HEALTH

DEPARTMENT:

Health

NORTHERN CAPE

STRATEGIC PLAN 2025-2030

2025/2030

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I. FOREWORD BY THE EXECUTIVE COUNCIL

It is with great pride and responsibility that I present the health sector's contribution to the first Annual Performance Plan of the 2024-2029 Medium-Term Development Plan (MTDP). This document represents our collective vision and commitment to advancing healthcare in the Northern Cape Province as we align with South Africa's broader development agenda.

The 2019-2024 period brought unprecedented challenges to our healthcare system, yet it also demonstrated the resilience and dedication of our healthcare workers across the province. Through careful analysis of what worked and what didn't, we have identified critical lessons that inform our path forward. Our evidence-based approach acknowledges both successes and areas requiring improvement, ensuring that this MTDP builds on solid foundations.

I am pleased to highlight tangible progress made during the 6th Administration, including the delivery of 22 new ambulances as we were closing the last term, that are currently in the licensing process. This investment in emergency medical services will significantly enhance our response capabilities, particularly in rural areas where access to healthcare remains challenging.

Our infrastructure development program has also made notable strides with the completion of several key facilities. In the John Taolo Gaetsewe District, the Bankhara Bodulong facility and TB Wing at Olifantshoek, along with the Kuruman Mortuary, represent our commitment to expanding healthcare infrastructure. In the ZF Mgcawu District, the Raaswater Clinic and Boegoeberg facility have improved access to primary healthcare services. Similarly, in the Namakwa District, the Rooivaal Clinic stands as testament to our determination to ensure healthcare reaches every corner of our vast province.

As part of our unwavering commitment to skills development, education, and training, the department welcomed 75 nursing graduates from the Henrietta Stockdale Nursing College in 2024. These nursing professionals completed a comprehensive four-year Diploma in Nursing (R425), with specializations in General, Community and Psychiatry, and Midwifery. Their integration into our healthcare system represented not only an achievement for these individuals but a significant boost to our province's healthcare capacity and service delivery capabilities.

This investment in human resources is complemented by our recent opening of the state-of-the-art Student Accommodation at the Henrietta Stockdale Nursing College. This provincially-owned facility currently houses nursing and Emergency Medical Services students, with capacity for significant expansion. The second phase of this transformative project is already underway, encompassing the construction of lecture rooms, a computer laboratory, library, office spaces, simulation rooms, and a cafeteria. This development ensures that the Northern Cape can continue to train and retain skilled professionals who understand our unique healthcare challenges, building a sustainable healthcare workforce for generations to come.

These achievements, while significant, are merely stepping stones toward our greater vision. The Annual Performance Plan outlines strategic interventions that address our province's specific health challenges, from reducing maternal and infant mortality to combating HIV, TB, and non-communicable diseases, while strengthening our healthcare system's resilience against future public health emergencies.

Our Theory of Change recognizes that improving health outcomes requires both targeted health interventions and addressing the social determinants of health. Therefore, this plan emphasizes cross-sectoral collaboration with departments such as water and sanitation, education, and social development, acknowledging that health is influenced by factors beyond clinical care.

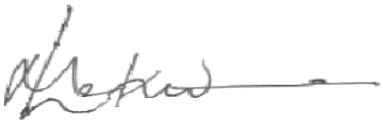
The development of this Annual Performance Plan was deliberately inclusive, drawing insights from frontline workers, community representatives, and partner organizations. We integrated emerging methodologies in planning and foresight to ensure our strategies are both evidence-based and adaptable to the unique challenges of our province.

As we move forward, in an endeavour to improve our infrastructure, the department will embark in the construction of new Nursing College Main Campus, construction of New Schmitsdrift Clinic, Upgrading and refurbishment of Keimoes Hospital, refurbishment of Tshwaragano Gateway and Construction of Frances Baard Forensic Mortuary.

In modernising the Department as part of the Vision of the 7th Administration, we will be Implementing Electronic Medical Record Management System in Connie Vorster Hospital Phokwane Sub District as the identified facility, aiming at implementing Contracting Unit for Primary Health Care (CUP) in the Province, to ensure the implementation of Universal Health Coverage. EMS digital call centres has been rolled-out as a tracking devices in ambulances and Call Centres will all be automated.

The sector engagements that took place from March to August 2024 were crucial in confirming interventions, indicators, and targets, while ensuring resource considerations were factored into our planning for the progressive realization of results. We can take out this one.

I extend my sincere gratitude to all stakeholders who have contributed to this draft and invite continued engagement as we refine and implement these strategies. Together, we can build a healthcare system in the Northern Cape that effectively serves all our people, contributing to a healthier, more equitable South Africa.



Mr Maruping Lekwene (MPL)

Northern Cape MEC for Health

II. STATEMENT BY THE HEAD OF DEPARTMENT (HOD)

According to Maya Angelou “Success is the sum of small efforts, repeated day in and day out,” and completion of Kuruman Hospital mortuary, Henrietta Stockdale Nursing College Accommodation, Bankhara Bodulong, Boegoeberg, Glenred and Heuningvlei clinics are testimony to that, despite the various challenges that were encountered during the process. We must be mindful of the valuable lessons from the different experiences that will be implemented in the new upcoming projects.

The Computer Aided Dispatch system of Emergency Medical Services and call centres are improving coordination of emergency patients so that they receive the services they need as soon as it is possible. The rural areas of the province have connectivity now and that is making life easy for personnel as we are a modern growing province. HPRS patient identifier number is assisting in proper management of patients so that medical history is easily accessible for health practitioners treating the patients anywhere in the province. Digital Patient Record, E-Prescription and E-Dispensing are some of the innovations of 4IR. Additionally, the Central Chronic Medicines Dispensing and Distribution (CCMDD) assists in decanting health facilities of patients who only need medication with long term scripts as medication is dispatched to their nearest collection point.

On another front collaboration with stakeholders including government departments, private entities and NGOs are yielding positive outcomes for an example the stakeholders dealing with Thuthuzela centres around the province to assist sexual violations especially of women and children. Over the number of years, it has been proven that department cannot fully address all the issues without the support of relevant stakeholders for an example reduction of teenage pregnancy is a societal challenge that should be addressed by everyone. The emphasis on dual protection is another strategy to deal with this challenge as it eliminates unwanted pregnancies and sexually transmitted infections.

In 2020 the province had the highest number of girls between 10-19 years delivering babies but has since declined though it is still high against the set targets and more progress can still be achieved if youth zones can be established at all health facilities. These youth zones ensure that teenagers access health services in youth friendly environment so that they can share message with their peers to access services.

HIV/AIDS and TB remain the leading underlying cause of death hence it is important to improve management of these chronic conditions. Antiretroviral Treatment (ART) has significantly improved and is a positive indication that the province will achieve the 95-95-95 HIV targets. TB Case Finding project is progressing well and completion of treatment improved to 75%. Even better news is the decrease of Drug Resistant TB, even its success rate has exceeded the target.

“Giving children a healthy start in life, no matter where they are born or the circumstances of their birth, is the moral obligation of every one of us,” Nelson Mandela once said hence, it is important to vaccinate all children as well as facilitate the catch-up vaccination programs as it minimises outbreaks in communities. Vaccinated children are not vulnerable to illnesses especially outbreaks as their immunity is boosted. The Integrated School Health Program teams are hard at work with the HPV campaign for young girls to eliminate onset of cancer later in life. In preparation for National Health Insurance implementation we are resetting the service platform to respond effectively to the current health trends.

“We may encounter many defeats, but we must not be defeated”, Maya Angelou encourages us as Team Health to improve the survival of neonates and eliminate stillbirths amongst our communities. In the same vein more can be done and achieved to deal with non-communicable diseases as new cases are increasing at an alarming rate newly diagnosed hypertension and years lived with disability in the province. Condom distribution is also moving at a low rate especially the female condoms. More creative strategies to deal with these challenges should be implemented as soon as possible.

In conclusion according to Martin Luther King Jr. “The time is right to do what is right”, it is time to turn the tide bearing in mind our key mandate as a department is to deliver quality health care services to our communities. I am certain that this plan will be implemented without fail.

Mr Mxolisi Mlatha

Head of Department (Acting)

III. OFFICIAL SIGN-OFF OF THE ANNUAL PERFORMANCE PLAN

It is hereby certified that this Annual Performance Plan:

- Was developed by the management of the Northern Cape Provincial Department of Health under the guidance of Mr Maruping Lekwene (MPL)
- Takes into account all the relevant policies, legislation and other mandates for which the Northern Cape Provincial Department of Health is responsible.
- Accurately reflects the Outcomes and Outputs which the Northern Cape Provincial Department of Health will endeavour to achieve over the period **April 2025 to March 2026.**

Name: Ms L.V. Moleleki **Manager Programme 1: Administration**	Signature:
Name: Z. C. Kiti **Manager Programme 2: Health Programmes**	Signature:
Name: M. Mfinte lo **Manager Programme 3: Emergency Medical Services**	Signature:
Name: Dr C.I Kantaa **Manager Programme 4: General (Regional) Hospitals**	Signature:
Name: Joseph Sandt **Manager Programme 5: Tertiary Hospital**	Signature:
Name: Ms Obakeng Cesejane **Manager Programme 6: Health Sciences and Training**	Signature:

Name: DR. D. THEYS **Manager Programme 7: Health Care Support Services**	Signature:
Name: Xola Mpekelana **Manager Programme 8: Health Infrastructure**	Signature:
Name: S.N. TSHOKO **Chief Financial Officer**	Signature:
Name: Mak Mocumi **Head official responsible for Planning**	Signature:
Name: MG. Mlatha **Accounting Officer**	Signature:
Name: M. LEKWENE **Executive Authority**	Signature:

PART A: OUR MANDATE

1. CONSTITUTIONAL MANDATE

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

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

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

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

- People also have the right to access information if it is required for the exercise or protection of a right;

- This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and

- This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively

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

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

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

2. LEGISLATIVE AND POLICY MANDATES

2.1 Legislation falling under the Department of Health's Portfolio

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2 Other legislation applicable to the Department

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. HEALTH SECTOR POLICIES AND STRATEGIES OVER THE FIVE YEAR PLANNING PERIOD

3.1 National Health Insurance Bill

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

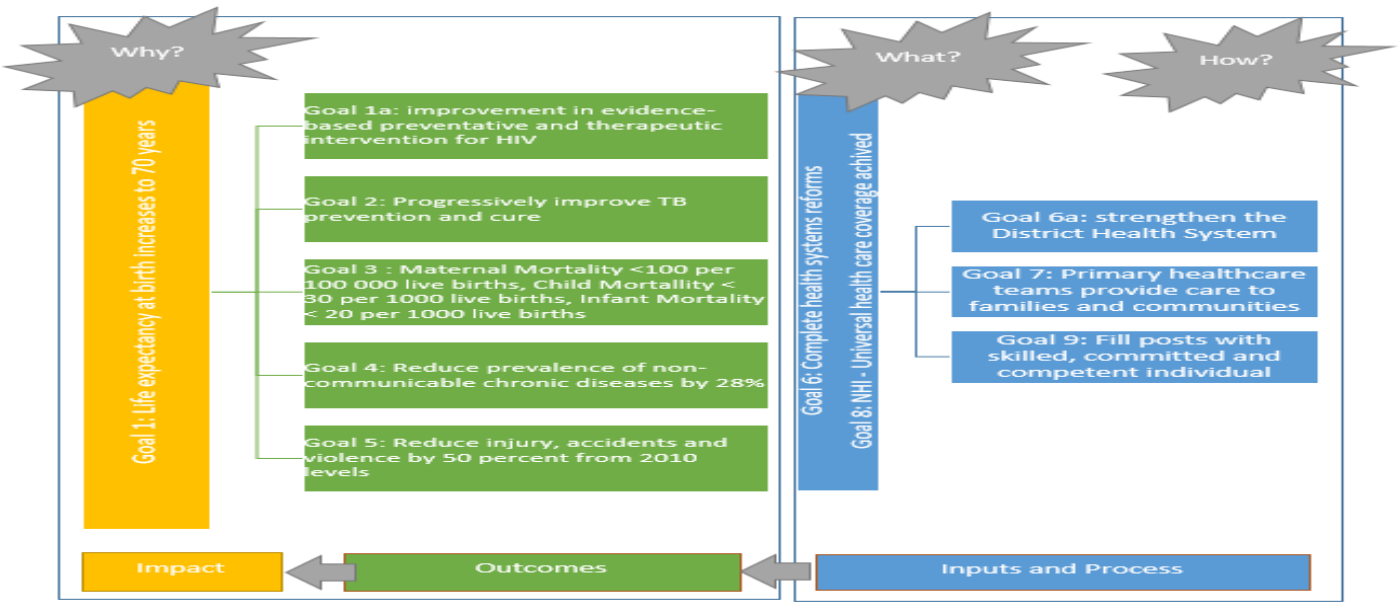
In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator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

