babies, women and youth by reducing morbidity and mortality and promoting the quality of life	Reduced maternal, child and youth mortality and morbidity
10. Efficient health management information system developed and implemented for improved decision making	To develop a complete departmental integrated patient based information system	A web based information system for the department

PROGRAMME 1: ADMINISTRATION

(a) PROGRAMME PURPOSE

To conduct the Strategic management, technical support to core programmes and the overall administration of the Department of Health, in Northern Cape Province

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Strengthening leadership and governance in the department and ensuring that there is collaborative planning at all levels	Creation of conducive environment for effective decision making and accountability	1.	Developed Provincial Long Term Health Plan	-	1
		2.	Number of Programme performance evaluations conducted	1	6
Develop a complete system design for a national integrated patient based information system	Overhaul the health information system in order to improve communication, integration and data usage for planning and service delivery	3.	Percentage of hospitals with broadband access	-	80%
		4.	Percentage of fixed PHC facilities with broadband access	-	75%
Produce, cost and implement human resources for health plans	Implement an effective and efficient recruitment and retention strategy for health workforce	5.	Number of Provincial Human Resources for Health Plans produced	1	1
Improve Financial Management skills and outcomes for the health sector	Ensure effective financial management and accountability by improving audit outcomes	6.	Audit opinion from Auditor General of South Africa	1 qualified audit opinion	5 unqualified audit opinions

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Administration

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
1. Office Of The MEC	8,145	8,460	5,797	9,018	9,068	9,367	9,515	10,038	10,540
2. Management	99,985	144,442	165,851	155,244	151,744	174,014	167,626	176,802	186,969
Total payments and estimates	**108,130**	**152,902**	**171,648**	**164,262**	**160,812**	**183,381**	**177,141**	**186,840**	**197,509**

The budget for administration has increased by 7.8 percent per cent from 2014/15 adjusted budget without considering the once off marginal reduction of budget since the posts were still vacant during the mid-year adjustment budget. This is mainly attributed to the allocation for CFO Office capacity building specifically for supply chain management and financial management, which was marginally reduced from main budget since the posts were still vacant. The 2016/17 budget increases by 5.5 percent and the 2017/18 budget increases by 5.7 percent.

Summary of payments and estimates by economic classification: Administration

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**95,372**	**147,844**	**161,108**	**160,952**	**157,502**	**177,701**	**175,177**	**184,770**	**195,335**
Compensation of employees	42,945	66,614	88,921	101,299	97,849	99,294	106,801	113,800	120,814
Goods and services	52,427	81,113	72,014	59,653	59,653	78,225	68,376	70,970	74,521
Interest and rent on land	–	117	173	–	–	182	–	–	–
Transfers and subsidies to:	**9,136**	**1,582**	**3,824**	**199**	**199**	**411**	**207**	**218**	**229**
Provinces and municipalities	100	219	–	–	–	69	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	105	105	30	110	116	122
Households	9,036	1,363	3,824	94	94	312	97	102	107
Payments for capital assets	**2,386**	**3,477**	**6,716**	**3,111**	**3,111**	**5,269**	**1,757**	**1,852**	**1,945**
Buildings and other fixed structures	–	–	1,211	–	–	813	–	–	–
Machinery and equipment	2,386	3,477	5,368	3,111	3,111	4,101	1,757	1,852	1,945
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	137	–	–	355	–	–	–
Payments for financial assets	**1,236**	–	–	–	–	–	–	–	–
Total economic classification	**108,130**	**152,902**	**171,648**	**164,262**	**160,812**	**183,381**	**177,141**	**186,840**	**197,509**

The compensation of employees budget has increased by 5.4 percent from 2014/15 adjusted budget in line with the inflationary increases, without considering the once off marginal reduction of budget since the posts were still vacant during the mid-year adjustment budget. The goods and services increased by 14.6 percent from 2014/15 main budget. This increase is attributed to additional budget to improve the connectivity of health facilities to internet, which is necessary for health information management and financial management systems. The payments for capital assets decreased significantly due to once off procurement of machinery and equipment for administration purposes.

(e) RISK MANAGEMENT

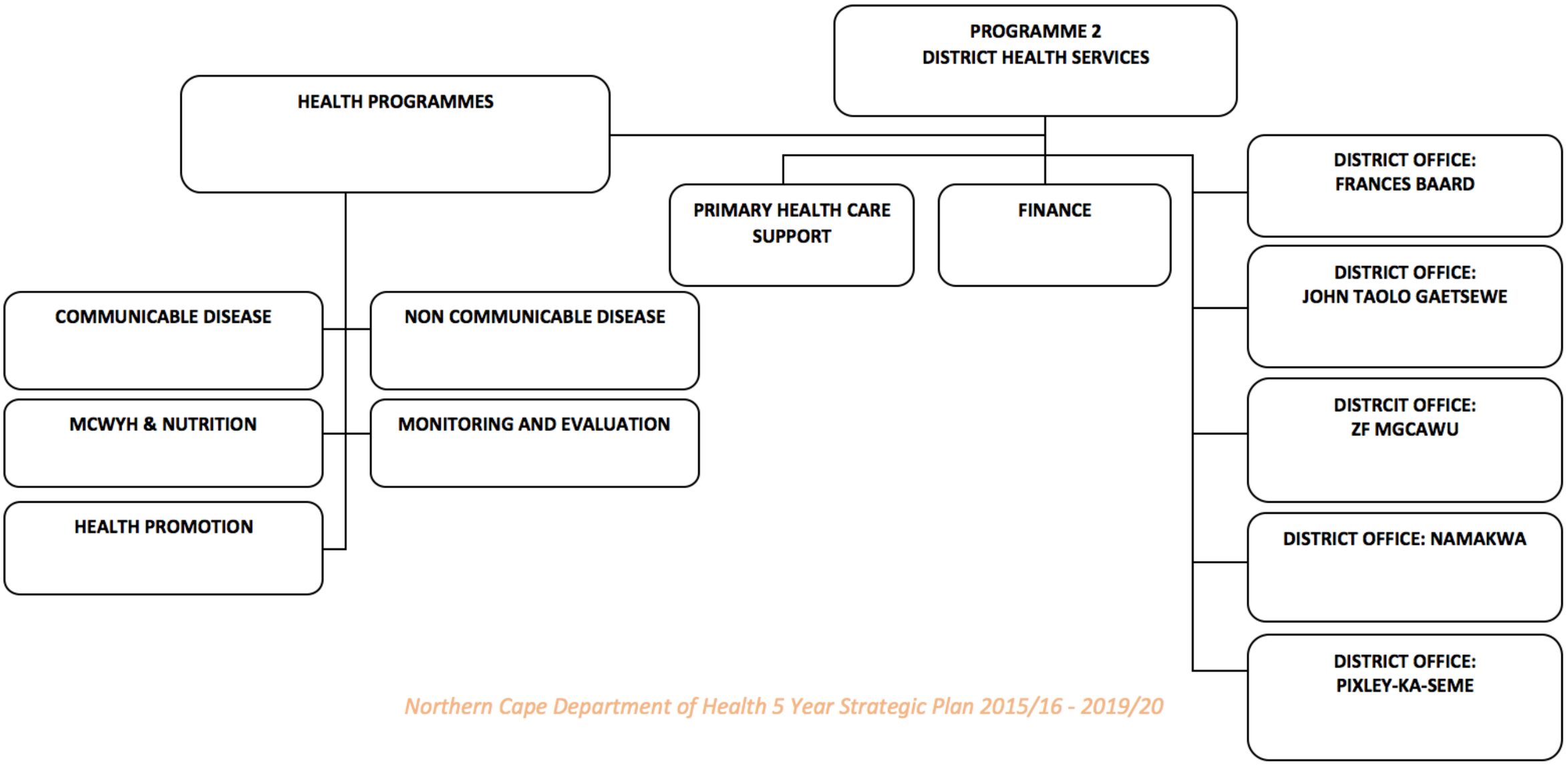
POTENTIAL RISK	RISK MITIGATION
POLICY AND PLANNING	
Inadequate compliance in submission of reports by programme managers	Management of Performance Information must be part of Performance Agreements of managers
RESEARCH AND DEVELOPMENT	
Inefficiencies or sub-standard research method and output	Improved data gathering system, training, ensure data quality and adequate funding
In adequate funding, funding of high-cost and/ or low – effect intervention	Provincial Health Research priority setting and adequate funding
HUMAN RESOURCE MANAGEMENT	
Delay in filling vacant funded post	Review of the HR delegations
Non- adherence to the overtime policy resulting into possible irregular expenditure	Facility managers to monitor the controls around overtime
FINANCIAL MANAGEMENT	
Under collection of revenue	Strengthening of the staff component of revenue management and debt collection at facility level.
Incomplete assets register	Implementation of LOGIS Appointment of personnel in the assets management division. Regular asset counts
INFORMATION, COMMUNICATION AND TECHNOLOGY	
Insufficient budget allocation for ICT	Timeous submission of budget bids to Finance and follow up discussions All 5 Districts to each do the necessary budgeting specifically for ICT needs
Telkom Infrastructure (Remote areas)	Ensure Telkom participation in planning process for connectivity and propose possible alternatives

PROGRAMME 2: DISTRICT HEALTH SERVICES, TB, HAST, MCWH AND NON-COMMUNICABLE DISEASES

(a) PROGRAMME PURPOSE

Comprehensive, integrated and sustainable health care services (preventive, promotive, curative and rehabilitative) based on the Re-engineered Primary Health Care (PHC) approach through the District Health System (DHS).

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Phased implementation of the building blocks of National Health Insurance	Achieve the full implementation of NHI through establishment of NHI Fora and strengthen inputs from patients of their experience of health care services	1.	Number of districts piloting NHI interventions	1	4
Establishment of NHI fora for engagement of non-state actors		2.	Established NHI Forum	-	1
Strengthen the input from patients on their experience on the health services		3.	Number of dialogues with patients groups on NHI	-	5
Improve compliance with National Core standards	Improve effectiveness and efficiencies in health care facilities	4.	Proportion of PHC facilities compliant with all extreme and vital measures of the national core standards for health facilities	-	70%
		5.	Proportion of District hospitals compliant with all extreme and vital measures of the national core standards for health facilities	-	100%
		6.	Percentage of Hospitals that have conducted gap assessments for compliance against the National Core Standards	-	100%
Introduce a patient-centred approach in the delivery of health services		7.	Patient Satisfaction rate at PHC facilities	80%	82%
		8.	Patient Satisfaction rate at Districts Hospitals	80%	82%
		9.	Proportion of health facilities that conduct patient satisfaction surveys at least once a year	80%	100%
		10.	Proportion of District hospitals that conduct patient satisfaction surveys at least once a year	80%	100%
Ensure quality primary health care services with optimally functional clinics by developing all clinics into Ideal	Ensure that all primary health care clinics are operating as Ideal clinics in all five districts	11.	Percentage of fixed PHC facilities scoring above 80% on the ideal clinic dashboard	-	89%
Expand coverage of ward-based primary health care outreach teams (WBPHCOTs)	To expand coverage of Ward Based Outreach Teams, Strengthen School Health Programme and accelerate the appointment of District Clinical Specialist teams	12.	Number of functional WBPHCOTs	-	194
Accelerate appointment of District Clinical specialist teams		13.	Number of districts with fully fledged district clinical specialist teams	1	5
Improved awareness and management of prevalence of NCDs through screening and counselling for high blood pressure and raised blood glucose levels		14.	Number of people counselled and screened for high blood pressure	-	333 443
		15.	Number of people counselled and screened for raised blood glucose levels	-	333 443
Screening of the population for mental health disorders	Maximising opportunity for screening and implementing a mental health strategy at least annually	16.	Percentage of people screened for mental disorders	-	30%
		17.	Percentage of people treated for mental disorders	-	1.8%
Prevent blindness through increased cataract surgery	Progressively implement programmes and systemic interventions that combat both Communicable Diseases and Non - Communicable Disease	18.	Cataract Surgery Rate	1351/1000 000	1500/1000 000
Intensify testing and screening to ensure that everyone in South Africa is tested for HIV and screened for TB at least annually	Increase access to a preventative package of sexual and reproductive health including medical circumcision and implement essential intervention to reduce HIV, TB and NCD mortality	19.	Number of men and women 15 – 49 years tested for HIV	158 459 (20.3%)	243 940 (49.5%)
		20.	Number of people screened for TB	596 633	1 000 000
Increasing access to a preventative package of sexual and reproductive health (SRH) services, including medical male circumcision	Increase access to a preventative package of sexual and reproductive health including medical circumcision and implement essential intervention to reduce HIV, TB and NCD mortality	21.	Number of male condoms distributed	7 964 800	23 000 000
		22.	Number of female condoms distributed	138 300	230 000
		23.	Number of men medically circumcised	6 544	52 186
Improve the effectiveness and efficiency of the TB		24.	TB new client treatment success rate	80%	95%
Improve TB treatment outcomes		25.	TB (new pulmonary) defaulter rate	7%	3%
Implement interventions to reduce TB mortality		26.	TB death rate	10.5% (884/8 404)	7%
Implement interventions to reduce TB mortality		27.	MDR-TB confirmed treatment initiation rate	93.7%	100%
Combat MDR by ensuring access to treatment		28.	MDR treatment success rate	21.7% (59/271) baseline based	50%