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

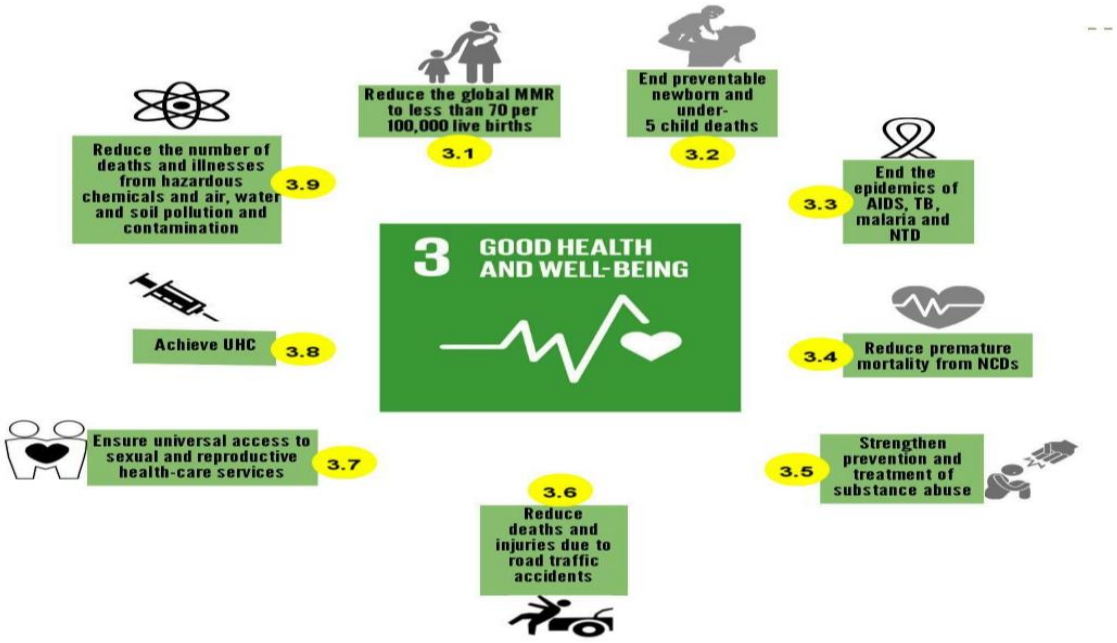
An external evaluation of the first phase of National Health Insurance was published in July 2019. Phase 2 of the NHI Programme commenced during 2017, with official gazetting of the National Health Insurance as the Policy of South Africa. The National Department of Health drafted and published the National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

3.2 National Development Plan: Vision 2030

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



3.3 Sustainable Development Goals



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

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

3.4 Medium Term Development Plan 2025-2030

The MTDP 2025−2030 aligns with the goals and objectives of the NDP and the minimum programme of priorities of the GNU. The NDP remains South Africa's long-term country plan towards 2030 and is aligned with its international commitments on the continent and globally. The introduction of the MTDP 2025−2030 as the implementation plan of the NDP, replacing the Medium Term Strategic Framework (MTSF), serves to align with international naming conventions and to place a greater emphasis on development outcomes.

The MTDP 2025−2030 sets out five goals missions for the next five years. These are intended to guide the actions of government in pursuing the goals of the NDP.

Impact: Life expectancy improved to 70 years by 2030	
Sector Outcome: Improved access to affordable and quality healthcare	
MTDP Priorities	**Strategic outcomes**
Pursue achievement of universal health coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care.	1.Financial Management strengthened in the health sector
	2.Improved access to equitable healthcare services
	3.National Health Insurance awareness improved
	4.Governance of Public Entities strengthened
Strengthen the primary health care (PHC) system by ensuring that home and community- based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative care services required for South Africa's burden of disease.	5.Improved responsiveness to community needs
	6.Reduced burden of disease
	7.HIV and AIDS related deaths reduced
	8.TB Mortality reduced
	9.Malaria related deaths reduced
	10.Mortality due to NCDs reduced
	11.Improved maternal and child health
	12.Improved access to School health programme
	13.Improved access to Youth health programme
	14.Mental health care integrated in Primary Health Care
	15.Early warning and response strengthened
Improve the quality of health care at all levels of the health establishments, inclusive of private and public facilities	16.Improved access to affordable and quality healthcare
Improve resource management by optimizing human resources and healthcare infrastructure and implementing a single electronic health record	17.Employment in line with equity targets
	18.Integrated electronic health record
	19.Equitable distribution of health professionals to health facilities
	20.Health infrastructure optimised for delivery of care

4. RELEVANT COURT RULINGS

NO	NAME	CASE NUMBER	SUMMONS SERVED	AMOUNT CLAIMED	DATE OF TRIAL
1	Davidene Chanelle Arends and S Jumad	2250/16	26 October 2016	R 1 170 000.00	27 March 2025 (Taxation)
2	Galaletsang Clementia Ntloeng	1506/23	21 August 2023	R 40 000 000.00	23/05/2025 (Rule 30(1) Application)
3	Chrizelle Radia Pemberton	1139/23	23 June 2023	R 2 150 000.00	23/05/2025 (Rule 30(1) Application)
4	Jaslene Nilene October obo Jade October	434/19	05 March 2019	R 20 300 000.00	02 - 05 June 2025 (Set down for Quantum Trial)
5	Mildred Kesaobaka Seeiso	692/21	14 April 2021	R 4 464 415.00	24 October 2025 (Condonation Application)
6	Marietta Anasia Andreas	2230/18	10 September 2018	R 1 130 000.00	26 – 29 January 2026 (Set down for Quantum Trial)
TOTAL				**R 69 214 415.00**	

PART B: OUR STRATEGIC FOCUS

5. VISION

A modern health system delivering quality care to a growing province.

6. MISSION

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

Better Health

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

Better Care

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

Better Value

Delivering better value through efficient allocation and use of resources.

7. VALUES

- Professionalism
- Teamwork
- Integrity
- Excellence

8. SITUATIONAL ANALYSIS

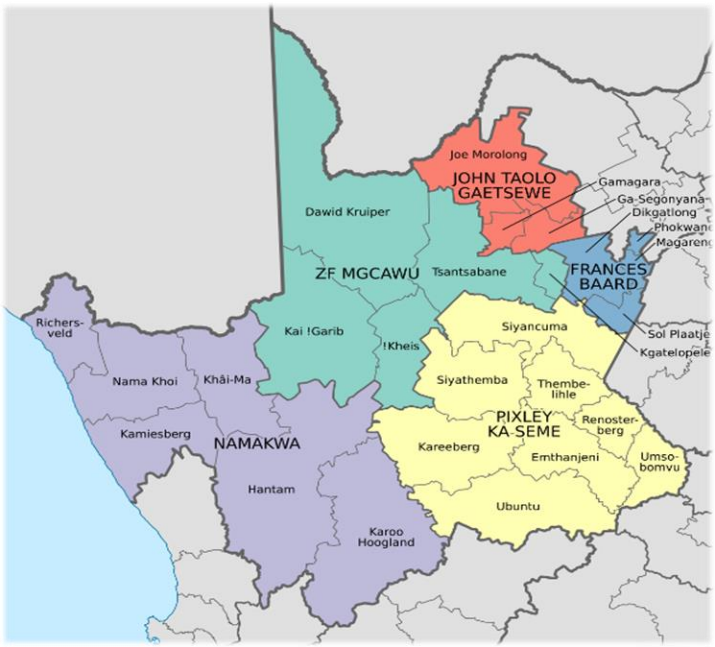
8.1 Overview of the province

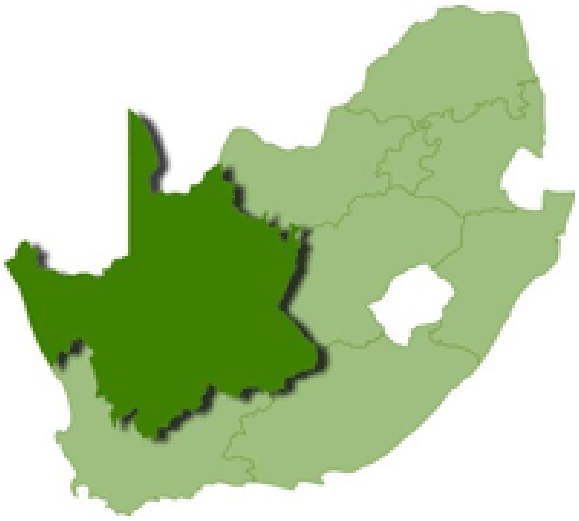
The Northern Cape is the largest province in South Africa, but has the least number of inhabitants. With only 1 372 943million people, with an increase of around 600 000 people, it remains as the province with the smallest share of the South African population – 2,2%. According to the Mid-year population estimates that were published in July 2024, the 1.37million people consists of 680 363 females and 692 580 males. Additionally, the province shares borders with four other provinces, namely Western Cape, Eastern Cape, Free State and North West; as well as borders with the states of Namibia and Botswana, respectively.

According to the latest statistics reported by StatsSA, about 53.8% of the Northern Cape population speaks Afrikaans, followed by 33.1% Setswana speaking, 4.5% isiXhosa speaking, 2.4% English speaking and only 1.2% Sesotho speaking while the 1.6% is made up of other languages including Khoi and Sign language. (StatsSA Census; 2023).

Demographic Data	
Geographical area	372,889 Km2
Total population Northern Cape: Census 2022	1,355,629
Population density (SA Mid-year estimates 2022)	3.1/Km2

Source: Census 2022, 2023

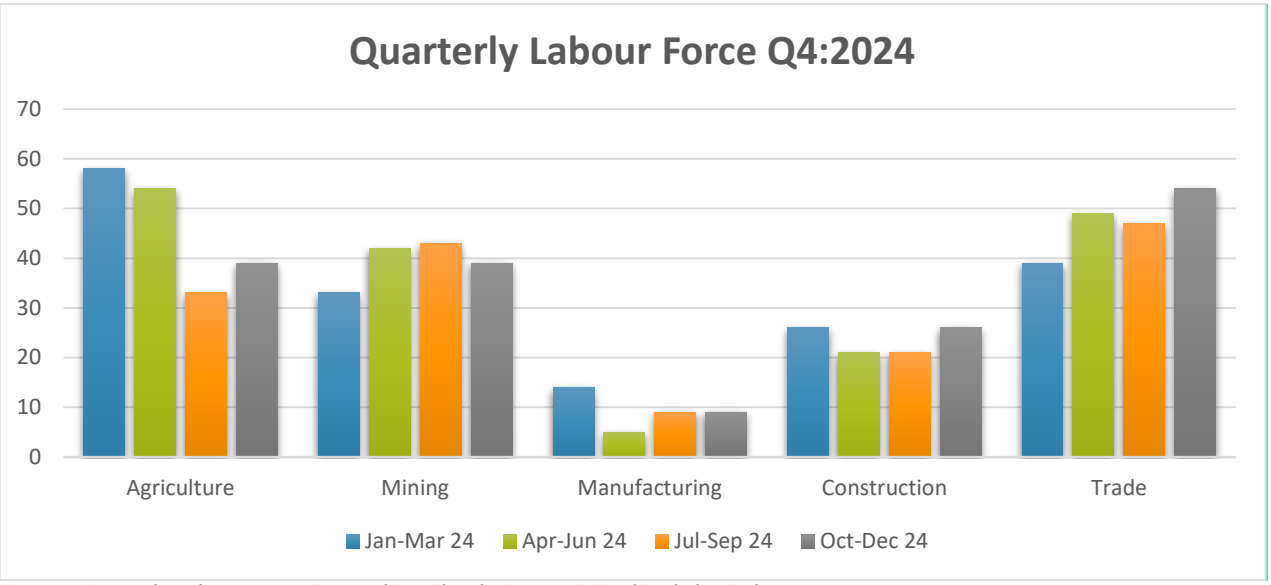




Economy

In 2023, the Northern Cape's forecasted GDP will be at an estimated R68 billion (constant 2010 prices) or 2.1% of the GDP of South Africa. The ranking in terms of size of the NC Province will remain the same between 2018 and 2023, with a contribution of 2.1% to the GDP of the country in 2023 compared to the 2.2% in 2018. With a 0.09% average annual GDP growth rate between 2018 and 2023, the province is ranked the lowest compared to the other regional economies. (source, *IHS Markit Regional eXplorer statistical review)*

Figure 1 Provincial employment by industry



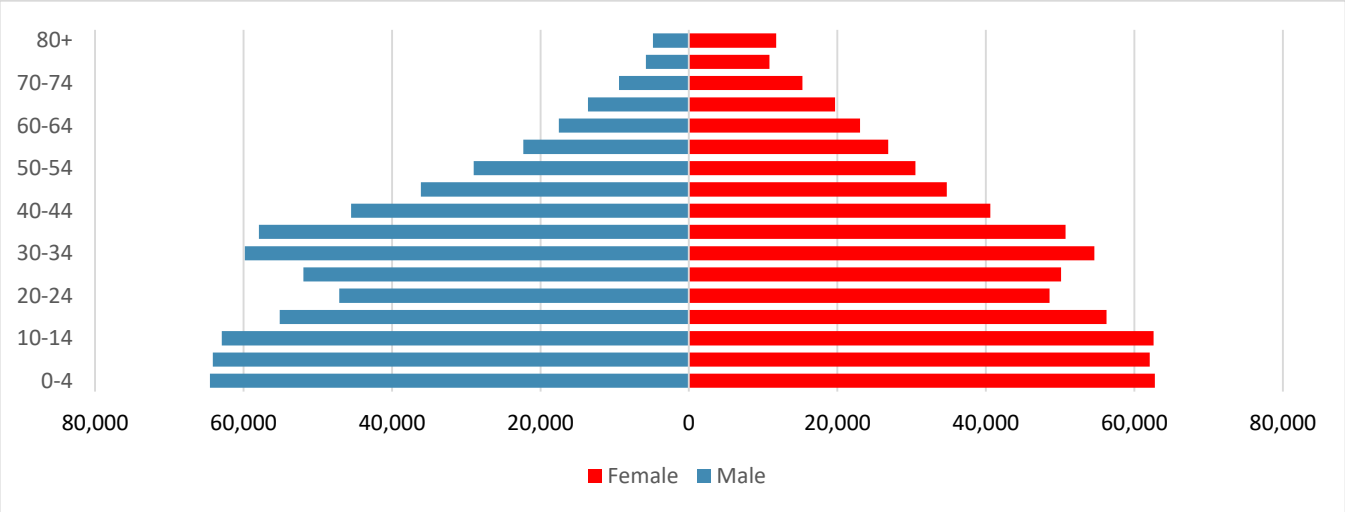
Source: Quarterly Labour Force Survey (QLFS), 4th Quarter 2024 (Statistics SA)

The trade sector has for the past few quarters seen a significant increase, the 4th quarter of 2023 being the highest when looking at trends over the past year. Manufacturing in the Northern Cape province is not quite popular thus the low numbers when compared to the other sectors. Mining in the province fluctuates due to the demand from foreign investments and an unstable market.

8.2 External Environment Analysis

8.2.1. Demography

Figure 2 Total population by age group and sex (Northern Cape)



Source: Census 2022 (Statistics SA)

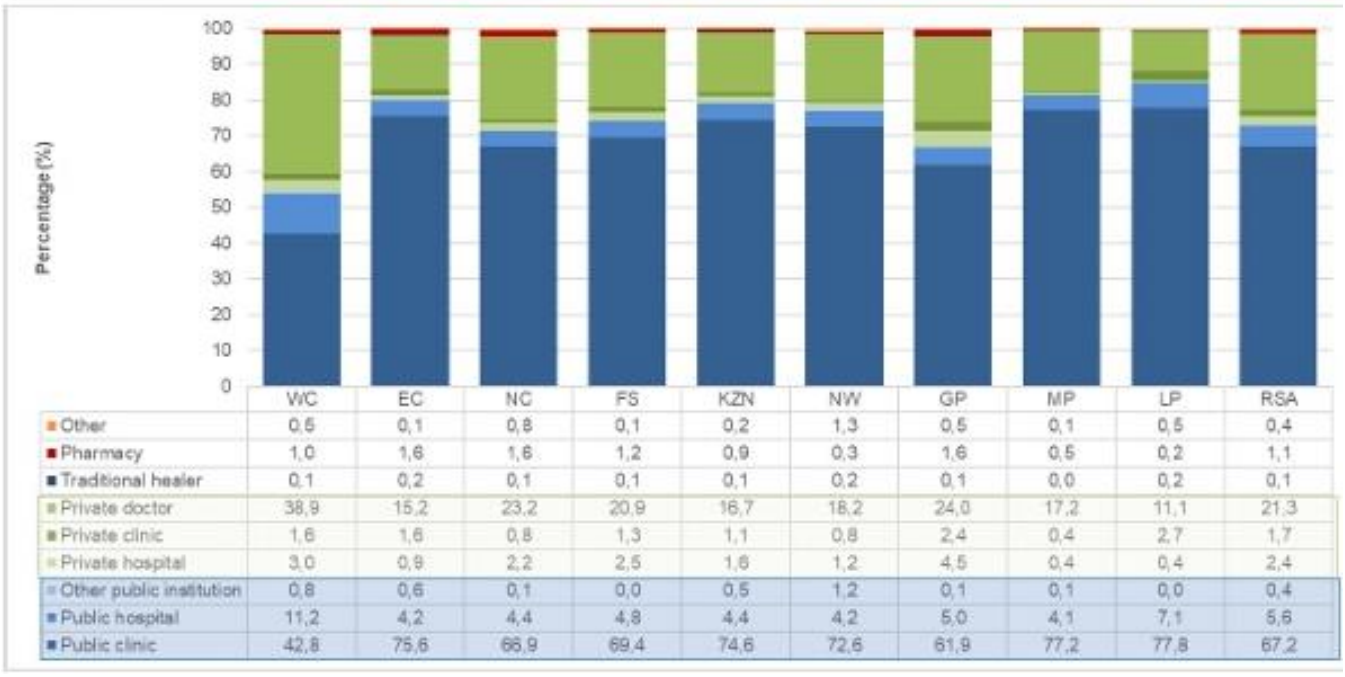
The figure above shows the overall population of the Northern Cape Province for the period of 2024. In comparison to 2023 (1 355 629) the population has increased by **17 314** to **1 372 943** as recorded in the Mid-year population estimates published in July of 2024. The age cohort under 15 years of age constitutes 27.62% of the overall population of the province and proportion of elderly aged 60+ years 12.42%. Given the fact that the under 15 years' age cohort forms the bigger part of the population, the department continues with activation of youth zones in all of the clinics in the province. Soul City and LoveLife continue to play an integral part in these initiatives. The department's Health Promotion directorate also have a huge to play in creating awareness and driving these initiatives.

8.2.2. Social Determinants of Health for Province and Districts

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

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

Figure 3 Percentage distribution of the type of health-care facility consulted first by households when members fall ill or get injured by province

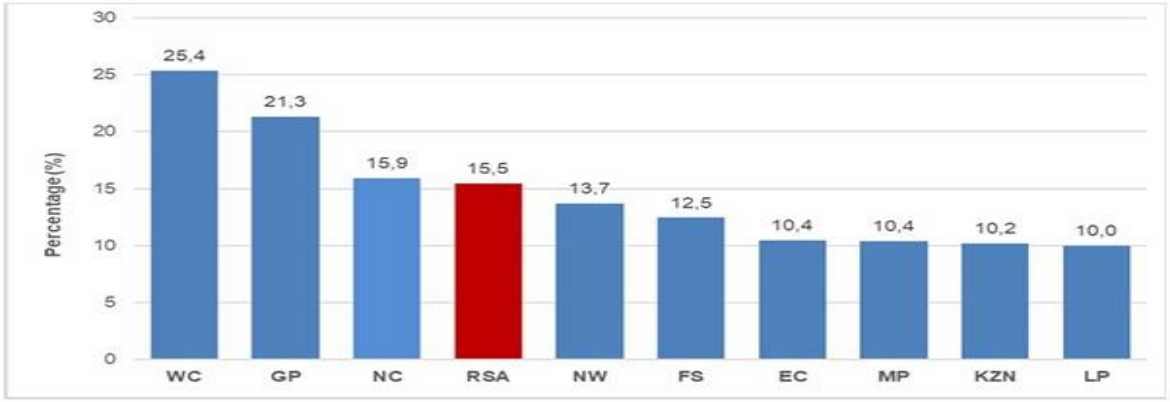


	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Other	0,5	0,1	0,8	0,1	0,2	1,3	0,5	0,1	0,5	0,4
Pharmacy	1,0	1,6	1,6	1,2	0,9	0,3	1,6	0,5	0,2	1,1
Traditional healer	0,1	0,2	0,1	0,1	0,1	0,2	0,1	0,0	0,2	0,1
Private doctor	38,9	15,2	23,2	20,9	16,7	18,2	24,0	17,2	11,1	21,3
Private clinic	1,6	1,6	0,8	1,3	1,1	0,8	2,4	0,4	2,7	1,7
Private hospital	3,0	0,9	2,2	2,5	1,6	1,2	4,5	0,4	0,4	2,4
Other public institution	0,8	0,6	0,1	0,0	0,5	1,2	0,1	0,1	0,0	0,4
Public hospital	11,2	4,2	4,4	4,8	4,4	4,2	5,0	4,1	7,1	5,6
Public clinic	42,8	75,6	66,9	69,4	74,6	72,6	61,9	77,2	77,8	67,2

Source: General Households Survey, 2024

Figure 3 above presents the type of healthcare facility that households generally visit first when household members fall ill or have accidents. This clearly shows the importance of ensuring that the quality of care being offered to the households/communities is of good quality. As a department we are monitoring the patient experience of care satisfaction in order to continuously improve the level and quality of care being offered by our respective public health care facilities.

Figure 4 Percentage of individuals who are members of medical aid schemes per province

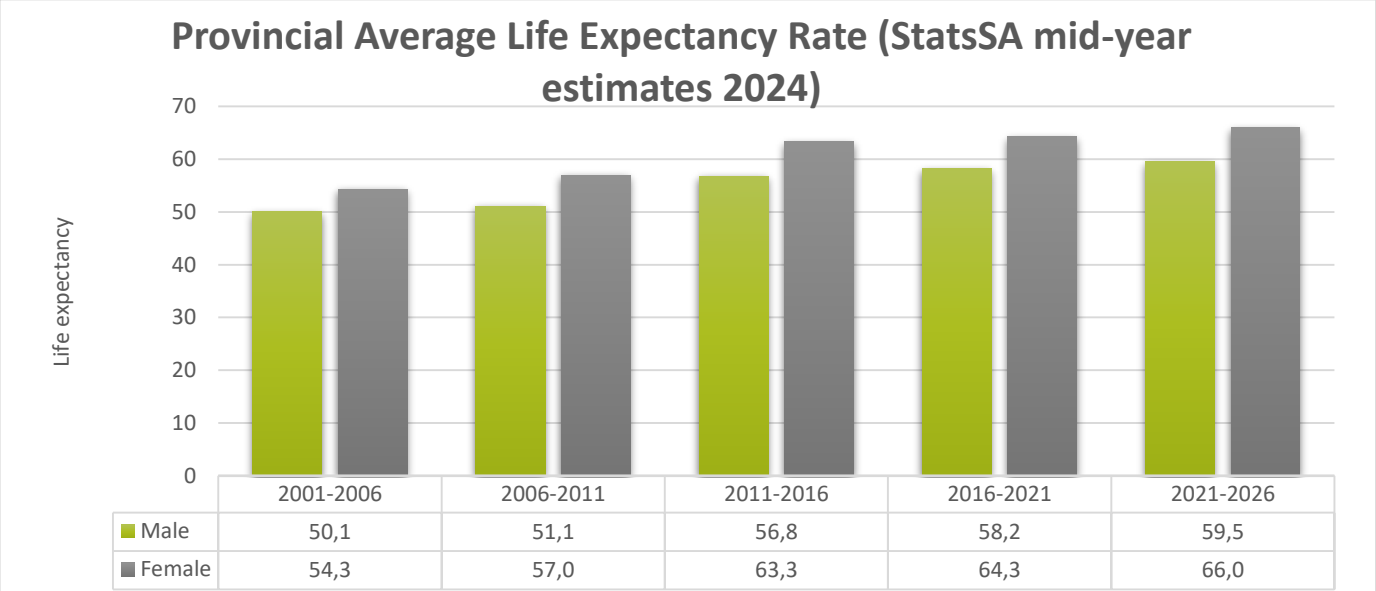


Source: General Households Survey, 2024

In the Northern Cape 19.6% of households have access to medical aid schemes, meaning the remaining 84,4% rely mainly on public health care facilities for health care services. Thus the initiation by the department to continuously monitor the patient satisfaction rate and management of patient safety incident is very pertinent.