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Improve the implementation of Basic Antenatal Care and Provision of PMTCT	To Improve the health of mothers, babies, women and youth by reducing morbidity and mortality and promoting the quality of life	28.	Antenatal visits before 20 weeks rate	54%	70%
		29.	Proportion of mothers visited within 6 days of delivery of their babies	51%	65%
		30.	Antenatal client initiated on ART rate	91.9%	98%
		31.	Infant 1st PCR test positive around 6 week rate	3%	1.5%
Protection of children against vaccine preventable diseases		32.	Immunisation coverage under 1 year	97%	100%
		33.	DTaP-IPV/ HIV 3-Measles 1st dose drop-out rate	9.5%	<10%
		34.	Measles 2nd dose coverage	98.7%	95%
		35.	Child under 5 years diarrhoea case fatality rate	3.4/1000	1.5 /1000
		36.	Child under 5 years severe acute malnutrition case fatality rate	11.8%	11.2%
Ensuring effectiveness and efficiencies in health care facilities through implementing intervention strategies	Expansion and strengthening of integrated school health services	37.	School Grade 1 screening coverage	26.8%	60%
		38.	School Grade 8 screening coverage	18.3%	50%
Expand access to sexual and reproductive health by expanding availability of contraceptives and access to cervical and HPV cancer screening services	Improve awareness of sexual and reproductive health through mobilization campaigns	39.	Couple year protection rate	32%	60%
		40.	Cervical cancer screening coverage (amongst women)	34%	70%
		41.	Human Papilloma Virus coverage 1st dose (HPV vaccine coverage amongst Grade 4 girls)	-	90%
Reduce child and youth morbidity and mortality		42.	Maternal Mortality Ratio	127/100 000 live - births	120/100 000 live - births
		43.	Infant Mortality Rate	8.1 / 1000	12 / 1000

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: District Health Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
1. District Management	77,090	102,450	101,128	101,613	102,213	122,713	107,100	112,884	118,782
2. Community Health Clinics	309,080	341,657	326,983	334,437	335,704	336,379	355,546	381,031	402,025
3. Community Health Centres	173,762	185,345	213,520	248,628	247,759	229,260	263,108	276,962	291,372
4. Community Based Services	–	–	–	–	–	–	–	–	–
5. Other Community Services	53,677	52,265	94,205	72,240	74,409	76,424	76,870	81,010	85,218
6. HIV/AIDS	237,064	230,612	331,546	371,906	383,820	383,820	408,776	450,044	504,987
7. Nutrition	3,268	3,030	3,467	4,336	4,356	5,513	4,646	4,884	5,134
8. Coroner Services	–	–	–	–	–	–	–	–	–
9. District Hospitals	415,270	365,007	394,761	460,979	456,641	505,281	459,882	484,643	510,222
Total payments and estimates	**1,269,211**	**1,280,366**	**1,465,610**	**1,594,139**	**1,604,902**	**1,659,390**	**1,675,928**	**1,791,458**	**1,917,740**

The budget for district health services has increased by 4.4 percent from 2014/15 adjusted budget, due to funding shift from departments to National Health Laboratory Services. The 2016/17 and 2017/18 MTEF estimates show an increase of 6.9 percent and 7.0 percent respectively. The following policy priorities have been funded in this programme:

- Improvement of District Hospital Norms and Standards;
- Implementation of Human Papilloma Virus vaccine for the 2016/17 fiscal year; and
- Improvement of HIV/AIDS awareness, prevention and treatment activities.

Summary of payments and estimates by economic classification: District Health Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**1,203,166**	**1,218,844**	**1,386,372**	**1,490,155**	**1,473,773**	**1,525,235**	**1,562,629**	**1,674,308**	**1,794,730**
Compensation of employees	723,845	773,490	866,155	879,343	899,139	898,530	953,570	995,473	1,064,735
Goods and services	479,309	445,304	519,203	610,812	574,634	625,716	609,059	678,835	729,995
Interest and rent on land	12	50	1,014	–	–	989	–	–	–
Transfers and subsidies to:	**54,497**	**53,640**	**49,781**	**75,638**	**89,600**	**85,933**	**94,306**	**99,421**	**104,393**
Provinces and municipalities	3,283	4,439	5,133	7,862	8,462	4,632	8,881	9,353	9,821
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	49,459	47,478	41,004	63,390	76,252	76,992	80,288	84,637	88,869
Households	1,755	1,723	3,644	4,386	4,886	4,309	5,137	5,431	5,703
Payments for capital assets	**11,548**	**7,882**	**29,457**	**28,346**	**41,529**	**48,222**	**18,993**	**17,729**	**18,617**
Buildings and other fixed structures	11,066	175	-556	–	–	321	–	–	–
Machinery and equipment	482	7,707	29,706	28,346	41,529	46,597	18,993	17,729	18,617
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	307	–	–	1,304	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**1,269,211**	**1,280,366**	**1,465,610**	**1,594,139**	**1,604,902**	**1,659,390**	**1,675,928**	**1,791,458**	**1,917,740**

The compensation of employees has increased by 6.0 percent from the 2014/15 adjusted budget, without considering the once off marginal reduction of budget since the posts were still vacant during the adjustment budget. The growth for 2016/17 will be 4.4 percent, while 2017/18 will be 6.9 percent. Goods and services have increased by 7.8 percent from 2014/15 adjusted budget to ensure adequate funding for Ministerial Non-negotiable items and compliance to National Core Standards.

(e) RISK MANAGEMENT

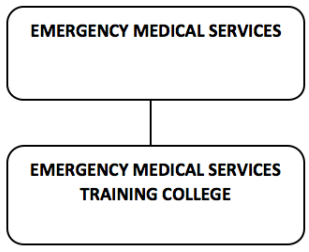
POTENTIAL RISK	RISK MITIGATION
Failure to abide by legal prescripts, protocols, guidelines SOPs and procedures	Ensure that all facilities have guidelines and protocols, SOP's and procedure manuals Regular support and supervision to districts Training of personnel on guidelines, protocols, procedures and SOP's
Exposure to personnel and patients to nosocomial infections	Strengthen infection control measures Train health care personnel on infection control Refurbish health facilities Provide protective clothing Strengthen community education
Poor drug management	Put in measures for proper drug ordering, quantification and drug supply at facility level Review SLA's and timeous payment of services
Lack of backup generators in facilities	Procure backup generators and ensure correct installation of it, scheduled service and maintenance plans
Misalignment of planning and budgeting processes	Correct budget systems at all levels Proper monitoring and evaluation of budget and expenditure Strengthening integrated planning

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

(a) PROGRAMME PURPOSE

To render Emergency Medical Services through the implementation of ambulance services, special operations, communications, planned patient transport, as well providing disaster management services in the province.

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Render an effective and efficient emergency medical services	Improving availability of management of emergency care services in all facilities	1.	EMS P1 urban response under 15 minutes rate	63%	70%
		2.	EMS P1 rural response under 40 minutes rate	47%	50%
		3.	EMS inter-facility transfer rate	New indicator	10%

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Emergency Medical Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
1. Emergency Transport	184,508	207,226	197,867	250,805	268,564	276,918	265,563	279,830	294,334
2. Planned Patient Transport	–	–	–	1,425	715	715	2,503	2,639	2,774
Total payments and estimates	**184,508**	**207,226**	**197,867**	**252,230**	**269,279**	**277,633**	**268,066**	**282,469**	**297,108**

The budget for this programme has increased by 6.2 percent from the 2014/15 adjusted budget, without considering the once off marginal reduction of budget since the posts were still vacant during the adjustment budget. The additional budget will increase the rural and urban response time. The 2016/17 and 2017/18 financial years' budget increases by 5.4 percent and 5.1 percent respectively.

Summary of payments and estimates by economic classification: Emergency Medical Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**181,296**	**180,407**	**189,193**	**221,323**	**212,813**	**212,885**	**236,626**	**251,718**	**264,820**
Compensation of employees	97,797	112,681	131,734	151,671	143,161	146,676	160,456	169,159	178,132
Goods and services	83,499	67,513	57,249	69,652	69,652	65,975	76,170	82,559	86,688
Interest and rent on land	–	213	210	–	–	234	–	–	–
Transfers and subsidies to:	**402**	**258**	**306**	**350**	**350**	**266**	**366**	**386**	**405**
Provinces and municipalities	237	202	163	320	320	166	366	386	405
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	165	56	143	30	30	100	–	–	–
Payments for capital assets	**2,810**	**26,561**	**8,368**	**30,557**	**56,116**	**64,482**	**31,074**	**30,365**	**31,883**
Buildings and other fixed structures	392	–	5,386	–	–	1,859	–	–	–
Machinery and equipment	2,418	26,561	2,917	30,557	56,116	62,571	31,074	30,365	31,883
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	65	–	–	52	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**184,508**	**207,226**	**197,867**	**252,230**	**269,279**	**277,633**	**268,066**	**282,469**	**297,108**

Compensation of employees allocation has increased by 5.8 percent from 2014/15 adjusted budget, without considering the once off marginal reduction of budget since the posts were still vacant during the adjustment budget. The budget for goods and services has been increased by 9.3 percent from the 2014/15 adjusted budget. This significant increase is made available to cover significant petrol hikes, and further improve the operational ambulance coverage. The growth rate for the 2016/17 will be 8.3 percent, while 2017/18 will be 5.0 percent. The payments for capital assets has been increased with by 1.7 percent from the 2014/15 adjusted budget, without considering the once off increase resulting from approved rollover of R25.559 million.

(e) RISK MANAGEMENT

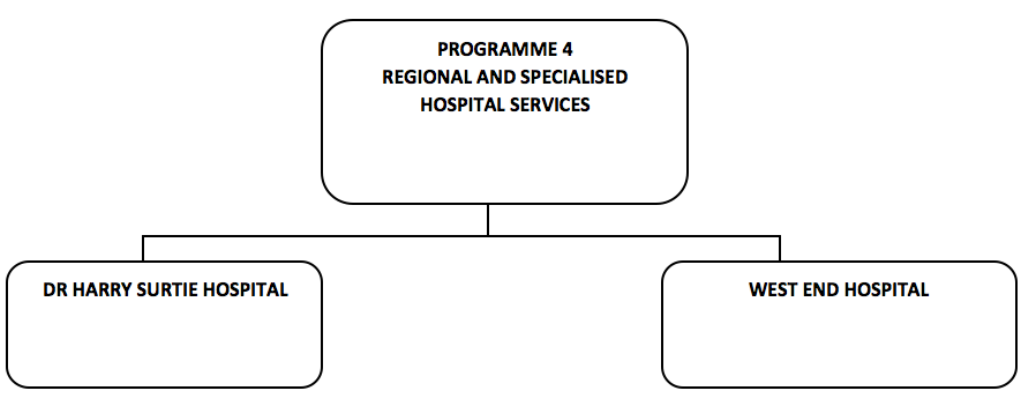
POTENTIAL RISK	RISK MITIGATION
EMERGENCY MEDICAL SERVICES	
Budgetary constraints	Budget accountability clarified and strengthened, full bottom-up costing model, fully funded and performance managed Accountable officers should have financial training
Limited ability to meet HPCSA rules on two-person crew	Recruitment of staff to vacant and funded post
Inadequate and dysfunctional control centres in the districts	Better infrastructure, furnishing, ICT, additional staff and training
Ageing ambulance fleet resulting is excessive breakdowns	Annual procurement ambulances / replacement of ambulances (life cycle management).
Limited EMS professional supervision at sub-district station and shift leaders	Supervisory appointments and training

PROGRAMME 4: REGIONAL HOSPITAL SERVICES

(a) PROGRAMME PURPOSE

Rendering of hospital services at a general and specialist level, and provide a platform for the training of health workers and research.