8.2.3 Life Expectancy

Figure 5 Provincial average life expectancy at birth (2001-2026)



Source: Mid-year Population Estimates, 2024 (Statistics SA)

Life expectancy at birth reflects the overall mortality of the population. According to the mid-year population estimates 2024, for the 2016-2021 period, males were at age 58.2 and females at age 64.3 respectively thus indicating an increase in life expectancy in the Northern Cape. The same increase up to 59.5 and 66.0 is noted for the period 2021-2026 and it shows the departmental progress towards achieving the 5-year Strategic Plan 2020-2025 impact of improving the life expectancy of the Northern Cape to 66.6 years by 2024, and 70 years by 2030.

8.2.4. Epidemiology and Burden of Disease

The World Health Organization (WHO) has issued an alarm on the rising non-communicable disease in many regions globally. In the past three decades, South Africa experienced the following four “colliding epidemics”:

I. Tuberculosis and TB.
II. Non-communicable diseases (chronic illnesses and mental health).
III. Maternal, neonatal and child mortality, and
IV. Injury and violence.

These has defined the health profile of many community members in the country, and have had a substantial impact of the well-being. There are underlying factors that recognizes provincial health inequalities which further the dynamics between different populations in the country.

Years Lived with Disability due to Diseases

In a study conducted by Achoki T, *et* al (2022), showed that the number of years lived with disability (between 1990 and 2019) jumped by nearly two-fold as a result of demographic change and rapid increases in non-communicable diseases. Between 2007 and 2019, all provinces experienced a significant increase in years lived with disability (YLDs) from NCDs (e.g. diabetes, chronic kidney disease), with

exception of the North West. The Northern Cape Province recorded the largest increase in YLDs as a result of NCDs, at 3.8% year-on-year and in all provinces, mental health disorders contributed to the highest total number of YLDs across all nine provinces. In terms of injuries, both Limpopo and Northern Cape accounted the highest at 4.6%, with Mpumalanga and Kwa-Zulu Natal recording the lowest.

Chronic Diseases in the Northern Cape (Source: DHIS)

Based on the data extracted from the District Health Information System (DHIS), there were close to 20 000 newly diagnosed cases of diabetes between 2020 and 2022, among people aged 18 years and above. JT Gaetsewe accounted for 56% of the reported cases in the Province while Frances Baard, accounted for a total of 1 811, which represent 9,1% (lowest in the Province despite the highest pop). The low recorded new diabetes cases in the Frances Baard could be attributed to under-reporting not necessarily the true picture. Pixley ka Seme recorded the decrease in terms of recorded diabetes cases (per 100 000 population) in 2022, which is the largest in the Province while JT Gaetsewe and ZF Mgcawu showed a notable increase.

Table 1 Newly diagnosed diabetes among 18 years and older, 2020 – 2022, NC – same with tables, not all are numbered correctly

DISTRICT	2020		2021		2022	
	NEW (Raw)	Per 1000 Population	New (Raw)	Per 1000 Population	New (Raw)	Per 1000 Population
Frances Baard	287	1.0	604	2.2	920	3.4
JT Gaetsewe	2 562	14.9	3 905	22.7	4 739	27.5
Namakwa	1 186	14.7	482	6.0	480	5.9
Pixley Ka Seme	729	5.4	1 611	11.9	572	4.2
ZF Mgcawu	657	3.4	277	1.4	939	4.8
NC	**5 421**	**6.3**	**6 879**	**8.0**	**7 650**	**8.9**

Source: District Health Information System (DHIS), NCDoH

In terms of hypertension, a total of 31 905 people newly diagnosed with hypertension in public health facilities across the Province, from 2020 – 2022. The spread of hypertension across the province ranges from 27,9% to 12,2% during the same period. Three district recorded the highest percentage of hypertension, namely Pixley ka Seme (at 27,9%), JT Gaetsewe (at 21,8%) and Frances Baard (at 21,3%). JT Gaetsewe recorded the largest increase in 2022, in terms of absolute numbers and per capita, with 23 people newly diagnosed with hypertension per 100 000 populations.

Table 2 Proportions of hypertension per district among 18 years and older, 2020 – 2022, NC

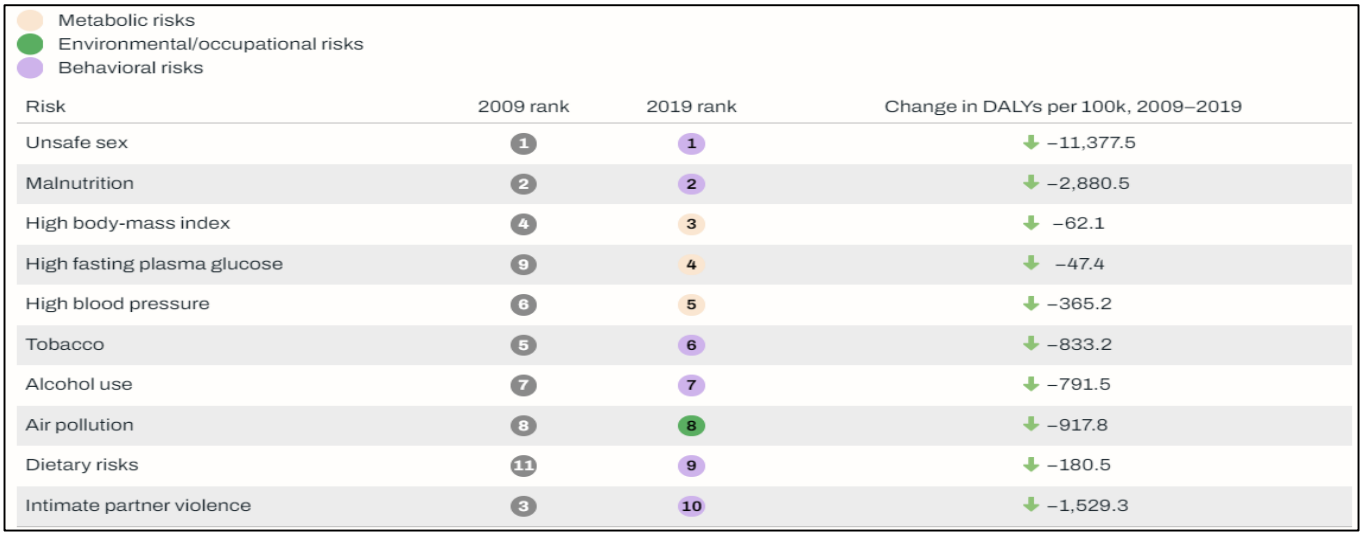
DISTRICT	2020		2021		2022	
	NEW (Raw)	Per 1000 Population	New (Raw)	Per 1000 Population	New (Raw)	Per 1000 Population
Frances Baard	1 264	4.6	2 527	9.2	2 999	10.9
JT Gaetsewe	1 905	11.1	1 038	6.0	4 011	23.3
Namakwa	2 165	26.8	9 40	11.6	7 85	9.7
Pixley Ka Seme	2 573	19.0	4 196	31.0	2 136	15.8
ZF Mgcawu	2 128	10.9	1 469	7.5	1 736	9.0
NC	**10 035**	**11.7**	**10 170**	**11.8**	**11 700**	**13.6**

Source: District Health Information System (DHIS), NCDoH

Risk Factors Associated with Mortality & Disability

The most important risk factors which drives the most deaths and disability combined are categorized into three groups: (a) metabolic risks; (b) environmental/occupational risks; and (c) behavioural risks. Comparing 2009 and 2019, unsafe sex and malnutrition remains the most important risk factors associated with mortality and disability (Figure 6).

Figure 6 Risk factors driving most number of deaths and disability combined



Source: Institute for Health Metrics and Evaluation (IHME)

Leading causes of deaths by geographical area (District Municipality)

In the Province Tuberculosis and HIV remains the leading underlying cause of deaths as reported in the last report by Statistics South Africa. Compared to the previous report (2013), it should be noted that the number of deaths recorded from these diseases had declined notably, with TB recording the highest decrease of 23.3% and HIV decreasing by 13.9%. Non-communicable diseases as been shown to be on a rise in an alarming rate, are affecting the well-being of the people of the Northern Cape, where in the same period, hypertensive diseases and cerebrovascular diseases increasing by 30.6% and 5%, respectively.

However, there are variations between districts which emphasizes the uniqueness that exists in each districts and coupled by other socio-economic factors such as employment, access to basic services, culture, lifestyle, etc. Below is a Table illustrating the top five (5) leading underlying cause of deaths per district municipality. Namakwa is mainly burdened by non-communicable diseases while the pattern in ZF Mgcawu and Pixley ka Seme are very similar except certain disorders of immune system recorded in ZF Mgcawu.

Table 3 Top 5 underlying causes of deaths per district, Northern Cape

Rank	Causes of Death				
	Frances Baard	JT Gaetsewe	Namakwa	Pixley ka Seme	ZF Mgcawu
1.	Human immunodeficiency virus (HIV)	Other forms of heart diseases	Chronic lower respiratory diseases	Tuberculosis	Tuberculosis
2.	Tuberculosis	Influenza & pneumonia	Ischaemic heart diseases	Chronic lower respiratory diseases	Chronic lower respiratory diseases
3.	Hypertensive diseases	Tuberculosis	Diabetes	Human immunodeficiency virus (HIV)	Human immunodeficiency virus (HIV)
4.	Cardiovascular diseases	Human immunodeficiency virus (HIV)	Hypertensive diseases	Cardiovascular diseases	Certain disorders of immune system
5.	Diabetes	Other viral diseases	Cardiovascular diseases	Hypertensive diseases	Hypertensive diseases

Source: Mortality & Causes of death in South Africa, 2018; Statistics South Africa

8.3 Internal Environment Analysis

Table 4 Service Delivery Platform/Public Health Facilities

Districts	Clinic	Community Health Centre	Mobile Service	Satellite Clinic	Health Post	District Hospital	Regional Hospital	Provincial Tertiary Hospital	EMS Station	EHS LG Service	EHS Port Health Service	EHS Prov Service
Frances Baard	27	4	4	5		2		1	7	3		4
JT Gaetsewe	38	5	3	1		2			8	3		3
Namakwa	22	10	1	8	15	2			17	6	1	6
Pixley ka Seme	28	8	1	4		3			19	8		8
ZF Mgcawu	15	6	22	17		2	1		9	5	1	5

Source: WebDHIS

8.3.2. Universal Health Coverage (Population and Service Coverage)

Key Interventions for National Health Insurance, The Department to Reposition for NHI by 2025

- The District Health Services Strategy was reviewed and finalized in 2023. **The Seven Goals below have been identified to give effect to this strategy:**
    1. Strengthen Leadership Development and Governance
    2. Optimize Comprehensive Health Service delivery to improve health outcomes
    3. Improve Quality of Health services
    4. Strengthen community involvement and social accountability
    5. Strengthen Inter-sectoral collaboration
    6. Strengthen the sub-district for UHC and the NHI
    7. Strengthen System Capacity (systems, policies, processes, tools, and resources)

- This project is running parallel with related nationally driven strategies such as the review and finalization of the 5-year District Health Service (DHS)Strategy, Health Digital platform strengthening interventions.
- Other interventions to support roll-out and implementation are Health Practitioners' Contracting through the Conditional Grant, IHFRM and Quality Learning Centres (QLCs).
- These projects are designed to prepare the facilities for accreditation by Office of Health Standard (OHS) and increase legibility probability for funding
- Phokwane is the selected sub-district for i-CUP to NHI realization, whilst other districts are not precluded from commencing with the implementation roll-out

Strategies to Enhance NHI Implementation

- CCMDD
- HPRS
- ISHP
- WBPHCOT
- Health Professionals
- ICRM

CCMDD

It is an initiative which seeks to improve Public Health Care service delivery, through centralised dispensing and distribution of medicines. The aim of this strategy is to decant stable patient from our health care facilities.

Benefits:

- Shorter patient waiting times
- Convenient Pick up Points for patients (closer to home/work place)
- Nurses have more time for critical patients and improve quality of patients
- Reduced congestion at clinics
- Reduced risk of cross infections
- Work load relief for clinic staff
- Allows patients to take control/ownership of their health

HPRS

National Patient Registry is a foundational building block for successful NHI, Health Patient Registration System (HPRS) developed by NDOH together with CSIR

- The HPRS creates and allocates a Unique Health Patient Identification Number (from cradle to grave)
- The HPRS is ***owned*** by the National Department of Health:
  - In the **current phase**, each patient's demographic data is linked to this Unique Health Patients Identification number and stored on the system.
  - The **next phases** of this programme will focus on linking the patients' Health Records to the number.
  - Additional Benefits of the HPRS include:
    - Generate a Patient File Number
    - Tracking of Patients from one facility to another
    - Lab Track functionality
    - Appointment System

- The province introduced the Bokamoso Digitalisation Project to address on the e-Health strategy, to enhance service delivery and to improve the patient experience of care in our health care facilities. Six (6) facilities were identified to pilot this project: Galeshewe Day Hospital, Ritchie Clinic, Ma-Doyle clinic, Florianville clinic, RMSH, and City clinic. This initiative's aim was to assist with the formation of a possible CUP structure and learn lessons from the Ecosystem of the HPRS.

The Bokamoso project seeks to address the following:

1. Electronic Patient record (with a unique identifier)
   a) Digital Electronic patient file,
   b) Data management (full implementation of HPRS, e-tick register-for the Rationalization of Registers)
2. e-Dispensing
3. e-Prescription
4. NHLS (interoperability of lab specimen system with HPRS) for proper gatekeeping
5. Appointment system
   - National Department of Health is planning to implement ABIS (Automated Biometric Identification System) in the Province, the plan is to implement comprehensive modules of the HPRS

ISHP

The Departments of Basic Education and Health jointly implemented the ISHP that extends, over time, the coverage of school health services to all leaners in primary and secondary schools
Its strategic objectives are to:

- increase knowledge and awareness of health-promoting behaviors
- develop systems for the mainstreaming of care and support for teaching and learning
- increase sexual and reproductive health knowledge, skills and decision-making among learners, educators and school support staff
- facilitate early identification and treatment of health barriers to learning
- increase knowledge and awareness of health
- promoting behaviors

Plans

- To make provision to scale up and strengthen ISHP
- Improve Inter-sectoral collaboration

WBPHCOT

This is the bedrock of District Health Service. The WBPHCOT policy framework promotes the following values and principles:

- Community participation and empowerment o community members are considered as their own 'agents of change' and not as passive recipients of government services o communities gain the understanding and authority required to ensure that appropriate action is taken in addressing the issues that affect their health and well-being
- Community passed PHC service are more cost effective than the curative healthcare service
- It assists to decant the clinic to enhance quality of service at the facility and improve patient experience of care
- CHWs appointed in the province: 1750

Plans

- Training and reorientation of CHWs – commences in January 2024
- Dimagi project: Digital platform for community health workers to enhance performance management
- Procurement of uniform and tools of trade to professionalize and assimilate the cadre to the service platform
- Finalization of reviewing the WBPHCOT policy at National level

Health professional Contracting

The aim of contracting professionals is to expand Primary Health Care coverage in the districts and improve on service delivery

Health Professionals contracted

District	Category
JT Gaetsewe	Medical Officers x1;Paediatrician x1
Pixley ka Seme	Medical Officers x9; Radiographer x1
Namakwa	Medical Officers x2; Professional Nurse x1; Clinical Nurse Practitionerx1

8.3.2 Ideal Clinic Realization and Maintenance

The purpose of a health facility is to promote health and to prevent illness and further complications through early detection, treatment and appropriate referral. To achieve this, a clinic should function optimally thus requiring a combination of elements to be present in order to render it an "Ideal Clinic".

- An Ideal Clinic is a clinic with good infrastructure1, adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies, that uses applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community. An Ideal Clinic will cooperate with other government departments as well as with the private sector and non-governmental organizations to address the social determinants of health. Primary Health Care (PHC) facilities must be maintained to function optimally and remain in a condition that can be described as the "Ideal Clinic".

Table 5 The Ideal Clinic Status

District	# of Facilities	# Facilities that	# Facilitie	% of Facilities with	# of Facilities with	# of Facilities with	# of Facilities with

		conducted SD	s with IC status	IC status	Silver Status	Gold Status	Platinum Status
Frances Baard	28	28	1	4%	1	0	0
John Taolo Gaetsewe	44	43	24	55%	4	6	14
Namakwa	32	31	8	25%	0	2	6
Pixley ka Seme	36	36	28	78%	2	5	21
Zwelentlanga Fatman Mgcawu	21	21	11	52%	0	1	10
Northern Cape Province (Total)	**161**	**159**	**72**	**45%**	**7**	**14**	**51**

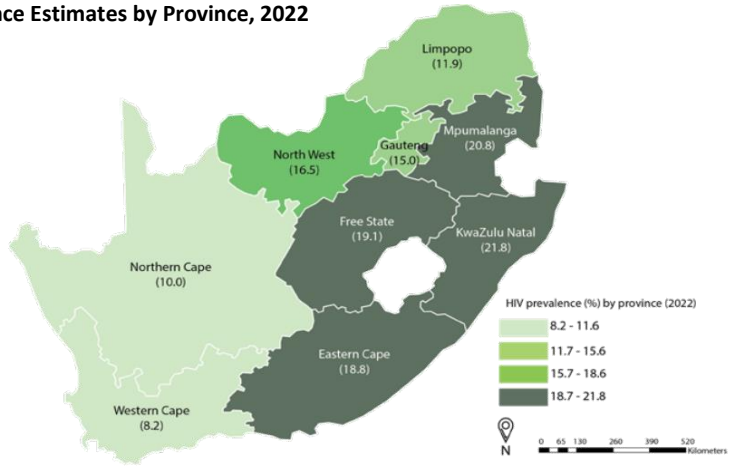
The Provincial Ideal Clinic Status is 45%, of which Pixley ka Seme did exceptionally well (78%). The ideal clinic category is as follows: Platinum: 51 facilities, Gold:14 and Silver:7

8.3.3 HIV & AIDS

HIV Prevalence

The Northern Cape has seen a reduction in new HIV infections over the past five years (2017 – 2022), having the second-lowest HIV prevalence after Western Cape, at 10% in 2022. In terms of new infections, based on the Naomi Model (2023), an estimated 146 780 new HIV infections were recorded in South Africa, with NC recording 2 207 (lowest in terms of absolute numbers). Frances Baard recorded the highest HIV new infections of 816, followed by JT Gaetsewe (528), ZF Mgcawu (483), Pixley ka Seme (280) and Namakwa with the least at 100. Over the past five years, new infections for HIV have decreased due to various interventions that have been put into place.

Figure 7 HIV Prevalence Estimates by Province, 2022



Source: SABSSM VI 2022, HSRC

HIV Testing Services

Testing of people on HIV remains a critical component of the HIV & AIDS Strategic Plan, and this programme has been performing well above its annual targets since the Covid-19 pandemic passed. During the 2023/24 financial year, the Province surpassed its annual target where 255 179 people were tested against a target of 226 755 (113% achievement rate). The National Department of Health has strategies in place to strengthen HIV Self-Screening and Index testing through revised HTS policy and updated index booklet, all provinces will adopt the strategies as a mechanism to expand HTS uptake.

Pre-Exposure Prophylaxis (PrEP) Programme

The province could not achieve its annual target on PrEP, with 3 556 clients initiated against the target of 9 482 (37.5% achievement rate). Pixley Ka Seme was the only district that managed to exceed its target, initiating more eligible clients compared to other districts and contributing 43% to the Province total. Despite the Frances Baard district being saturated with supporting partners/non-governmental organizations, it underperformed. To improve performance and coverage, there are engagements between province, districts and NGOs that are implementing PrEP in order to identify the gaps.

Post Exposure Prophylaxis (PEP)

The province experienced high number of sexual assaults reported in healthcare facilities, from 714 in 2022/23 to 1 025 in 2023/24, resulting in 717 receiving PEP (eligible). This was higher than the target of 495 with all the districts having surpassed their targets which is a negative deviation as a result of increased sexual assaults cases. Health education and awareness campaigns continue at facility level and within communities on awareness about sexual assaults, the importance of presenting early after assault. The high reported sexual assault cases could be attributed to this intervention where victims presented on time to the facilities. However, this is also a reflection of a deeper societal problem where women are vulnerable to sexual assault and other forms of gender based violence.

Condom Distribution & Promotion

The distribution of both male and female condoms targets were not achieved, however, compared to the previous financial year, there's been a significant improvement in the distribution of male condoms. In 2023/24, there were close to 13 million male condoms distributed against a target of 15 million, translating into an increasing almost three fold compared to 2022/'23. JT Gaetsewe and Frances Baard managed to achieve and surpass their annual targets while other three districts failed, Namakwa the worst performing among all in the Province.

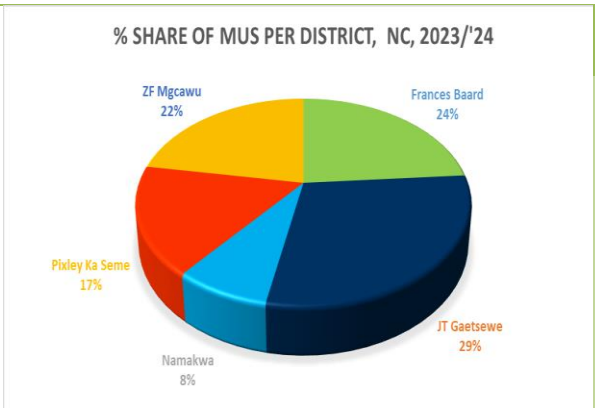
Distribution and uptake of female condoms remains a challenge due to client preferences and lack of knowledge on usage. However, there was an improved distribution compared to the previous year, where an increase of 82% was recorded year-on-year. To improve uptake of condoms, a training was conducted which focused improving skills on demonstration models with a goal of ensuring correct usage among people accessing public health facilities and other strategic points. The interventions for new financial year, are to advertise vacant posts, conduct the 15 million condom campaign, which will emphasise importance of condom usages and demonstration on how to use them, this will also assist in supporting the districts for better distribution, provision of transport provincially and across the districts. There was a gross under performance on the number of male condoms distributed in the Namakwa districts, due to lack of coordination and supervision since the district does not have the Condom Logistic Officer and the HIV/STI Prevention Clinical Programme Coordinator.

Sexually Transmitted Infections (STIs)

In terms of prevention and control of sexually transmitted infections, the Province has strengthened STI screening and awareness, with the new infections among men (male urethritis syndrome) increasing to 7 677 in 2023/24 financial year. Despite this increase, the annual increase of STI incidence showed signs of stabilisation, where in 2021/'22, the annual increase was 47.8%, 29.9% in 2022/'23 and in 2023/'24 increasing by 1.1%. Apart from biomedical interventions, the Province has embarked on various activities which are community-led such as targeted dialogues for key populations, the first Provincial Summit on Key Population was held in November 2024, collaboration with various stakeholders (i.e. Higher Health at tertiary institutions, mines, private sector, civil society, etc.).

Table 8: STI New Episodes per District, NC, 2023/24

District Municipality	No. (MUS – New)
Frances Baard	1 826
JT Gaetsewe	2 244
Namakwa	599
Pixley Ka Seme	1 294
ZF Mgcawu	1 714
Province Total	**7 677**



Source: District Health Information System (DHIS), May 2024

There's about 24 350 dual syphilis test kits which screen both HIV and Syphilis that has been distributed across all facilities. The target population is pregnant women, with implementation taking place at PHC, CHC and hospitals. This intervention will improve STI screening, diagnosis and timeous treatment initiation.

A national STI meeting has highlighted that Northern Cape has low syphilis testing rate, with high positivity rate among pregnant women, which tallies with 2022 survey. And, there is high Neisseria Gonorrhoea in males and females.