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Improve compliance with national core standards	Ensure that all necessary resources are in place to render regional health care services	1.	Proportion of Regional Hospitals compliant with all extreme and vital measures of the national core standards for health facilities	-	100% (1 Regional Hospital)
		2.	Percentage of hospitals that have conducted gap assessments for compliance against the National Core Standards (regional hospital)	57%	100%
Introduce a patient centred approach in the delivery of health service		3.	Proportion of Regional Hospitals that conduct patient satisfaction surveys at least once a year	-	100%
		4.	Patient Satisfaction rate at Regional Hospitals	100%	82%
Improve compliance with national core standards	Ensure that all necessary resources are in place to render mental health care services	5.	Proportion of Specialist Hospitals compliant with all extreme and vital measures of the national core standards for health facilities	100% (1 Specialised hospital)	100% (1 Specialised hospital)
		6.	Percentage of hospitals that have conducted gap assessments for compliance against the National Core Standards (specialised hospital)	-	100%
Introduce a patient centred approach in the delivery of health service		7.	Proportion of Specialised Hospitals that conduct patient satisfaction surveys at least once a year	100%	100%
		8.	Patient Satisfaction rate at Specialised Hospitals	100%	82%

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Provincial Hospital Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
1. General (Regional) Hospitals	105,696	125,533	149,624	209,777	197,227	218,422	239,738	252,894	266,070
2. Tuberculosis Hospitals	20,698	12,043	6,294	13,098	13,198	15,172	13,639	15,167	15,950
3. Psychiatric/Mental Hospitals	24,959	27,120	45,164	45,110	45,410	51,167	48,376	50,994	53,672
Total payments and estimates	**151,353**	**164,696**	**201,082**	**267,985**	**255,835**	**284,761**	**301,753**	**319,055**	**335,692**

The budget of Provincial Hospital Services has increased by 12.6 percent from the 2014/15 main budget without considering the once off marginal reduction of budget since the posts were still vacant during the adjustment budget. The sub-programme General Hospital shows an increase of 14.3 percent to accommodate the phased-in operationalization of the new Dr Harry Surtie Hospital including the appointment of the clinical staff, specialists and other health professionals. The additional budget for capacity building will improve patient satisfaction rate for regional hospital services. The growth rate for the 2016/17 will be 5.7 percent, while 2017/18 will be 5.2 percent.

Summary of payments and estimates by economic classification: Provincial Hospital Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**138,266**	**163,063**	**197,048**	**266,410**	**254,260**	**280,579**	**300,559**	**317,798**	**334,372**
Compensation of employees	92,709	110,713	140,251	187,149	174,999	180,604	215,848	228,504	240,616
Goods and services	45,553	52,350	56,782	79,261	79,261	99,960	84,711	89,294	93,756
Interest and rent on land	4	–	15	–	–	15	–	–	–
Transfers and subsidies to:	**1**	**–**	**144**	**979**	**979**	**1,136**	**1,028**	**1,082**	**1,136**
Provinces and municipalities	1	–	–	–	–	377	–	–	–
Departmental agencies and accounts	–	–	–	–	–	2	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	–	–	144	979	979	757	1,028	1,082	1,136
Payments for capital assets	**13,086**	**1,633**	**3,890**	**596**	**596**	**3,046**	**166**	**175**	**184**
Buildings and other fixed structures	9,942	–	2,826	–	–	897	–	–	–
Machinery and equipment	3,126	1,633	1,064	596	596	2,144	166	175	184
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	18	–	–	–	–	5	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**151,353**	**164,696**	**201,082**	**267,985**	**255,835**	**284,761**	**301,753**	**319,055**	**335,692**

Compensation of employees has increased by 15.3 percent from the 2014/15 adjusted budget, without considering the once off marginal reduction of budget since the posts were still vacant during the adjustment budget. The goods and services has increased by 6.8 percent from the 2014/15 adjusted budget to ensure adequate funding for Ministerial Non-negotiable items and compliance to National Core Standards.

(e) RISK MANAGEMENT

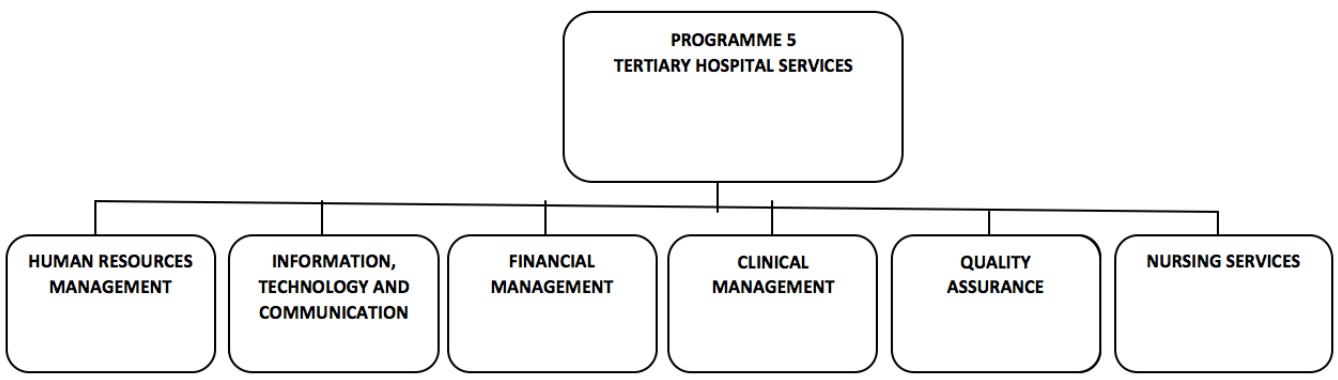
POTENTIAL RISK	RISK MITIGATION
DR HARRY SURTIE AND WEST END	
Failure of on-going treatment of discharged patient	Outreach service by District Health Feedback system from PHC to hospital Staging Regular meetings between hospital and district health Availability of palliative services
Poor Infection Control measures	Implementation of best practices, IPC policies and protocols Appointment of IPC coordinator
Safety within institution	Roll out of biometric system in high risk areas, Fire detection systems Review and update disaster plan, nurse call system, intercom, experienced trained security personnel Enforcing adherence to asset management processes
Compromise and exposure of employees Health and Safety hazards	Enforce adherence to OHS Disciplinary process

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

(a) PROGRAMME PURPOSE

To deliver Tertiary services which are accessible, appropriate, effective and provide a platform for training health professionals

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Improve compliance with national core standards	Ensure that all necessary resources are in place to render tertiary health care services	1.	Proportion of Tertiary Hospitals compliant with all extreme and vital measures of the national core standards for health facilities	-	100% (1 Tertiary hospital)
		2.	Percentage of hospitals that have conducted gap assessments for compliance against the National Core Standards (Tertiary hospital)	76%	100%
Introduce a patient centred approach in the delivery of health service		3.	Proportion of Tertiary Hospitals that conduct patient satisfaction surveys at least once a year	76%	100%
		4.	Patient Satisfaction rate at Tertiary Hospitals	72%	82%

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Central Hospital Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
1. Provincial Tertiary Hospital Services	665,511	729,538	739,655	786,472	791,172	816,370	831,184	876,798	921,771
Total payments and estimates	**665,511**	**729,538**	**739,655**	**786,472**	**791,172**	**816,370**	**831,184**	**876,798**	**921,771**

The budget for this programme has increased by 5.1 percent from the 2014/15 adjusted budget, due to funding shift from departments to National Health Laboratory Services. This is slightly below the CPI inflation rate of 5.8 percent due to reduction of National Tertiary Services Grant allocation.

The growth rate for the 2016/17 will be 5.5 percent, while 2017/18 will be 5.1 percent.

Summary of payments and estimates by economic classification: Central Hospital Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**647,415**	**695,766**	**701,498**	**764,393**	**769,093**	**792,625**	**812,880**	**860,507**	**903,899**
Compensation of employees	410,353	443,536	475,616	526,016	530,716	526,571	555,315	573,471	603,865
Goods and services	237,060	252,230	225,882	238,377	238,377	266,054	257,565	287,036	300,034
Interest and rent on land	2	–	–	–	–	–	–	–	–
Transfers and subsidies to:	**2,198**	**2,457**	**9,163**	**1,860**	**1,860**	**1,856**	**1,989**	**2,094**	**2,199**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	864	1,039	622	635	635	629	679	715	751
Households	1,334	1,418	8,541	1,225	1,225	1,227	1,310	1,379	1,448
Payments for capital assets	**15,898**	**31,315**	**28,994**	**20,219**	**20,219**	**21,889**	**16,315**	**14,197**	**15,673**
Buildings and other fixed structures	2,756	–	6,070	–	11,300	11,796	–	–	–
Machinery and equipment	13,142	31,255	22,924	20,219	8,919	10,093	16,315	14,197	15,673
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	60	–	–	–	–	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**665,511**	**729,538**	**739,655**	**786,472**	**791,172**	**816,370**	**831,184**	**876,798**	**921,771**

Compensation of employees has increased by 4.6 percent compared to the 2014/15 adjusted budget, which is below the CPI inflation rate. This is attributable to the reduction of National Tertiary Services Grant. The allocation for goods and services is increased by 8.0 percent for the 2014/15 adjusted budget. This is attributable to additional funds allocated specifically to relieve budget pressure on Ministerial Non-negotiable items such as patient catering, laboratory services, maintenance of medical equipment, medical gas and medical supplies. The payments for capital assets has been decreased by 19.3 percent; while the transfers and subsidies increased by 6.9 percent to the 2014/15 adjusted budget to cater for unexpected personnel exit.

(e) RISK MANAGEMENT

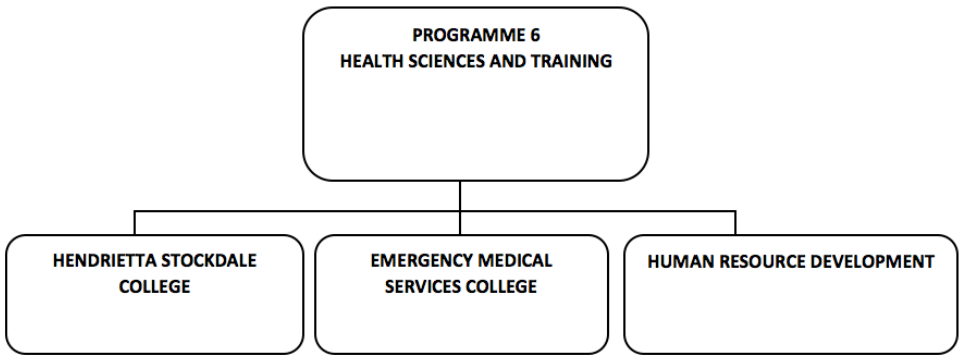
POTENTIAL RISK	RISK MITIGATION
TERTIARY HOSPITAL	
Ability to recruit and retain scarce skills	Granting of HR and financial delegations Strengthen academic support with Universities in neighboring provinces, empowerment at management level Human resource provisioning strategy
Ability of the institution to perform its mandate	Consultative budgeting process. Costing interventions. Appropriate funding as per level of care
Effective and efficient management of transversal contracts	Proper legal processes and exit clauses Consultation during tender processes for the end user Having access to SLA's / contracts Contracts to be clear on penalties for non- performance
Safety of patients, personnel and assets	Roll out of biometric system in high risk areas Fire detection, Installation of CCTV, Nurse call system Enforcing adherence to asset management processes Enforce adherence to OHS Disciplinary process In source security services
Over flooding of patients and straining of the resource base through inappropriate referrals	Adherence to referral protocols and guidelines Improve access to lower level of care e.g. extension of operational hours at PHC Establishment of district hospital in Sol Plaatje municipal area. Resourcing of district hospitals

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

(a) PROGRAMME PURPOSE

Deliver graduates who acquired basic knowledge and principles in the provisioning of nursing, emergency, medical care and other health professions to enable them to have the ability to perform basic and comprehensive health care.

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Increase production of human resources of health	To develop a responsive health workforce by ensuring adequate training and accountability measures	1.	Intake of Medicine Students increased	-	250
Train learners to qualify as professional nurses		2.	Proportion of bursary holders permanently appointed	15%	100% (65)
Ensure optimum clinical competency levels of EMS staff		3.	Number of employees enrolled for training on Intermediate Life Support	36	180

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Health Sciences

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
1. Nurse Training College	14,667	15,380	45,098	54,488	54,488	51,033	56,269	55,466	59,273
2. Ems Training College	–	–	2,043	3,810	3,810	3,810	4,031	4,253	4,465
3. Bursaries	24,569	31,974	34,861	21,562	21,562	45,040	22,619	25,381	26,650
4. Primary Health Care Training	697	36	297	1,362	1,362	424	1,429	1,505	1,580
5. Training Other	29,219	39,394	5,756	33,701	31,971	27,326	39,744	41,278	39,342
Total payments and estimates	**69,152**	**86,784**	**88,055**	**114,923**	**113,193**	**127,633**	**124,092**	**127,883**	**131,310**

The budget for this programme has increased by 7.9 percent compared to 2014/15 adjusted budget, without considering the once off marginal reduction of budget since the auxillary nurses posts were still vacant during the adjustment budget. This is attributed to the skills development levy which is based on the per cent increase in the total wage bill. The additional budget will address retention of scarce skills through the implementation of human resource plan. The allocation for the Nursing College sub-programme was affected by the reduction of Health Professionals Training and Development Grant allocation. The overall growth rate for the 2016/17 will be 3.1 percent, while 2017/18 will be 5.8 percent.

Summary of payments and estimates by economic classification: Health Sciences

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	2011/12	2012/13	2013/14	2014/15			2015/16	2016/17	2017/18
Current payments	**69,006**	**85,141**	**65,413**	**112,698**	**98,968**	**88,073**	**108,868**	**111,930**	**114,559**
Compensation of employees	23,648	32,901	27,296	47,440	45,710	33,969	50,248	52,595	55,210
Goods and services	45,358	52,240	38,113	65,258	53,258	54,104	58,620	59,335	59,349
Interest and rent on land	–	–	4	–	–	–	–	–	–
Transfers and subsidies to:	**–**	**18**	**21,075**	**77**	**12,077**	**38,257**	**12,741**	**13,441**	**14,113**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	–	–	–	–	2	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	–	18	21,075	77	12,077	38,255	12,741	13,441	14,113
Payments for capital assets	**146**	**1,625**	**1,567**	**2,148**	**2,148**	**1,303**	**2,483**	**2,512**	**2,638**
Buildings and other fixed structures	–	912	–	–	–	–	–	–	–
Machinery and equipment	146	713	1,567	2,148	2,148	1,288	2,483	2,512	2,638
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	15	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**69,152**	**86,784**	**88,055**	**114,923**	**113,193**	**127,633**	**124,092**	**127,883**	**131,310**

The compensation of employees reflect an increase by 0.2 percent of the 2014/15 adjusted budget, without considering the once off marginal reduction of budget since the posts were still vacant during the mid-year adjustment budget. This is attributed to funding for student intake which represents the monthly stipends to be paid. The goods and services grow by 13.4 percent compared to 2014/15 adjusted budget. This is attributed to the skills development levy which is based on the percent increase in the total wage bill. It will improve the training of personnel on the service platform.

(e) RISK MANAGEMENT

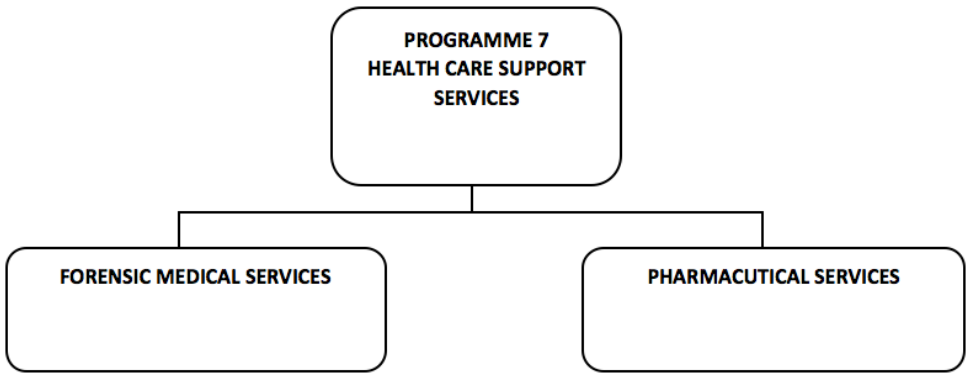
POTENTIAL RISK	RISK MITIGATION
HEALTH SCIENCES AND TRAINING	
Inadequate resources: Human e.g. high vacancy rate Physical e.g. own infrastructure and equipment Financial e.g. college budget	Appoint and fill all vacant posts Acquire own training infrastructure and satellite campuses Source own funding e.g. college budget/equitable share
Non-accredited clinical facilities Single campus for the whole province	Identify funding model for colleges
Unapproved curriculum Failure rate Absence of academic specialists	Apply for accreditation of additional clinical facilities Apply for the accreditation of satellite campuses in the districts Submit curricula for approval Recruitment of students with the correct subjects and scoring Improve recruitment and selection process. Strengthen support system for students Establish an academic support structure Subscribe to the CHE criteria for offering new nursing qualification
Low / decreased number of student intake	Promote nursing profession at schools. Open satellite campuses to increase student intake

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

(a) PROGRAMME PURPOSE

To render Health Care Support Services and specialized forensic medical and medico-legal services to meet the objectives of the department

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Render health care support services through supply of medicine to all facilities	Improve patient waiting times in all facilities	1.	Percentage availability of tracer medication (EML and STG) in the health facilities and institutions	95%	100%
		2.	Percentage of medication written off vs. medication on hand	0.1	0.05
		3.	Number of districts implementing an alternative dispensing and distribution system for chronic medicines	3	5
		4.	Average out-patient waiting time at hospital pharmacies	≤30 minutes	≤15 minutes
Render health care support service through specialised forensic medical services	Improve Forensic Medical Services	5.	Percentage of autopsies completed within 4 working days[1]	54%	90%
		6.	Percentage of autopsy reports submitted in 14 days to stakeholders (SAPS)	-	80%

The actual performance on percentage of autopsies completed for previous years (2011/12 to 2013/14) was based on performance conducted within two working days.

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Health Care Support Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
1. Laundry Services	6,060	7,077	10,483	6,309	6,359	11,824	6,639	6,999	7,368
2. Engineering	16,845	11,240	18,519	18,779	18,879	22,209	19,810	20,900	21,978
3. Forensic Services	26,606	25,615	27,179	28,333	29,610	21,507	31,547	33,275	35,010
4. Orthotic And Prostetic Services	5,368	5,802	4,850	8,408	9,822	11,414	8,815	9,286	9,760
5. Medicine Trading Account	13,242	14,707	23,493	24,845	25,005	30,200	28,294	29,821	31,374
Total payments and estimates	**68,121**	**64,441**	**84,524**	**86,674**	**89,675**	**97,154**	**95,105**	**100,281**	**105,490**

The budget for this programme has increased by 6.0 percent compared to the 2014/15 adjusted budget. The Medicine trading account sub-programme increased by 13.1 percent to improve the supply of pharmaceuticals and medical supplies to health facilities; while the Forensic services sub-programme increased by 6.5 percent to improve specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death. The Orthotic and Prosthetic Services sub-programme shows a significant decrease from adjusted budget, due to once-off increase resulting from the approved roll over request.

The growth rate for the 2016/17 will be 5.4 percent, while 2017/18 will be 5.1 percent.

Summary of payments and estimates by economic classification: Health Care Support Services

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**60,583**	**56,234**	**83,766**	**83,906**	**84,436**	**92,280**	**91,979**	**96,987**	**102,032**
Compensation of employees	31,652	34,029	52,879	56,075	56,605	58,220	60,166	63,463	66,827
Goods and services	28,931	21,941	30,816	27,831	27,831	34,056	31,813	33,524	35,205
Interest and rent on land	–	264	71	–	–	4	–	–	–
Transfers and subsidies to:	**31**	**19**	**147**	**–**	**–**	**212**	**–**	**–**	**–**
Provinces and municipalities	17	19	–	–	–	6	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	14	–	147	–	–	206	–	–	–
Payments for capital assets	**7,507**	**8,188**	**611**	**2,768**	**5,239**	**4,662**	**3,126**	**3,294**	**3,458**
Buildings and other fixed structures	7,466	6,776	117	–	–	348	–	–	–
Machinery and equipment	41	1,412	494	2,768	5,239	4,314	3,126	3,294	3,458
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**68,121**	**64,441**	**84,524**	**86,674**	**89,675**	**97,154**	**95,105**	**100,281**	**105,490**

The compensation of employees increased by 6.2 percent compared to 2014/15 adjusted budget to improve the conditions of service at the state mortuaries. The goods and services were reduced by 14.3 percent as result of a once off adjustment amount of R3.500 million previously earmarked for the allocated to TB Hospital. The payments for capital assets decreases significantly from the 2014/15 adjusted budget due to once-off increase from the approved roll over request.

(e) RISK MANAGEMENT

POTENTIAL RISK	RISK MITIGATION
PHARMACEUTICAL SERVICES	
Inadequate funding for pharmaceuticals	Earmark/ring-fence pharmaceutical budgets
Security risks at pharmacies (pilferage, lack of cameras)	Install security systems and proper monitoring and evaluation mechanisms
Non-payment of creditors on time	Weekly scheduled pro-active meetings with all Stakeholders
Late delivery of pharmaceuticals to facilities	Strengthen communication between Medical Depot and facilities

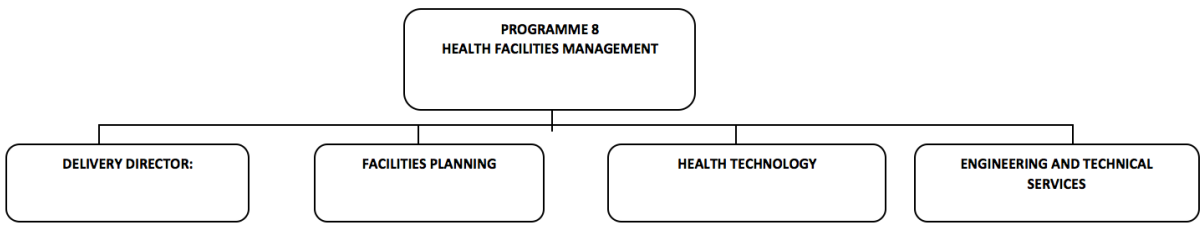
POTENTIAL RISK	RISK MITIGATION
FORENSIC MEDICAL SERVICES	
Inadequate budget	Lobby for appropriate funding and pursue sponsorships where possible to augment Reprioritise services to implement within available budget and put controls and efficiencies in place
Shortage of doctors and specialists	Lobby for appropriate funding Continue with Head-hunting process Train doctors and interest Medical Officers in Forensics Approach medical schools, negotiate with Free State for assistance and involve National Department to assist
Poor and inappropriate working environment(s)	Lobby for dedicated funding towards Upgrading and building new mortuaries including erecting park homes where possible for clinical forensic services. Lobby for finalisation of Dispute halting upgrade process of mortuaries.

PROGRAMME 8: HEALTH FACILITY MANAGEMENT

(a) PROGRAMME PURPOSE

Effective and efficient delivery of Infrastructure and provision of technical support services to the Department

(b) PROGRAMME STRUCTURE



(c) STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES

Strategic Objective	Objective Statement	No	Performance Indicator	Baseline (2013/14)	Expected Outcome Target (2019)
Major and minor refurbishment of health facilities	Construction of new facilities, major and manor refurbishment and strengthening relationships with public works to accelerate infrastructure delivery	1.	Number of health facilities that have undergone major and minor refurbishment	14	23 health facilities
Strengthen partnership with Department of Public Works to accelerate infrastructure delivery		2.	Number of provincial health departments that have established Service Level Agreements with the Departments of Public Works	-	1

(d) RESOURCE CONSIDERATIONS

Summary of payments and estimates by sub-programme: Health Facilities Management

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
1. District Hospital Services	467,395	378,130	286,816	423,543	287,453	306,996	337,792	354,260	366,430
2. Provincial Hospital Services	22,361	101,415	166,544	6,065	185,667	166,124	263,327	32,297	18,430
Total payments and estimates	**489,756**	**479,545**	**453,360**	**429,608**	**473,120**	**473,120**	**601,119**	**386,557**	**384,860**

The Health Facilities Management budget consists mainly of the Hospital Facility Revitalisation Grant. The budget for this programme has increased by 27.0 percent compared to 2014/15 adjusted budget.
This significant increase will improve the condition of various health facilities and implementation of maintenance of health facilities.

Summary of payments and estimates by economic classification: Health Facilities Management

	Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-Term Estimates		
R thousand	**2011/12**	**2012/13**	**2013/14**	**2014/15**			**2015/16**	**2016/17**	**2017/18**
Current payments	**23,624**	**8,351**	**29,710**	**25,400**	**25,430**	**33,362**	**44,668**	**47,940**	**50,408**
Compensation of employees	3,471	3,770	3,343	3,602	7,988	6,719	9,207	9,714	10,229
Goods and services	20,153	4,581	26,262	21,798	17,442	26,311	35,461	38,226	40,179
Interest and rent on land	–	–	105	–	–	332	–	–	–
Transfers and subsidies to:	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	–	–	–	–	–	–	–	–	–
Payments for capital assets	**466,132**	**471,194**	**423,650**	**404,208**	**447,690**	**439,758**	**556,451**	**338,617**	**334,452**
Buildings and other fixed structures	427,416	465,740	381,392	379,738	423,220	411,472	482,778	262,915	269,457
Machinery and equipment	38,716	5,454	42,258	24,470	24,470	28,286	73,673	75,702	64,995
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Total economic classification	**489,756**	**479,545**	**453,360**	**429,608**	**473,120**	**473,120**	**601,119**	**386,557**	**384,860**

The compensation of employees increased by 15.2 percent compared to 2014/15 main budget. This is attributable to the funding set aside for the implementation of generic organisational structure for the infrastructure management unit. The goods and services increases has doubled to cater for maintenance costs of various facilities and rigorous approach towards facility maintenance. The payments for capital assets increased by 24.2 percent. This is attributable to shift from constructing new infrastructure to preventative maintenance and also to further complete the construction of Mental Health Hospital and De Aar District Hospital.