High Transmission Areas (HTA)

The province is currently having two (2) fixed HTA sites, both in the Pixley ka Seme district, at Hanover Truck Stop and Colesberg. Additionally, there are outreach and mobile HTA services provided in other districts through collaboration with partners, resulting in increase in number of HTA sites (74). The total number of clients seen at these HTA sites across the Province were 4 049 and broken down as follows: *truck driver's* x 3 673; *sex worker's* x 23; *Men having sex with men (MSM)* x 21 and *transgender* x 13. Around 1 345 clients seen at HTA sites were tested for HIV, yielding a positivity rate of 2% (i.e. 28 clients testing HIV positive). This rate is slightly higher than among 15-24 years old recorded in the general population which is consistent with many findings.

Medical Male Circumcision (MMC)

The MMC programme has not been perform well for the past two financial years (, where 10 444 MMCs were performed in 2022/23 and dropping to 7 547 in 2023/24. To address this, two new service providers who are appointed through the National TR35 2023-26 tender, which are: Lister Health (covering ZF Mgcawu, Pixley Ka Seme and Namakwa) and Innovo (covering JT Gaetsewe and Frances Baard). The previous service provider (J-Galt) could not provide MMC services to all five districts, which posed a challenge resulting in limited access, especially in the Namakwa areas. Additionally, the MMC programme put plans into place to expand institutionalization of MMC services in qualifying public facilities and currently available in five facilities (1 x Frances Baard, 1 x JT Gaetsewe, 3 x ZF Mgcawu). Furthermore, Innovo and Lister Health will look at possibility of contracting private doctors across all districts which involves quality assessment before accreditation.

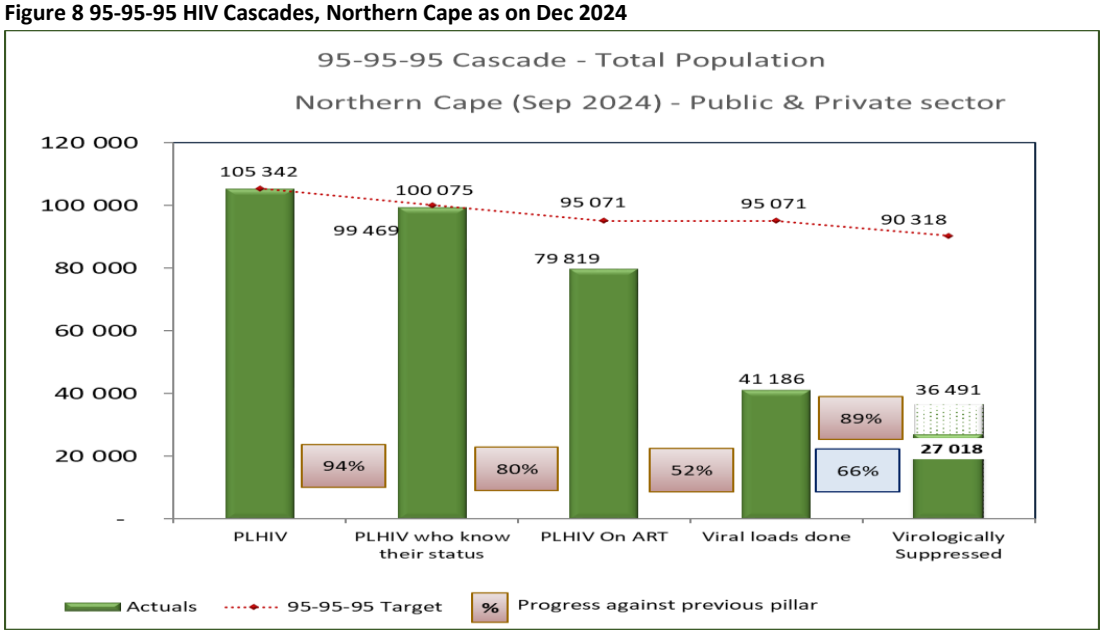
Vertical Transmission Prevention (VTP)

The (VTP), previously known as Prevention of HIV from mother to child (PMTCT) has been the cornerstone of prevention HIV related deaths among children where this intervention has brought the HIV incidence to below one percent of babies born to HIV positive mothers. Children are tracked up to 18 months for ensuring there's a low levels of sero-conversion for those who tested HIV negative at births.

Treatment, Care and Support and Progress on 95-95-95 HIV Strategy

The antiretroviral treatment (ART) coverage in the Northern Cape increased from 54.9% in 2017 to 86.2% in 2022. This translates to an estimated 103,440 PLHIV in the province receiving ART in 2022. As a result, the Province has seen a significant improvement in its endeavour to achieving the 95-95-95 HIV Targets: 94% of PLHIV were aware of their HIV status, 80% of those who knew their status were on ART and 89% of those on ART were virally suppressed. To achieve the second 95 (PLHIV enrolled into ART), the Province close the gap of total Clients on ART by 19 650.

Figure 8 95-95-95 HIV Cascades, Northern Cape as on Dec 2024



Source: Thembisa Model, National Department of Health (2024)

Tuberculosis Control

As part of the Provincial TB Recovery Plan, the Province has been focusing on finding missing TB cases due to undiagnosed TB or those who were diagnosed but not enrolled into treatment. During the 2023/'24 financial year, 2 362 559 people were screened for TB against a total headcount of 2 683 494, translating into 88% screening rate. This slightly lower than the 90% annual target. By age group, the TB screening rate among under 5-year-old group was higher (91%) compared to people aged 5 years and older.

The table below illustrates the TB positivity rate from those eligible for TB testing. There were 67 167 people deemed eligible for further TB testing as per screening tool which resulted into 12.8% TB positivity rate. The highest positivity rate was in the Frances Baard district, significantly higher than other districts. The positivity rate among the remaining four (4) districts were similar around 11%.

Table 6 DS-TB Positivity per district, 2023/24, Northern Cape

District	No. eligible for TB test	No. confirmed with TB	TB Positivity Rate
Frances Baard	15 877	2947	18.6%
JT Gaetsewe	9 162	1 065	11.6%
Namakwa	7 728	850	11.0%
Pixley ka Seme	12 212	1 359	11.1%
ZF Mgcawu	22 188	2 344	10.6%
NC Total	**67 167**	**8 565**	**12.8%**

The TB Control Programme has done tremendously well with the number of confirmed DS-TB increasing substantially in 2023/'24 (40% increase) compared to 2022/'23 financial year. This brought the Province closer to achieving its annual Finding Missing TB Cases target of 9 680, translating into an achievement rate of 88.5%. The three (3) districts managed to reach and surpass their annual targets, namely, Frances Baard (122%), ZF Mgcawu (101%) and Namakwa (100%), while JT Gaetsewe and Pixley ka Seme both achieving below 65%.

Table 7 DS-TB Confirmed cases between 2022/23 and 2023/24, Northern Cape

District	2022/'23	2023/'24	% Change	Target	% Achieved
Frances Baard	1583	2947	86,2%	2423	121,6%
JT Gaetsewe	809	1065	31,6%	1872	56,9%
Namakwa	584	850	45,5%	849	100,1%
Pixley ka Seme	1356	1359	0,2%	2214	61,4%
ZF Mgcawu	1769	2344	32,5%	2322	100,9%
NC	**6101**	**8565**	**40,4%**	**9680**	**88,5%**

DR-TB Case finding

During the financial year, the number of newly recorded multi-drug resistant TB in the Province reduced by 16.1%, and similarly in the two MDR-TB sites (i.e. Dr. Harry Surtie Hospital and West End Hospital).

Table 8 DS-TB Confirmed cases between 2022/23 and 2023/24

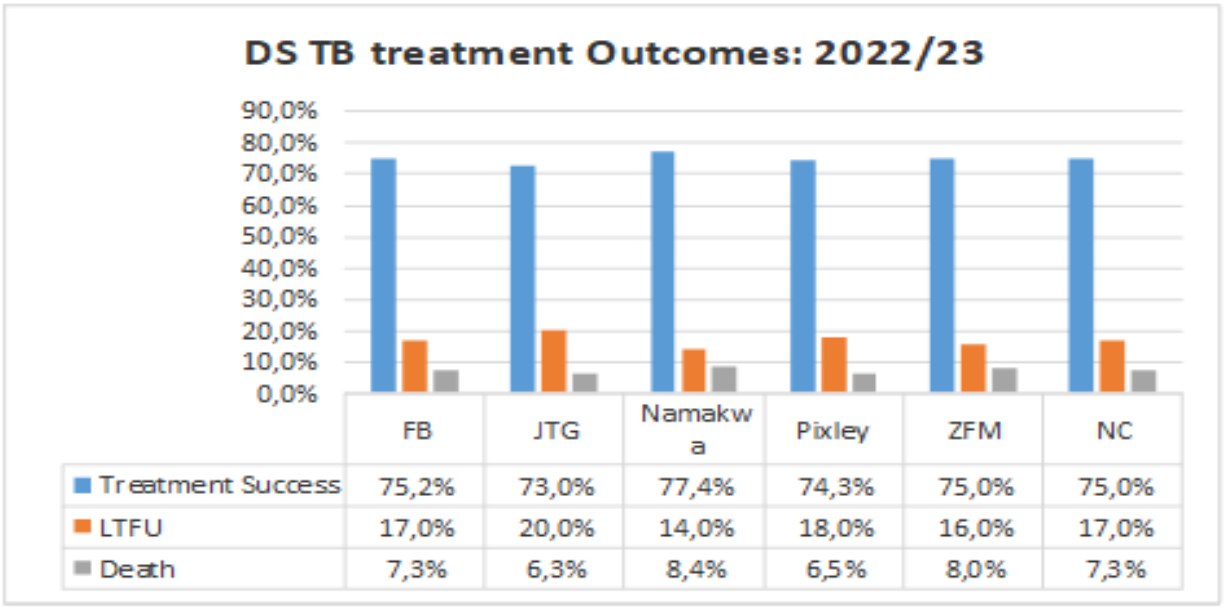
District	2022/23 FY	2023/24 FY
West End Hospital (TB Specialized)	210	173
Dr. Harry Surtie Hospital (DR-TB Site)	137	118
NC	**347**	**291**

Source: EDRWeb

DRUG SENSITIVE TB (DS-TB) TREATMENT OUTCOMES

Those who successfully completed TB treatment improved to 75% in 2023/'24 compared to 69% in 2021/'22. All district did not achieve the treatment success rate target of 80%. Namakwa recorded the highest success rate of 77,4% (483/624) followed by Frances Baard (75,2%; 1091/1449), ZF Mgcawu - 75%; (1137/1520). Pixley Ka Seme achieved 74,3% (863/ 1161) and JT Gaetsewe with the lowest rate of 73% (537/735). Attrition of DS-TB clients from treatment is mainly affected by those not adhering to their treatment, that is, loss to follow-up.

Table 9 DS-TB Treatment outcomes (2022/'23 cohort), Northern Cape



Source: Tier.Net, NCDoH

DRUG-RESISTANT TB (DR-TB)

There was a significant decrease noted in the DR-TB case finding noted year on year moving from 347 cases in 2023 to 291 in 2024. Treatment success rate for the Rifampicin Resistant and MDR TB decreased year on year by 5% from 67% in 2021 to 45% in 2022, mainly influenced by death rate of 14/83 (17%) and loss to follow up of 15/83 (16%). The decentralization of DR-TB services of outreach services by the West End Specialised Hospital resulted in a total of 455 patients seen, with 9 patients successfully treated while 229 missed, same traced and linked to next outreach.

Management of multi-drug resistant patients continues to be the shining light for the province, where treatment outcomes, such as the target on "DR-TB treatment success rate" was exceeded. Successful implementation of shorter treatment regimen, at 98% initiation. And lastly, as the best performer in the country, the World Health Organization-Afro Region Drug Resistant TB Programme conducted benchmarking at two DR-TB sites (West End Hospital and Dr Harry Surtie Hospital) to learn best practices on implementation of BPaL-L.