(e) RISK MANAGEMENT

POTENTIAL RISK	RISK MITIGATION
Delays in the SCM process	Monthly monitoring of the requisitions
Insufficient budget to build new facilities and maintain existing facilities	Fully spend the allocated budget Accelerate project progress on site. Engage the office of the CFO on IYM reports and IRM reports
Lack of preventative maintenance	Establish district maintenance teams
Lack of skilled maintenance personnel	Engage HR on the establishment of maintenance staff organogram in the districts and appointment of skilled personnel

8. PART C: LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

No.	Project name	Municipality / Region	MTEF Forward estimates			IMPLEMENTING AGENT (IDT/ DRPW/ NCDOH)
R thousands			MTEF 2015/16	MTEF 2016/17	MTEF 2017/18	
1. New and replacement assets						
	New Mental Health	Frances Baard	185,000	150,000	30,000	DRPW
	Upington Hospital	Siyanda	15,000	5,000	0	DRPW
	De Aar Hospital	Pixley Ka Seme	130,000	20,000	10,000	DRPW
	Kuruman hospital	JTG	5,000	30,000	150,000	DRPW
	Heuningsvlei Clinic	JTG	10,000	10,000	0	IDT
	Ka Gung Clinic	JTG	16,000	0	0	IDT
	Williston CHC	Namakwa	20,952	60,000	25,048	IDT
	Port Nolloth CHC	Namakwa	51,000	30,000	15,000	IDT
	Springbok Hospital Pharmacy	Namakwa	2,529	10,000	10,000	DRPW
	Facility Replacements:	All				
	Boegoeberg Clinic	ZF Mgcawu	10,000	15,000	0	DRPW
	Dingleton Clinic	JTG	10,000	15,000	0	DRPW
	Vioolsdrift Clinic	Namakwa	0	15,000	10,000	DRPW
	Caroulesburg	Namakwa	0	0	15,000	DRPW
	Lerato Park Clinic	Frances Baard	0	15,000	10,000	DRPW
	Kuboes Clinic	Namakwa	0	15,000	10,000	DRPW
	Welkom Clinic	ZF Mgcawu		15,000	10,000	DRPW
	Provincial Office	Frances Baard	5,000	5,000	40,000	DRPW
	New Nursing College	Frances Baard	10,000	20,000	50,000	DRPW
	EMS College	Frances Baard	2,000	7,000	30,000	DRPW
	Namakwa Forensic Mortuary	Namakwa	0	0	20,000	DRPW
	Grant Management	Frances Baard	29,000	29,000	29,000	NCDoH
Total New infrastructure assets			**501,481**	**466,000**	**464,048**	
2. Upgrades and additions						
	Clinics, Hospitals & CHC upgrades:	Frances Baard				
	Kakamas Clinic	ZF Mgcawu	1,000			NCDoH
	Alheit Satellite Clinic	ZF Mgcawu	1,000			NCDoH
	Cillie Clinic	ZF Mgcawu	1,000			NCDoH
	Vredesvallei Satellite	ZF Mgcawu	500			NCDoH
	Griekwastad CHC	Pixley Ka Seme	3,381	5,572		NCDoH
	Breipaal Clinic	Pixley Ka Seme	500			NCDoH
	Glen Red Clinic	JTG			1,000	NCDoH
	Logobate Clinic	JTG	129			NCDoH
	Connie Vorster Hospital	Frances Baard	3,000	5,000	5,000	NCDoH
	Jan Kempdorp CHC	Frances Baard	2,000	6,000	2,000	NCDoH
	Garies Clinic	Namakwa	1,069			NCDoH
	Okiep Clinic	Namakwa	1,000			NCDoH
	Nababeep CHC	Namakwa	9,500	20,000	23,000	NCDoH
	Kimberley Hospital	Frances Baard	0	0	7,000	DRPW
	West End overnight stay	All	2,499	0	0	IDT
	Office Accomodation/Plant Engineering Workshop	Frances Baard				NCDoH
Total Upgrades and additions			**26,578**	**36,572**	**38,000**	
3. Rehabilitation, renovations and refurbishments						
	Renovation of House no.20 (Monument Road)		500	0	0	NCDoH
	Refurbishment of Tswaragano Hospital	JTG	0	10,000	20,000	DRPW

No.	Project name	Municipality / Region	MTEF Forward estimates			IMPLEMENTING AGENT (IDT/ DRPW/ NCDOH)
R thousands			MTEF 2015/16	MTEF 2016/17	MTEF 2017/18	
	Conditions Assesment	Frances Baard	0	10,000	20,000	NCDoH
	Refurbishment of Galeshewe Day Hospital	Frances Baard	3,500	5,000	3,800	DRPW
	Renovation of Kuruman Forensic Mortuary	JTG	3,000	0	0	DRPW
	Carnavon CHC Refurbishment	Namakwa	5,000	0	0	DRPW
	Refurbishment of Alexander Bay CHC	Namakwa	0	5,000	0	DRPW
Total Rehabilitation, renovations and refurbishments			**12,000**	**30,000**	**43,800**	
4. Maintenance and repairs						
	Internal Roads Upgrade	All	5,000	7,505	20,000	DRPW
	Standby Generators:	All	15,000	3,000	10,000	IDT
	Olifantshoek CHC	JTG				IDT
	Kagisho Health Centre	JTG				IDT
	Alexander Bay CHC	Namakwa				IDT
	Nababeep CHC	Namakwa				IDT
	Fraserburg CHC	Namakwa				IDT
	Brandvlei CHC	Namakwa				IDT
	Louriesfontein CHC	Namakwa				IDT
	Williston CHC	Namakwa				IDT
	Prieska CHC	Pixley Ka Seme				IDT
	Carnavon CHC	Pixley Ka Seme				IDT
	Richmond CHC	Pixley Ka Seme				IDT
	Noupoort CHC	Pixley Ka Seme				IDT
	Hopetown CHC	Pixley Ka Seme				IDT
	Pampierstad CHC	Frances Baard				IDT
	Keimoes CHC	ZF Mgcawu				IDT
	Kenhardt CHC	ZF Mgcawu				IDT
	Guardhouse & Fencing	All	10,000	10,000	10,000	IDT/ DRPW
	Building & Roof Structures Maintenance	All	5,000	30,000	50,000	NCDoH
	Medical Gas/ LP Gas	Frances Baard	3,000	3,000	3,000	IDT/DRPW
	Compliance of Electrical, pressure vessels & transformers and Health Technology Equipment (as per Regulation)	All	7,000	7,000	7,000	NCDoH
	Laundry and Kitchen Equipment	All	5,000	10,000	5,000	NCDoH
	Autoclaves	All	3,000	3,000	3,000	NCDoH
Total maintenance and repairs			**53,000**	**73,505**	**108,000**	
Total HFRG			**593,059**	**606,077**	**653,848**	
Equitable Share Projects						
	Compensation of employees		1,535	1,735	1,822	NCDoH
	Fire fighting equipment	All	3,000	5,000	5,000	NCDoH
	Solar & Plumbing Upgrade	All	10,465	10,000	10,000	NCDoH
	HVAC/ electrical	All	7,000	7,000	7,000	NCDoH
	Medical Equipment maintenance	All	2,000	2,000	2,000	NCDoH
	Laundry and Kitchen Equipment	All	1,000	1,000	1,000	NCDoH
	Plant engineering Equipment	Frances Baard	5,000	5,000	5,000	NCDoH
Total Equitable Share Projects			**30,000**	**31,735**	**31,822**	
5. Infrastructure transfers - current						
1						
…						
n						
Total Infrastructure transfers - current						
6. Infrastructure transfers - capital						
1						
…						
n						
Total Infrastructure transfers - capital						
Total Health Infrastructure			**623,059**	**637,812**	**685,670**	

9. Conditional Grants

Name Of Conditional Grant	Purpose Of The Grant	Performance Indicators	Continuation/ Discontinuation over the next 5-Years	Motivation for Continuation/ Discontinuation
Comprehensive HIV/ AIDS Conditional Grant	To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV counselling and testing. To support the implements of National operational plans for comprehensive HIV and AIDS treatment and care. To subsidise in-Part funding for the antiretroviral plan.	Total number of fixed public health facilities offering ART Services Number of new patients that started ART Total number of patients that on ART remaining in care Number of beneficiaries served by home-based categories Number of active home-based carers receiving stipends Number of Male and Female condom distributed Number of High Transmission Areas (HTA)intervention sites Number of Antenatal Care (ANC) clients initiated on long life ART Number of babies Polymerase Chain Reaction (PCR) tested at 6 weeks Number of HIV positive clients screened for TB Number of HIV positive clients that started IPT Number of active lay councillors on stipend Number of clients pre-test counselled on HIV testing (including Antenatal) Number of HIV tests done Number of health facilities offering MMC services Number of MMC performed Sexual assault cases offered ARV prophylaxis Step down care (SDC) facilities/units Doctors and professionals nurses training on HIV/ AIDS,STI,TB and chronic diseases	Continued	HIV/ AIDS is a National Priority and therefore treatment and prevention should be prioritised
National Tertiary Services Grant	To ensure provision of tertiary health services for all South African citizens To compensate tertiary facilities for the costs associated with provision of these services including cross border patients	Number of National Central and Tertiary hospitals providing components of Tertiary services	Continued	Tertiary services are the key health care services and the cost of maintaining these services cannot be afforded through equitable share funding only.

Name Of Conditional Grant	Purpose Of The Grant	Performance Indicators	Continuation/ Discontinuation over the next 5-Years	Motivation for Continuation/ Discontinuation
Health Professional Training and Development Grant	Support provinces to fund health service costs associated with training of health science trainees on the public service platform Co-funding of the National Human Resource Plan for Health in expanding undergraduate medical education for 2012 and beyond (2025)	Number of undergraduate health science trainees supervised Number of postgraduate health science trainees(excluding registrars) supervised Number of registrars supervised Number of community services health professionals and other health sciences trainees supervised	Continued	Health care training will always remain an important aspect as it is responding to the empowerment of officials who are rendering services in the Health facilities.
National Health Grant	To help accelerate construction, maintenance, upgrading, rehabilitation of new and existing infrastructure in health including, inter- alia, health technology, Organisational Development (OD) and quality assurance (QA). Supplement expenditure on health infrastructure delivered through public-private partnerships	Number of health facilities planned Number of health facilities designed Number of health facilities constructed Number of health facilities equipped Number of health facilities operationalized	Continued	As the roll-out of NHI is continuing in other districts, there will be a need for the revitalisation of infrastructure to continue. Strengthening aspect of public health care system, lays a foundation for developing contracting mechanism for various health care professionals and other private providers e.g. private hospitals
National Health Insurance Grant	Develop frameworks and models that can be used to roll out the National Health Insurance (NHI) pilots in districts and central hospitals critical to achieving the phased implementation of NHI	**Central hospitals** Strengthening revenue collection and development of alternative hospital reimbursement tools **NHI Pilot Districts** Strengthening M & E capacity Improved supply chain processes to enhance district health system performance (ordering systems, etc.); Strengthening referral systems with linkages to PHC streams	Continued	National Health Insurance is one of the key national priority. It allows the provincial department of health to test the innovations on service delivery and to undertake other health systems strengthening initiatives.

10. Public Entities

Name Of Public Entity	Mandate	Outputs	Current Annual Budget (R'thousand)	Date of next evaluation
1. N/A	-	-	-	-
2. N/A	-	-	-	-

The Department does not have any Public Entities

11. Public-Private Partnerships (PPP)

Name Of PPP	Purpose	Outputs	Current Annual Budget (R' Thousands)	Date of next evaluation
1. N/A	-	-	-	-
2. N/A	-	-	-	-

12. CONCLUSIONS

In the current set up of the Primary Health Care Re-engineering, the success to provide quality health care reforms relies entirely on the capacity of the districts to manage properly and provide leadership. As such it is critical to ensure that the structuring of functions in the department allows for delegated authority, competency and resources to implement national policies and strategies. This will enhance effective and efficient service delivery to the people of the Northern Cape.