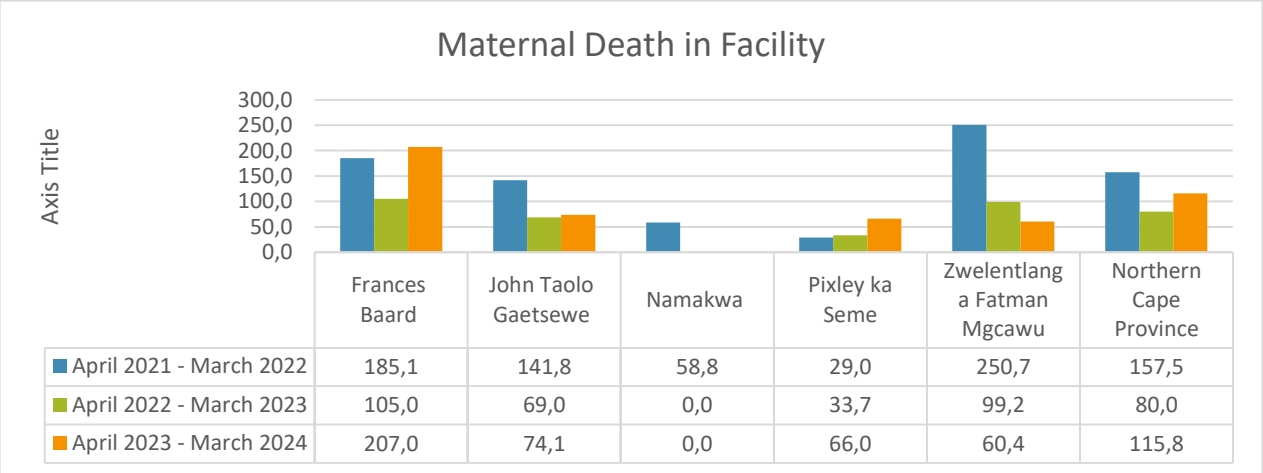
Table 10 DR-TB Treatment Outcomes: 2021/2022 Cohort – table numbering

Province	2021	2022
Treatment Success	49,0%	45,0%
LTFU	20,0%	18,0%
Death	20,0%	14,0%

8.3.5 Maternal, Child, Youth, Women's Health & Nutrition

In-Facility Maternal Mortality Ratio (iMMR)

Figure 9 Maternal Death in Facility



Source: WebDHIS

Recovery strategy for the MCYWH&N service delivery is embodied in the concept of "Survive, Thrive and Transform" to prevent morbidity and mortality and improve health outcomes. The trend for the in-facility Maternal Mortality Ratio (iMMR) is fluctuating as seen with the performance during the FY 2021/22 157.5/100 000 live births, FY 2022 /23 80.0/ 100 000 live births and FY 2023/2024 115.8 /100 000 live births. Hypertensive Disorders in Pregnancy still accounting for most of maternal deaths. In addition, concerning are deaths occurring outside health facilities with patient dying after discharge and where the cause of death is unknown.

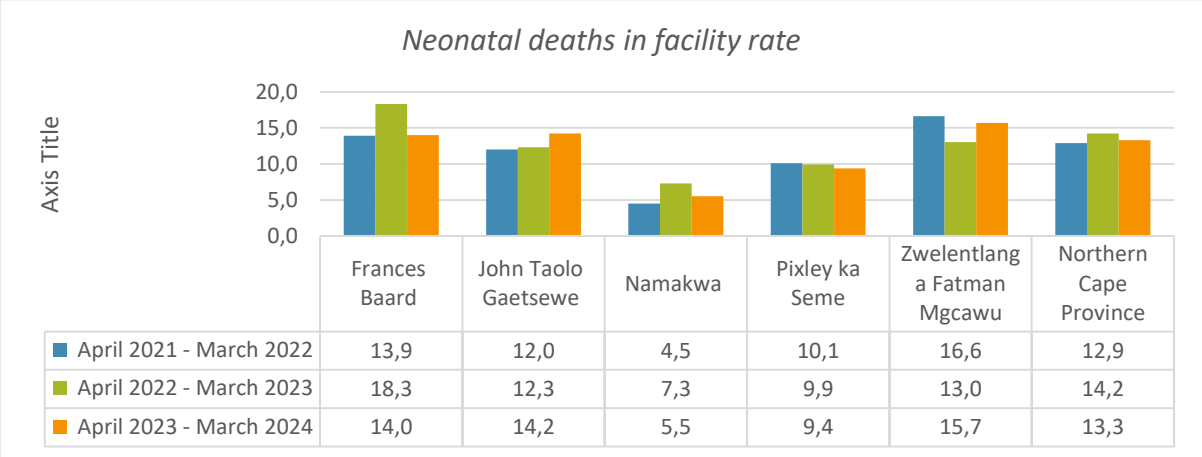
Plans for the reduction of preventable maternal mortality are continually adjusted to focus and respond to avoidable factors causing maternal deaths. Therefore, the priority interventions to be implemented are:

- Skills development of clinicians including Emergency Medical Services;
- Conduct road shows by maternal death assessors committee members to districts;
- Improve access and provision of appropriate contraceptive services at all levels of care;
- Adherence to the minimum standards on the safe caesarean delivery;
- Implementation of guidelines;
- Availability of basic essential equipment, transport, sufficient human resources;
- Public health education and awareness towards patient related factors (late bookings, un-booked);

Coverage and quality of antenatal care that is prioritizing person centred care and wellbeing, remains the cornerstone towards prevention of maternal morbidity and mortality.

8.3.6 Neonatal Death in Facility

Figure 10 Neonatal deaths in facility rate



	Frances Baard	John Taolo Gaetsewe	Namakwa	Pixley ka Seme	Zwelentlanga Fatman Mgcawu	Northern Cape Province
April 2021 - March 2022	13,9	12,0	4,5	10,1	16,6	12,9
April 2022 - March 2023	18,3	12,3	7,3	9,9	13,0	14,2
April 2023 - March 2024	14,0	14,2	5,5	9,4	15,7	13,3

Source: WebDHIS

Most Neonatal Deaths occur during the first week of life (0 – 6 days). Neonatal Death in Facility rate performance fluctuating, not achieved for FY 2022/2023 (14.2/1000 live births) against the set target of 14/1000 with performance achieved for FY 2021/22 (12.9/1000 live births) 2023/24 (13.3/1000 live births) respectively.

The following causes of deaths preterm birth, childbirth-related complications (birth asphyxia), infections still remain. There is an opportunity to improve survival and health of new-born's and end preventable stillbirths by strengthening of health systems e.g. establishment of designated neonatal units in district hospitals, KMC units, availability of basic essential equipment, appointment of staff and improvement of skills and knowledge of clinicians.

VERTICAL TRANSMISSION & PREVENTION

Infant PCR test positive around 6 months' performance not achieved for the FY 2023/24 (1.1%) and HIV test positive around 18 months' rate achieved FY 2023/24 (0.5%) against the target of ≤1%. There are still challenges with HIV positive pregnant women not adhering to treatment, late booking, monitoring of viral loads, mixed feeding, lost to follow up, etc. It is with noting that stigmatization and potential non-disclosure of HIV status to partners and families. Efforts will be directed towards emphasis on maternal contraception, Pre- Exposure Prophylaxis (PrEP) initiation during pregnancy and post-delivery; early booking and initiation of HIV positive pregnant women on treatment, integration of Child health services, public health education and awareness campaigns.

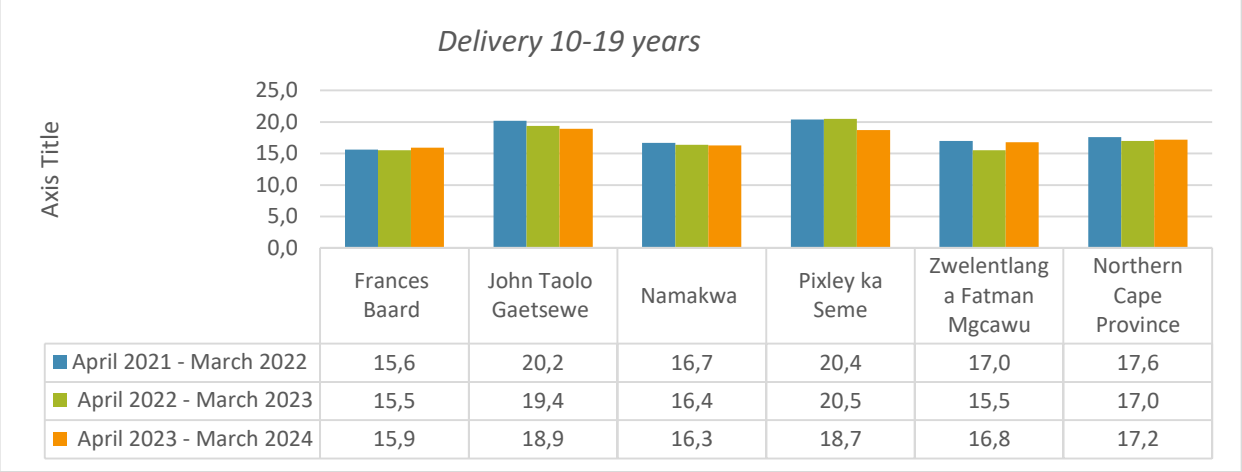
Sexual Reproductive Health

The couple year protection rate trends fluctuate over the past 3 years from 44.5% in 2021/22 to 38.3% in 2022/23 and 57.5% in 2023/24. The reasons included intermittent national stock-outs of contraceptive methods including condoms.

The dual protection strategy needs to be emphasized so that sexually active young individuals are protected against unwanted/unplanned pregnancies and sexually transmitted diseases. The priority interventions are to ensure constant supply of contraceptives, capacity building and public health education and awareness. Upscale the availability of competent clinicians and sites for the provision of Choice on Termination of Pregnancy services.

Delivery 10 – 19 Years

Figure 11 Delivery 10-19 years (a comparison between 2019/20, 2020/21 and 2021/22



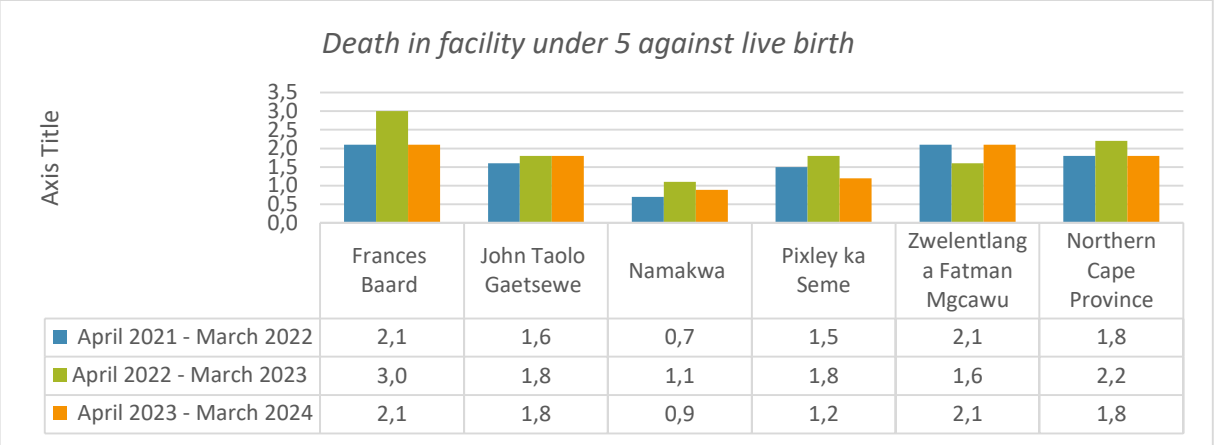
	Frances Baard	John Taolo Gaetsewe	Namakwa	Pixley ka Seme	Zwelentlanga Fatman Mgcawu	Northern Cape Province
April 2021 - March 2022	15,6	20,2	16,7	20,4	17,0	17,6
April 2022 - March 2023	15,5	19,4	16,4	20,5	15,5	17,0
April 2023 - March 2024	15,9	18,9	16,3	18,7	16,8	17,2

Source: WebDHIS

Delivery 10-19 years' trend remains similar and high against the set target of ≤ 16% for the past three (3) Financial Years. Interdepartmental collaborative approach and collective responsibility become important to address multiple factors that contribute to high teenage pregnancy including societal issues affecting young people which are difficult to tackle. Youth zones are established in all health care facilities in order to improve access and provide the integrated, comprehensive services to adolescents and youth including promotion of contraceptives using social media. However, there is still a greater need to ensure that the young people access the services by marketing youth zones.

Child Health

Figure 12 Death in facility under 5 against live birth



	Frances Baard	John Taolo Gaetsewe	Namakwa	Pixley ka Seme	Zwelentlanga Fatman Mgcawu	Northern Cape Province
April 2021 - March 2022	2,1	1,6	0,7	1,5	2,1	1,8
April 2022 - March 2023	3,0	1,8	1,1	1,8	1,6	2,2
April 2023 - March 2024	2,1	1,8	0,9	1,2	2,1	1,8

Source: WebDHIS

Death in facility under 5 years' rate performance fluctuating with similar levels of 1.8% for both Financial Year 2021/22 and Financial Year 2023/24 respectively. The major contributing category to under 5 deaths is during the neonatal period where the need for service delivery exceeds the current capacity of both the Regional and Tertiary hospitals. Efforts to be directed towards improving the neonatal care at district hospitals. The targets for "under-five year case fatality rate" (Diarrhea and SAM) have been achieved during the financial year 2023/24 except for Pneumonia case fatality.