13. ANNEXURE A

DEFINITIONS OF INDICATORS

PROGRAMME 1

Policy and Planning

Indicator title	Develop Provincial Long Term Health Plans
Short definition	Develop Provincial Long Term Health Plans aligned to NDP 2030
Purpose/importance	To ensure compliance with the goals of the NDP 2030
Source/collection of data	STATSSA, DHIS, Approved Strategic Plan and Annual Performance Plan, PFMA, Health Act, Treasury Framework for Plans, Approved Provincial Long Term Health Plan
Method of calculation	N/A
Data limitations	None
Type of indicator	Output
Calculation type	N/A
Reporting cycle	Annually
New indicator	Yes
Desired performance	Plan developed and implemented, aligned to NDP 2030
Indicator responsibility	Senior Manager Policy and Planning

Research and Epidemiology

Indicator title	Conduct Programme Performance Evaluation
Short definition	Evaluate the impact of interventions by a specific programme
Purpose/importance	Establish the effectiveness and efficiency of programme performance
Source/collection of data	Programme Evaluation Report
Method of calculation	Total number of programme performance evaluations conducted
Data limitations	N/A
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	No
Desired performance	Establish the outcomes and impact of individual programmes or intervention
Indicator responsibility	Senior Manager Research and Development

Information, Communication and Technology

Indicator title	Percentage of hospitals with broadband access
Short definition	Proportion of hospitals that have access to at least 2 Mbps connection
Purpose/importance	To ensure implementation and compliance with a national integrated patient based information system
Source/collection of data	Hospital ICT Register
Method of calculation	Total number of hospitals with a minimum of 2 Mbps connectivity/ Total number of hospitals
Data limitations	N/A
Type of indicator	Input
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	To have connectivity in all facilities
Indicator responsibility	Senior Manager Information Communication and Technology

Indicator title	Percentage of fixed PHC facilities with broadband access
Short definition	Proportion of PHC facilities s that have access to at least 512 Kbps connection
Purpose/importance	To ensure internet access at all PHC's
Source/collection of data	Network Infrastructure Report
Method of calculation	Total number of fixed PHC facilities with minimum of 512 Kbps connectivity/ Total number of fixed PHC facilities
Data limitations	N/A
Type of indicator	Input
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	To have connectivity in all facilities
Indicator responsibility	Senior Manager Information Communication and Technology

Human Resource Management

Indicator title	Number of Provincial Human Resources for Health Plans produced
Short definition	Develop provincial Human Resources for Health (HRH) Plan
Purpose/importance	To encourage DoH to plan efficiently
Source/collection of data	PERSAL and Vulindlela
Method of calculation	Number of HRP
Data limitations	N/A
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	Yes
Desired performance	Plan developed
Indicator responsibility	Senior Manager Human Resources Management

Financial Management

Indicator title	Audit opinion from Auditor General of South Africa
Short definition	Outcome of the audit conducted by Office of the Auditor General
Purpose/importance	To improve financial management
Source/collection of data	Audit Report
Method of calculation	N/A
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Categorical
Reporting cycle	Annually
New indicator	No
Desired performance	Improve on previous audit outcome
Indicator responsibility	Senior Manager Finance

PROGRAMME 2

Indicator title	Number of districts piloting NHI interventions
Short definition	Total number of Districts piloting NHI interventions using the conditional grant funding
Purpose/importance	Ensure that NHI interventions are implemented to improve health care
Source/collection of data	Activity Plans
Method of calculation	Number of Districts piloting NHI interventions
Data limitations	N/A
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	No
Desired performance	Ensure that NHI is piloted in all districts
Indicator Responsibility	Senior Manager NHI

Indicator title	Established NHI consultation Forum
Short definition	Provincial DoH has established a forum to consult non-state actors, patient and non-patient groups on NHI
Purpose/importance	To ensure that there is a forum that allows engagements with communities on NHI
Source/collection of data	Approved forum by the accounting officer, signed appointment letters
Method of calculation	Total number of NHI fora established
Data limitations	None
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	Yes
Desired performance	Ensure that all provinces have NHI fora
Indicator Responsibility	Senior Manager NHI

Indicator title	Number of dialogues with patients groups on NHI
Short definition	Total number of Districts that have been consulted by the provincial consultative forum
Purpose/importance	To ensure that there is consultation with patients on NHI
Source/collection of data	Minutes and attendance register
Method of calculation	Total number of dialogues with patients groups on NHI
Data limitations	None
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	Yes
Desired performance	Ensure that all patients are consulted on NHI
Indicator Responsibility	Senior Manager NHI

Indicator title	Proportion of PHC facilities compliant with all extreme and vital measures of the national core standards for health facilities

Short definition	Fixed health facilities that have passed all extreme measures of National Core Standards in self assessment as a proportion of fixed health facilities
Purpose/importance	Monitors quality in PHC facilities
Source/collection of data	NCS assessment tool, DHIS
Method of calculation	Total number PHC facilities compliant to all extreme measures and at least 90% of vital measures of national core standards / Number of PHC facilities that conducted national core standards self assessments to date in the current financial year
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	All PHC facilities to be compliant to all extreme measures of the National Core Standards
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	**Proportion of District Hospitals compliant with all extreme and vital measures of the national core standards for health facilities**
Short definition	District Hospitals that have passed all extreme measures of NCS in self assessment as a proportion of fixed health facilities
Purpose/importance	Monitors quality in hospitals
Source/collection of data	NCS assessment tool, DHIS
Method of calculation	Total number of District Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards / Number of District Hospitals that conducted National Core Standards self assessment to date in the current financial year
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicates better compliance/ improved monitoring the core standards
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	**Percentage of hospitals that have conducted gap assessments for compliance against the National Core Standards**
Short definition	Fixed health facilities that have conducted annual National Core Standards self assessment as a proportion of fixed health facilities. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	To track the level of compliance against National Core Standards
Source/collection of data	NCS assessment tool, DHIS
Method of calculation	Number of Hospitals that conducted National Core Standards self assessment to date in the current financial year / Total number of hospitals
Data limitations	Accuracy depends on the completeness of gap assessments
Type of indicator	Process
Calculation type	Percentage
Reporting cycle	Annually
New indicator	Yes
Desired performance	Higher percentage indicates better compliance/ improved monitoring the core standards
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	**Percentage of fixed PHC facilities scoring above 80% on the ideal clinic dashboard**
Short definition	Percentage of fixed PHC facilities scoring above 80% on the ideal clinic dashboard
Purpose/importance	Ensure that all fixed PHC facilities have perfomed above 80% on the ideal clinic dashbord
Source/collection of data	Ideal clinic assessment Tool, DHIS
Method of calculation	Number of fixed facilities scoring above 80% on the ideal clinic dashboard/ Number of fixed PHC facilities that conducted an assessment to date in the current financial year
Data limitations	Accurate reporting on ideal clinic
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	quarterly
New indicator	Yes
Desired performance	All fixed PHC facilities achieved above 80% on the ideal clinic dashboard
Indicator responsibility	Senior Manager District Health Services

Indicator title	**Patient Satisfaction Rate at PHC facilities**
Short definition	Average PHC Patient Satisfaction score of all PHC facilities that conducted the annual patient satisfaction survey
Purpose/importance	To monitor satisfaction of patients using PHC facilities
Source/collection of data	Patient Satisfaction Survey Tool
Method of calculation	Sum of Patient Satisfaction Scores of all PHC Facilities that conducted a Patient Satisfaction Survey to date in the current financial year / Total number of Fixed PHC Health facilities that conducted a Patient Satisfaction Survey to date in the current financial year
Data limitations	Generalisability depends on the number of users participating in the survey
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Higher percentage indicates better compliance to Batho Pele Principles
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	Patient Satisfaction rate at District Hospitals
Short definition	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey
Purpose/importance	Track the service satisfaction of the District Hospital users
Source/collection of data	Patient Satisfaction Survey Tool
Method of calculation	Sum of Patient Satisfaction Scores of District Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year / Total number of District Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year
Data limitations	Generalizability depends on the number of users participating in the survey
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Higher percentage indicates better levels of satisfaction in District Hospitals services
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	Proportion of health facilities that conduct patient satisfaction surveys at least once a year
Short definition	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	To monitor satisfaction of patients using PHC facilities
Source/collection of data	PSS report
Method of calculation	Total number of fixed PHC facilities that conducted a patient satisfaction survey to date in the current financial year / Total number of fixed PHC facilities (fixed clinic / CDC / CHC)
Data limitations	None
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Annually
New indicator	Yes
Desired performance	Higher percentage indicates better compliance to Batho Pele principles
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	Proportion of District hospitals that conduct patient satisfaction surveys at least once a year
Short definition	District hospitals that have conducted Patient Satisfaction Surveys. The target population will be divided by 12 in the formula to make provision for annual reporting
Purpose/importance	To measure the patients satisfaction in District Hospitals
Source/collection of data	PSS report
Method of calculation	Total number of Fixed PHC Health facilities that conducted a Patient Satisfaction Survey to date in the current financial year/Total number of Fixed PHC facilities
Data limitations	None
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that all District Hospitals has conducted patient satisfaction survey
Indicator Responsibility	Senior Manager Quality Assurance

Indicator title	Number of functional WBPHCOTs
Short definition	Outreach households registered by Ward Based Outreach Teams as a proportion of OHH in population. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	Identifies the availability of outreach services to households
Source/collection of data	Facility register PERSAL
Method of calculation	Total number of complete Ward Based Outreach teams appointed
Data limitations	N/A
Type of indicator	Input
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher number indicates greater availability of outreach services
Indicator Responsibility	Senior Manager District Health Services

Indicator title	Number of districts with fully fledged district clinical specialist teams
Short definition	Number of Districts who have DCSTs functioning with all required members, as per the Ministerial Task Team (MTT) report
Purpose/importance	Track the availability of clinical specialists in the Districts
Source/collection of data	Facility register PERSAL
Method of calculation	Number of districts with fully-fledged district clinical specialist teams / Number of districts
Data limitations	None
Type of indicator	Input
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	All facilities to have a full complement of DCST
Indicator Responsibility	Senior Manager District Health Services

Indicator title	Number of people counselled and screened for high blood pressure
Short definition	Number of clients not on treatment for hypertension screened for hypertension in PHC clinics and OPD

Purpose/importance	Ensure that all patients with high blood pressure are counselled and screened and put on treatment
Source/collection of data	Chronic disease register,DHIS
Method of calculation	Number of clients, not on treatment for hypertension, screened for hypertension
Data limitations	None
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	All hypertension patients screened , counselled and put on treatment
Indicator Responsibility	Senior Manager CDC

Indicator title	**Number of people screened and counselled for raised blood glucose levels**
Short definition	Number of clients not on treatment for diabetes screened for diabetes in PHC clinics and OPD
Purpose/importance	Ensure that all patients with diabetic patients are counselled and screened
Source/collection of data	Chronic disease register DHIS
Method of calculation	Number of clients, not on treatment for diabetes, screened for diabetes
Data limitations	None
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	All diabetes patients screened and counselled
Indicator Responsibility	Senior Manager CDC

Indicator title	**Percentage of people screened for mental disorders**
Short definition	Clients screened for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders and substance use disorders at PHC facilities
Purpose/importance	Monitors access to and quality of mental health services in PHC facilities
Source/collection of data	Facility register ,DHIS
Method of calculation	PHC Client screened for mental disorders /PHC headcount total
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that all patients that are presented with mental disorders are screened.
Indicator Responsibility	Senior Manager District Health Services

Indicator title	**Percentage of people treated for mental disorders**
Short definition	Clients treated for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders and substance use) as a proportion of clients screened for mental disorders at PHC level
Purpose/importance	Monitors access to mental health services
Source/collection of data	Facility register, DHIS
Method of calculation	Client treated for mental disorders at PHC level/ Clients screened for mental disorders at PHC level
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that all patients that are presented with mental disorders are treated
Indicator Responsibility	Senior Manager District Health Services

Indicator title	**Cataract surgery rate (uninsured population)**
Short definition	Clients who had cataract surgery per 1 million uninsured population. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	Monitor access to cataract surgery
Source/collection of data	Facility register,DHIS
Method of calculation	Cataract surgeries total /Uninsured population
Data limitations	Accuracy dependent on quality of data from health facilities
Type of indicator	Outcome
Calculation type	Rate per 1million population
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher levels reflects a good contribution to sight restoration, especially amongst the elderly population
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Number of men and women 15-49 years tested for HIV**
Short definition	Number of all clients tested for HIV, including under 15 years and antenatal clients
Purpose/importance	Monitor the number of people knowing their HIV status
Source/collection of data	HCT Register, DHIS
Method of calculation	Clients tested for HIV (incl ANC)
Data limitations	Dependant on the accurate completion of the HCT register
Type of indicator	Process

Calculation type	Number
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Higher percentage indicate increased population knowing their HIV status
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Number of people screened for TB**
Short definition	Number of people screened for TB in health facilities and at household level for symptoms of tuberculosis
Purpose/importance	To improve early TB case detection and early treatment in order to reduce transmission, reduction in diagnostic delays and improve treatment outcomes
Source/collection of data	TBregister,ETR.Net; DHIS
Method of calculation	Number of people screened for active TB in facility and/or through community outreach campaigns (TB case finding campaigns)
Data limitations	Accuracy and recording of data collected through household campaigns
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	High TB screening coverage among high risk groups e.g. informal settlement, prisons, mines, pregnant women, HIV positive people, etc.
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Number of male condoms distributed**
Short definition	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).
Purpose/importance	Track the contraceptive measures and reduce transmission of HIV and other STIs
Source/collection of data	Facility register,DHIS
Method of calculation	Total number of male condoms distributed in that month
Data limitations	Poor reporting and recording of condoms distributed to non – medical sites e.g. Taverns
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher coverage indicates better contraceptive measures which should lead to decrease in HIV/AIDS incidence
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Number of female condoms distributed**
Short definition	Female condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).
Purpose/importance	Track the contraceptive measures and measure access at community level
Source/collection of data	Facility register,DHIS
Method of calculation	Total number of female condoms distributed in that month
Data limitations	Poor reporting and recording of condoms distributed
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher coverage indicates better contraceptive measures which should lead to decrease in HIV/AIDS incidence.
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Number of men medically circumcised**
Short definition	Total medical male circumcisions performed - Records all males who are circumcised under medical supervision
Purpose/importance	Tracks the number of the MMC conducted
Source/collection of data	Facility register,DHIS
Method of calculation	Sum of Males 10 to 14 years and Males 15 years and older who are circumcised under medical supervision
Data limitations	Cultural issues
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	Increase in uptake of MMC
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**TB new client treatment success rate**
Short definition	Proportion TB patients (All types of TB) cured or those who completed treatment
Purpose/importance	Monitors success of TB treatment for All types of TB
Source/collection of data	TB register,ETR.Net, EDR.Web
Method of calculation	TB client successfully completed treatment /TB client start on treatment
Data limitations	Accuracy dependant on quality of data from reporting facility
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage suggests better treatment success rate
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	TB (new pulmonary) defaulter rate
Short definition	Proportion TB patients who were lost to follow up as a proportion of TB clients who started on treatment
Purpose/importance	Decrease defaulter rate so as to decrease the risk of TB infections
Source/collection of data	TB register,ETR.Net, EDR.Web
Method of calculation	TB client lost to follow up / TB client start on treatment
Data limitations	Accuracy dependant on quality of data from reporting facility
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	TB death rate
Short definition	TB clients who died during treatment as a proportion of TB clients started on treatment
Purpose/importance	Monitors the number of deaths caused by TB
Source/collection of data	TB register,ETR.Net (Susceptible TB); EDR.Web (MDR and XDR – TB)
Method of calculation	TB client died during treatment / TB client start on treatment
Data limitations	Some patients may die not of TB and this should be considered carefully when interpreting results
Type of indicator	Outcome/Impact
Calculation type	Percentage
Reporting cycle	Annually
New indicator	Yes
Desired performance	Lower TB related mortality coupled with improved patient management and high cure rates
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	MDR TB confirmed treatment initiation rate
Short definition	MDR TB confirmed clients started on treatment as a proportion of TB MDR confirmed clients
Purpose/importance	Monitor treatment of MDR TB patients
Source/collection of data	MDR-TB register,ETR.Net, EDR.Web
Method of calculation	TB MDR confirmed client start on treatment / TB MDR confirmed client
Data limitations	Accuracy on quality of data from reporting facility
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Monitor the number of patients initiated on MDR TB
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	MDR treatment success rate
Short definition	Proportion TB smear positive and culture positive (pulmonary TB) clients success
Purpose/importance	Monitors success of TB treatment for MDR TB clients
Source/collection of data	MDR-TB register,ETR.Net, EDR.Web
Method of calculation	TB (new pulmonary) clients success / TB (new pulmonary) client initiated on treatment
Data limitations	Accuracy dependent on quality of data from reporting facility
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Annually
New indicator	Yes
Desired performance	Increase MDR TB treatment success rate
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	Antenatal visits before 20 weeks rate
Short definition	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits
Purpose/importance	Utilisation of ANC services
Source/collection of data	Antenatal register,DHIS
Method of calculation	Antenatal 1st visits before 20 weeks **/** Antenatal 1st visit total
Data limitations	Reliant on accurate assessment of the number of weeks each antenatal client is pregnant
Type of indicator	Process
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicates better access to antenatal care
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	Proportion of mothers visited within 6 days of delivery of their babies
Short definition	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities
Purpose/importance	Monitors access to and utilisation of postnatal services. May be more than 100% in areas with low delivery in facility rates if many mothers who delivered outside health facilities used postnatal visits within 6 days after delivery
Source/collection of data	Facility register, DHIS
Method of calculation	Mother postnatal visit within 6 days after delivery/Delivery in facility total
Data limitations	None

Type of indicator	Quality
Calculation type	Proportion
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that all mothers receive postnatal care within 6 weeks after delivery
Indicator Responsibility	Senior Manager MCWH

Indicator title	**Antenatal clients initiated on ART rate**
Short definition	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART
Purpose/importance	Monitor the effective implementation of the PMTCT Programme
Source/collection of data	Antenatal Registers, DHIS
Method of calculation	Antenatal clients started on ART / Antenatal clients eligible for ART initiation
Data limitations	Dependant on the accurate completion of the Antenatal registers
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	All pregnant HIV-positive or exposed women receive appropriate treatment as per PMTCT Policy & Protocol
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Infant 1st PCR test positive around 6 week rate**
Short definition	Infants tested PCR positive for the first time around 6 weeks after birth as proportion of infants PCR tested around 6 weeks
Purpose/importance	Measure mother to child transmission rate
Source/collection of data	Facility register,DHIS
Method of calculation	Infant 1st PCR test positive around 6 weeks **/** Infant 1st PCR test around 6 weeks
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Lower percentage indicates fewer infants received HIV from their mothers
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Immunisation coverage under 1 year**
Short definition	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	Monitor the implementation of Extended Programme in Immunisation (EPI)
Source/collection of data	Facility register,DHIS
Method of calculation	Immunised fully under 1 year / Population under 1-year
Data limitations	Reliant on under 1 population estimates from Stats SA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered)
Type of indicator	Output
Calculation type	Percentage Annualised
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicate better immunisation coverage
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**DTaP-IPV/HIB 3-measles 1st dose drop-out rate**
Short definition	Proportion children who dropped out of the immunisation schedule between DTaP-IPV-HepB-Hib 3rd dose, normally at 14 weeks and measles 1st dose, normally at 9 months
Purpose/importance	Monitors children who drops out of the vaccination program after 14 week vaccination. Vaccines given as part of mass vaccination campaigns should not be counted here. DTaP-IPV-HepB-Hib (also known as Hexaxim) will be implemented in 2015 and DTaP-IPV/Hib (Pentaxim) will be phased out as stocks are replaced with Hexaxim.
Source/collection of data	Facility register DHIS
Method of calculation	DTaP-IPV / HIB 3 to Measles 1st dose drop-out/ DTaP-IPV/HIB 3rd dose
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that all children who dropped out in 14 weeks are vaccinated
Indicator Responsibility	Senior Manager MCHW

Indicator title	**Measles 2nd dose coverage**
Short definition	Children 1 year (12-23 months) who received measles 2nd dose, normally at 18 months as a proportion of population under 1 year. The population will be divided by 12 in the formula to make provision for annual reporting. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	Monitors protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here
Source/collection of data	Facility register,DHIS

Method of calculation	Measles 2nd dose/ Population 1 year
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that children are protected against measles
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Child under 5 years diarrhoea case fatality rate**
Short definition	Children under 5 years admitted with diarrhoea who died as a proportion of children under 5 years with diarrhoea admitted
Purpose/importance	Monitors treatment outcome for children under 5 years who were admitted with diarrhoea. Include under 1 year diarrhoea deaths
Source/collection of data	Midnight count census register,DHIS
Method of calculation	Child under 5 years with diarrhoea deaths / Children under 5 years diarrhoea admitted
Data limitations	Reliant on accuracy of diagnosis / cause of death
Type of indicator	Outcome
Calculation type	Rate
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Lower children mortality rate is desired
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Child under 5 years severe acute malnutrition case fatality rate**
Short definition	Children under 5 years admitted with severe acute malnutrition who died as a proportion of children under 5 years pneumonia admitted
Purpose/importance	Monitors treatment outcome for children under 5 years who were admitted with severe acute malnutrition. Includes under 1 year severe acute malnutrition deaths
Source/collection of data	Midnight count census register,DHIS
Method of calculation	Child under 5 years severe acute malnutrition deaths / Children under 5 years severe acute malnutrition admitted
Data limitations	Reliant on accuracy of diagnosis / cause of death
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Lower children mortality rate is desired
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Schools Grade 1 screening coverage**
Short definition	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package
Purpose/importance	Monitors implementation of the Integrated School Health Program (ISHP)
Source/collection of data	School health register,DHIS
Method of calculation	School Grade 1 - learners screened / School Grade 1 - learners total
Data limitations	N/A
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicates greater proportion of school children received health services at their school
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Schools Grade 8 screening coverage**
Short definition	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package
Purpose/importance	Monitors implementation of the Integrated School Health Program (ISHP)
Source/collection of data	School health register,DHIS
Method of calculation	School Grade 8 - learners screened / School Grade 8 - learners total
Data limitations	N/A
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicates greater proportion of school children received health services at their school
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Couple year protection rate**
Short definition	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year
Purpose/importance	Track the extent of the use of contraception (any method) amongst women of child bearing age
Source/collection of data	Facility register,DHIS
Method of calculation	Contraceptive years dispensed : Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) +) + (Subdermal implant x3) + Male condoms distributed / 200) + (Female condoms distributed / 200) + (Male sterilisation x 20) + (Female sterilisation x 10 / Population 15-49 years females
Data limitations	Reliant on accuracy of data collection
Type of indicator	Output

Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicates higher usage of contraceptive methods
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Cervical Cancer Screening coverage**
Short definition	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	Monitors implementation of policy on cervical screening
Source/collection of data	Facility register, DHIS
Method of calculation	Cervical cancer screening in woman 30-years and older / Population 30 years and older female / 10
Data limitations	Reliant on population estimates from Stats SA for women in age category 30 years and older and accurate recording of women screened according to the policy (i.e. correct age group AND counted only once every 10 years)
Type of indicator	Output
Calculation type	Percentage Annualised
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicate better cervical cancer coverage
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**HPV 1st dose coverage 1st dose (HPV Vaccine coverage amongst 9 and 10 year old girls)**
Short definition	Proportion of girls 9 years and older which received the HPV 1st dose
Purpose/importance	Monitors the HPV Vaccine coverage
Source/collection of data	HPV register,DHIS
Method of calculation	Girls 9 years and older that received HPV 1st dose / Grade 4 girl learners ≥ 9 years
Data limitations	Reliant on accuracy of the number of Grade 4 girls estimated by DBE
Type of indicator	Output
Calculation type	Percentage Annualised
Reporting cycle	Annually
New indicator	No
Desired performance	Higher percentage indicate better coverage
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Maternal Mortality Ratio**
Short definition	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 1000 live births n facility
Purpose/importance	Monitors maternal deaths in facilities
Source/collection of data	Maternity registers, DHIS
Method of calculation	Maternal death in facility / Live births in facility
Data limitations	Reliant on accuracy of classification of inpatient death
Type of indicator	Outcome
Calculation type	Ratio per 100 000 live births
Reporting cycle	Annually
New indicator	No
Desired performance	Reduction of maternal deaths
Indicator Responsibility	Senior Manager Health Programmes

Indicator title	**Infant Mortality Rate**
Short definition	Early neonatal deaths (0-7 days) as a proportion of infants who were born alive in health facilities
Purpose/importance	Monitors trends in early neonatal deaths in health facilities. Indication of health system results in terms of antenatal, delivery and early neonatal care
Source/collection of data	Midnight count census register, DHIS
Method of calculation	Inpatient death early neonatal / Live births in facility
Data limitations	Reliant on accuracy of classification of inpatient death
Type of indicator	Outcome
Calculation type	Ratio per 1000
Reporting cycle	Annually
New indicator	Yes
Desired performance	Reduction of neonatal deaths
Indicator Responsibility	Senior Manager Health Programmes

Programme 3: Emergency Medical & Patient Transport Services

Indicator title	**EMS P1 urban response under 15 minutes rate**
Short definition	Emergency P1 calls in urban locations with response times under 15 minutes as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time of the first dispatched medical resource arrives on scene
Purpose/importance	Monitors compliance with the norm for critical ill or injured clients to receive EMS within 15 minutes in the urban areas
Source/collection of data	Call recording cards/tally sheets
Method of calculation	EMS P1 urban response under 15 minutes / EMS P1 urban calls
Data limitations	Accuracy dependant on quality of data from reporting EMS station
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly

New indicator	No
Desired performance	Higher percentage indicate better response times in the urban areas
Indicator responsibility	Senior Manager Emergency Medical Services

Indicator title	**EMS P1 rural response under 40 minutes rate**
Short definition	Emergency P1 calls in rural locations with response times under 40 minutes as a proportion of EMS P1 rural call
Purpose/importance	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 40 minutes in rural areas
Source/collection of data	Call recording cards/tally sheets
Method of calculation	EMS P1 rural response under 40 minutes / EMS P1 rural calls
Data limitations	Accuracy dependant on quality of data from reporting EMS station
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher percentage indicate better response times in the rural areas
Indicator responsibility	Senior Manager Emergency Medical Services

Indicator title	**EMS inter-facility transfer rate**
Short definition	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported
Purpose/importance	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses
Source/collection of data	DHIS
Method of calculation	EMS inter-facility transfer / EMS clients total
Data limitations	Accuracy dependant on quality of data from reporting EMS station
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	To improve quality patient care
Indicator responsibility	Senior Manager Emergency Medical Services

Programme 4: Regional and Specialised Hospitals

Indicator title	**Proportion of (Regional / Specialised Hospitals) compliant with all extreme and vital measures of the national core standards for health facilities**
Short definition	Hospitals that have passed all extreme measures of NCS in self assessment as a proportion of fixed health facilities
Purpose/importance	Monitors quality in hospitals
Source/collection of data	Assessment reports
Method of calculation	Total number hospitals that are compliant to all extreme measures and at least 90% of vital measures of National Core Standards / Total number of hospitals that conducted national core standards self assessment to date in the current financial year
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Higher number indicates greater number of facilities compliant to all extreme measures of National Core Standards
Indicator responsibility	Senior Manager Quality Assurance

Indicator title	**Percentage of hospitals that have conducted gap assessments for compliance against the National Core Standards**
Short definition	Fixed health facilities that have conducted annual National Core Standards self assessment as a proportion of fixed health facilities. The population will be divided by 12 in the formula to make provision for annualisation
Purpose/importance	Tracks the levels of compliance against the core standards
Source/collection of data	Assessment reports
Method of calculation	Number of Hospitals that conducted National Core Standards self assessment to date in the current financial year / Total number of Hospitals
Data limitations	None
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Compliance with the core standards in Regional Hospitals
Indicator responsibility	Senior Manager Quality Assurance

Indicator title	**Proportion of Regional / Specialised Hospitals that conduct patient satisfaction surveys at least once a year**
Short definition	The measurement of Regional/ Specialised Hospitals conducting patient satisfaction survey at least once a year
Purpose/importance	To monitor satisfaction of patients using regional and specialised hospitals
Source/collection of data	Patient Satisfaction Survey report
Method of calculation	Total number of Regional or Specialised Hospitals that conducted a patient satisfaction survey to date in the current financial year / Total number of Regional and Specialised Hospitals
Data limitations	None
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes

Desired performance	Ensure that all Regional and Specialised Hospital are conducting Patient Satisfaction Survey Annually
Indicator responsibility	Senior Manager Regional or Specialised Services

Indicator title	**Patient Satisfaction rate at Regional / Specialised Hospitals**
Short definition	Average patient satisfaction score of all Hospitals that conducted the annual patient satisfaction survey
Purpose/importance	Track the service satisfaction of the Regional / Specialised Hospital users
Source/collection of data	Patient Satisfaction Survey Report
Method of calculation	Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year / Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year
Data limitations	Generalizability depends on the number of users participating in the survey
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Compliance with core standards at Regional / Specialised Hospital
Indicator responsibility	Senior Manager Quality Assurance

Programme 5: Tertiary Hospitals

Indicator title	**Proportion of Tertiary Hospitals compliant with all extreme and vital measures of the national core standards for health facilities**
Short definition	Hospitals that have passed all extreme measures of NCS in self assessment as a proportion of fixed health facilities
Purpose/importance	Monitors quality in hospitals
Source/collection of data	Assessment reports
Method of calculation	Total number hospitals compliant to all extreme measures and at least 90% of vital measures of National Core Standards / Number of tertiary hospitals that have conducted national core standards self assessment to date in the current financial year
Data limitations	N/A
Type of indicator	Outcome
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Higher number indicates greater number of facilities compliant to all extreme measures of National Core Standards
Indicator responsibility	Senior Manager Quality Assurance

Indicator title	**Percentage of Hospitals that have conducted gap assessments for compliance against the National Core Standards**
Short definition	Percentage of Hospitals that have conducted gap assessments for compliance against the National Core Standards
Purpose/importance	To track level compliance against National Core Standards
Source/collection of data	Assessment reports
Method of calculation	Total number of hospitals that have conducted gap assessments against the National Core Standards / Total number of tertiary hospitals
Data limitations	Accuracy depends on the completeness of gap assessments
Type of indicator	Process
Calculation type	Percentage
Reporting cycle	Annually
New indicator	Yes
Desired performance	Higher percentage indicates better compliance/ improved monitoring the core standards
Indicator responsibility	Senior Manager Quality Assurance

Indicator title	**Proportion of Tertiary hospitals that conduct patient satisfaction surveys at least once a year**
Short definition	The measurement of Tertiary Hospital conducting patient satisfaction survey at least once a year
Purpose/importance	To monitor satisfaction of patients using tertiary hospital
Source/collection of data	Patient Satisfaction Survey report
Method of calculation	Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year / Total number of Hospitals
Data limitations	None
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Ensure that a Tertiary Hospital conducted patient satisfaction survey annually
Indicator responsibility	Senior Manager Tertiary Hospital

Indicator title	**Patient Satisfaction rate at Tertiary Hospitals**
Short definition	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey
Purpose/importance	Track the service satisfaction of the Tertiary Hospital users
Source/collection of data	Patient Satisfaction Survey Tool
Method of calculation	Sum of Patient Satisfaction Scores Tertiary Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year / Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year
Data limitations	Generalizability depends on the number of users participating in the survey
Type of indicator	Quality
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	Compliance with the core standards in n in Tertiary Hospital
Indicator responsibility	Senior Manager Quality Assurance

Programme 6: Health Sciences and Training

Indicator title	Intake of medicine students increased
Short definition	Number of Bursaries awarded for first year medicine students
Purpose/importance	To address the shortage of doctors
Source/collection of data	Registrar database
Method of calculation	Number of Medicine Students
Data limitations	None
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	Yes
Desired performance	Higher levels of intake are desired, to increase the availability of Medical Officers in future
Indicator responsibility	Human Resources Development Programme

Indicator title	Proportion of bursary holders permanently appointed
Short definition	Proportion of bursary holders that go on to be permanently employed
Purpose/importance	Tracks the absorption of bursary holders into the system
Source/collection of data	Bursary database
Method of calculation	Bursary holders permanently appointed / Total number of bursary holders
Data limitations	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions
Type of indicator	Impact
Calculation type	Percentage
Reporting cycle	Annually
New indicator	No
Desired performance	High uptake signifies increasing skills mix in the public sector and value for money with respect to bursaries
Indicator responsibility	Senior Manager Human Resources Management

Indicator title	Number of employees enrolled for training on Intermediate Life Support
Short definition	To train EMS employees on Intermediate Life Support
Purpose/importance	To develop and capacitate employees and improve quality of patient care
Source/collection of data	PERSAL
Method of calculation	Budget spent on Maintenance / Total maintenance budget
Data limitations	Depends on the number of persons that meet the course pre-requisites
Type of indicator	Impact
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	More EMS employees with higher levels of skills
Indicator responsibility	Senior Manager Emergency Medical Services College

Programme 7: Health Care Support Services
Forensic Medical Services

Indicator title	Percentage of autopsies completed within four working days
Short definition	Percentage of post-mortems done from time of arrival of body at the mortuary until the time of actual post-mortem performance
Purpose/importance	To improve turn-around time of autopsies
Source/collection of data	Death registers and dockets, Post-mortem reports
Method of calculation	Total number of post-mortems conducted in four days per quarter / Total number of post-mortems conducted in the quarter
Data limitations	Poor record keeping
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	To achieve 80% of post-mortems in four days
Indicator responsibility	Senior Manager Forensic Medical Services

Indicator title	Percentage of autopsy reports submitted in 14 days to stakeholders (SAPS)
Short definition	Percentage of post-mortem reports submitted to stakeholders (SAPS) 14 days after actual post-mortem performance
Purpose/importance	To improve turn-around time of autopsy reports
Source/collection of data	Acknowledgement of receipt registers, Weekly and Monthly reports
Method of calculation	Total number of post-mortem reports submitted in 14 days per quarter / Total number of unnatural post-mortems done in quarter
Data limitations	Timeous completion and submission of report
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Timely submission of report to stakeholders
Indicator responsibility	Senior Manager Forensic Medical Services

Pharmaceutical Services

Indicator title	Percentage availability of tracer medication (EML and STG) in health facilities and institutions
Short definition	Percentage of tracer medicines that were requested versus replaced
Purpose/importance	Provide tracer medication in all facilities
Source/collection of data	Stock management report
Method of calculation	Quantities replaced / Quantities requested
Data limitations	Systemic challenges, Inaccurate data capturing
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	No
Desired performance	Keep optimal levels of stock
Indicator responsibility	Senior Manager Pharmaceutical Services

Indicator title	Percentage of medication written off / medication on hand
Short definition	Percentage of medication written off
Purpose/importance	Reduce shrinkage/obsolete/expiries of medication in facilities
Source/collection of data	Stock management report
Method of calculation	Value of medication written off / Total medication available at the end of second and fourth quarters
Data limitations	Accuracy of data dependant on facility recording the expired medication on the system
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Bi-annually
New indicator	No
Desired performance	To reduce medication losses (expired and damaged medication) within the 1% target
Indicator responsibility	Senior Manager Pharmaceutical Services

Indicator title	Number of districts implementing an alternative dispensing and distribution system for chronic medicines
Short definition	Number of districts implementing an alternative dispensing and distribution system for chronic medicines
Purpose/importance	Facilitate improved access to chronic medication
Source/collection of data	Facility pharmaceutical registers
Method of calculation	Total number of districts implementing an alternative dispensing and distribution system for chronic medicines
Data limitations	Poor record keeping
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	Improve accessibility to chronic medication
Indicator responsibility	Senior Manager Pharmaceutical Services

Indicator title	Average out-patient waiting time at hospital pharmacies
Short definition	Reduce out-patient waiting time.
Purpose/importance	Improve turn-around time on waiting period
Source/collection of data	Patient Time Register
Method of calculation	Sum of weekly average times/by the number of weeks
Data limitations	Poor record keeping
Type of indicator	Efficiency
Calculation type	Rate
Reporting cycle	Quarterly
New indicator	No
Desired performance	Reduced waiting time
Indicator responsibility	Senior Manager Pharmaceutical Services

Programme 8: Health Facilities Management

Indicator title	Number of health facilities that have undergone major and minor refurbishment
Short definition	Total number of health facilities that have undergone full major and minor refurbishment
Purpose/importance	Ensure that all health facilities that major and minor refurbishment are fully done
Source/collection of data	Infrastructure Register, IRM, National Health Reports, Quarterly and Monthly Reports
Method of calculation	Total number health facilities refurbished
Data limitations	N/A
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	No
Desired performance	Improve access to health care services
Indicator responsibility	Senior Manager Health facility Management

Indicator title	Number of provincial health departments that have established Service Level Agreements with the Departments of Public Works
Short definition	Total number of provincial health departments that have signed Service Level Agreements with Department of Public Works and other implementing agencies
Purpose/importance	Establish Service Level Agreements (SLAs) with Departments of Public Works (and any other implementing agent)
Source/collection of data	Signed SLA's
Method of calculation	Number of SLA's signed
Data limitations	N/A
Type of indicator	Output
Calculation type	Number
Reporting cycle	Annually
New indicator	Yes
Desired performance	Improved standards in facilities
Indicator responsibility	Senior Manager Health facility Management