However, children present late at health facilities resulting in a poorer prognosis and ultimately death. Late presentation and comorbid conditions such as neurological disorders, chronic conditions, etc. and missed opportunities related to TB/HIV have been reported as some of the contributing factors to Severe Acute Malnutrition (SAM) deaths. The interventions to address health systems inefficiencies namely; shortage of staff, lack of essential equipment and high care units, etc. will improve the child health outcomes. Auditing of all under 5's deaths is conducted and continuous training provided to improve quality of care. The 1st 1000 days is an apex and remain the priority to be implemented to address the well-being of our mothers, neonates and children under 5 years of age.

Expanded Programme On Immunizations (EPI)

The performance achieved for both indicators Immunization under 1-year and Measles 2nd dose 1-year coverage for the past 3 FY's FY 21/22 (72.8%) FY 22/23(75.9%) and FY 2023/24, 77.1% against the target of 70% and FY 21/22(72.2%), FY 22/23(73.6%) and FY 23/24 (77.7%) against the target of 70%. Public Private Partnerships (PPP's) improved access and resulted in a positive impact in achieving the two indicators. The priority is to vaccinate as many children under 5 years as possible, prioritizing the zero dose (unimmunized) and under immunized children to improve the coverages, achieve herd immunity which will mitigate the outbreaks of Vaccine Preventable Diseases (VPD). The country is embarking towards implementing Immunization Agenda (IA2030), which is supported by the World Health Organization. The agenda seeks to address key challenges in immunizations over the next decade and emphasises the need for all people to benefit from recommended immunizations throughout the life course.

Table 11 EPI Surveillance

Year	Expected AFP cases	Total non-Polio AFP cases	Case detection rate 4,0 cases/100 000 of <15 year olds	Stool adequacy rate Target	Stool adequacy rate
2021	15	11	3,2	80%	53,8%
2022	15	9	2,4	80%	100%
2023	15	10	3,0	80%	90%

In the past 3 years the province has not been able to reach detection rate of 4/100 000 cases, however achievement is noted in the stool adequacy rate performance of 80% for three consecutive years.

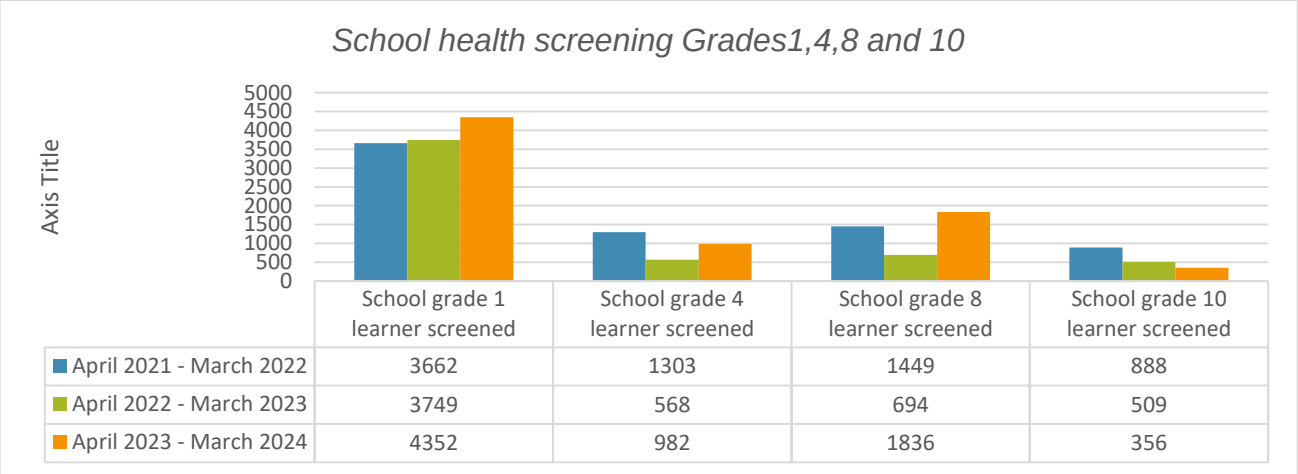
Table 12 Measles statistics

Year	Expected suspected Measles cases	Total detected Measles cases	Total Measles confirmed cases	Measles Incident rate (Target <1/10000000 population)	Proportion of cases investigated with blood (Target 80%)
2021	26	12	0	0,0	92,3
2022	26	26	0	0,0	92,3
2023	26	121	3	2,3	100.0

Furthermore, the province experienced Measles outbreak in one district, namely; Frances Baard with (3) positive cases. Furthermore, PKS accounted for most Rubella confirmed cases (163) and six (6) from FB. The province is in the process of transitioning to implement Rubella/Measles containing vaccine and catch up vaccinations to mitigate the spread of infections and prevent outbreaks.

Integrated School Health Programme (ISHP) & HPV

Figure 13 School health screening Grades1,4,8 and 10



Source: WebDHIS

Comprehensive ISHP services are still sub-optimal due to health system inefficiencies. However, HPV vaccination is implemented in all districts. INNOVO, Tshela, Pathways to change and SIOC-CDT contributed with the screening of learners in their designated districts. HPV round 1 was conducted during February/March 2023 and (82%) learner coverage and (99%) school coverage was achieved against the target of 80% for both the indicators. Plans are in progress to appoint outreach team leaders who will be assisting with the ISHP.

Table 13 Maternal and Women's Health

Indicator	Type of Indicator	Period	NC	Frances Baard	JTG	Namakwa	PKS	ZFM
Maternal mortality in facility ratio (per 100k)	Impact	FY23/24	115.8/100000	207/100000	74.1/100000	0	66/100000	60.4/100000
Maternal death in facility (Number)		FY23/24	28	19	4	0	2	3
Live birth in facility (Number)		FY23/24	24186	9180	5395	1610	3030	4971
Delivery in 10 to 19 years in facility rate	Outcome	FY23/24	17.2%	15.9%	18.9%	16.3%	18.7%	16.8%
Delivery in 10 to 19 years in facility (Number)		FY23/24	3608	1205	890	213	504	766
Delivery in facility- total (Number)		FY23/24	21027	7557	4714	1494	2702	4560
Mother postnatal visit within 6 days rate	Output	FY23/24	65.2%	49.5%	92.2%	56.7%	77.5%	58.7%
Mother postnatal visit within 6 days after delivery(Number)		FY23/24	13704	3741	4346	847	2095	2675
Delivery in facility – total		FY23/24	21027	7557	4714	1494	2702	4560
Antenatal 1st visit before 20 weeks rate	Output	FY23/24	57.2%	49.8%	57.9%	63.8%	65.4%	61.7%
Antenatal 1st visit before 20 weeks (Number)		FY23/24	14107	4318	3434	1093	2074	3188
Antenatal 1st visit- total		FY23/24	24655	8669	5929	1714	3173	5170
Couple year protection rate	Output	FY23/24	57.5%	69.1%	59.4%	33.4%	65.5%	44.2%

Table 14 Child Health

Indicator	Type of Indicator	Period	Northern Cape	Frances Baard	JTG	Namakwa	PKS	FZM
Death in facility under 5 against live birth	Impact	FY23/24	1.8%	2.1%	1.8%	0.89%	1.2%	2.1%
Death in facility under 5 years (Number)		FY23/24	339	152	71	10	28	78
Live birth in facility (Number)		FY23/24	21793	8555	4648	1464	2657	4469
Diarrhea case fatality under 5 years rate	Impact	FY23/24	1.8%	5.7%	0.76%	0	0.65%	0.87%
Diarrhoea case fatality under 5 years (Number)		FY23/24	16	11	1	0	1	3
Diarrhoea separation under 5 years (Number)		FY23/24	876	193	132	0	155	343
Pneumonia case fatality under 5 years rate	Impact	FY23/24	3.1%	10.5%	6.1%	1	0	1.7%
Pneumonia case fatality under 5 years (Number)		FY23/24	23	8	10	1	0	4
Pneumonia separation under 5 years (Number)		FY23/24	753	76	165	97	181	234
Severe acute malnutrition case fatality under 5 years rate	Impact	FY23/24	5%	8.8%	3.1%	3%	2.8%	4.2%
Severe acute malnutrition case fatality under 5 years (Number)		FY23/24	25	13	2	1	3	6
Severe acute malnutrition inpatient under 5 years (Number)		FY23/24	499	148	65	33	109	144
Neonatal death in facility rate (per 1K)	Impact	FY23/24	13.3/1000	14/1000	14.2/1000	5.5/1000	9.4/1000	15.7/1000
Neonatal deaths (under 28 days) in facility (Number)		FY23/24	289	120	66	8	25	70
Live birth in facility:		FY23/24	21793	8555	4648	1464	2657	4469
Infant PCR test positive around 6 months rate	Outcome	FY23/24	1.1%	1.4%	1.6%	2.8%	0.98%	0.38%
Infant PCR test positive around 6 months (Number)		FY23/24	10	2	3	2	2	1
Infant PCR test around 6 months (Number)		FY23/24	870	148	182	71	204	265
HIV test positive around 18 months rate	New indicator	FY23/24	0.49%	0.44%	0.72%	0.83%	0.3%	0.41%
HIV test positive around 18 months(Number)		FY23/24	35	8	12	3	4	8
HIV test around 18 months(Number)		FY23/24	7108	1799	1665	361	1314	1969
Immunisation under 1 year coverage	Output	FY23/24	77.1%`	80.3%	82.6%	75.3%	65.4%	75.8%
Immunisation fully under 1 year new (Number)		FY23/24	19198	6381	5015	1352	2723	3727
Measles 2nd dose coverage		FY23/24	77.7%	77.5%	82.5%	75.1%	67%	82.2%
Measles 2nd dose (Number)		FY23/24	19664	6232	5030	1378	2828	4196

Table 15 Collaboration with other government and non-government stakeholders

Sub Programme	Type of collaboration	Name of stakeholder
MCYWH&N	**Integrated School Health Programme (ISHP)** The Department of Education, Health and Social Development are key role players in the implementation of Integrated School Health Programme (ISHP), early intervention to address health and psychosocial barriers, learning is critical to enhance children's development and educational gains. The partners/ NGO's are aiming to support the department with the implementation of the ISHP comprehensive package.	• Department of Education • Department of Social Development • Innovo NGO at FB, PKS, JTG and Nam • Tshela Bophelo Solution Wellness JTG • Pathways to change (FB) • Grass roots (FB)
	Expanded Programme on immunization(EPI) Establishment of Public Private Partnerships(PPP's) to improve access and coverage to vaccination services for children to increase the Herd immunity of the community at large.	• **Frances Baard**:1x Doctor, 3x Nurse Practitioners, 2x Private Pharmacies • **JTG:** 1x Private Pharmacy, 6x Nurse Practitioners: 1x Private game reserve • **ZFM**: 1x Private Doctor • **PKS:** 1x Private Pharmacy • **Namakwa**: 1x Private Pharmacy
	Adolescent and Youth Programme(AYP) Provision of Adolescent and Youth comprehensive package of services. Stakeholders engagement in the promotion of health among Adolescent and Youth and addressing commitments and social ills	• NGO's /Partners • Department of Education • Department of Social Development • Department of SAPS • Department of Justice • SANDFS
		• Health promotion through radio slots

8.4 Change Management and Transformation

PILLAR 4: Response, Care, Support and Healing

Outcome: Victim-Centred and survivor-focused, accessible, equitable and quality services that are readily available across the criminal justice system, health system, education system and social support system at all respective levels.

The Department of Health has forged an integrated approach in a quest to addressing and making its contribution in the fight against GBVF by partnering with other stakeholders such as NPA, DSD and SAPS. There are Service Level Agreements in place with these stakeholders which are collaboratively designed to ensure that the services provided are survivor-focused, accessible, equitable and of a good quality.

However, the primary deliverable as the department other than providing gender mainstreaming is creating a platform for victim empowerment by providing access to care and support services at the five Thuthuzela Centres in support of the NPA lead initiatives. Thuthuzela Centres are supported by partners (Lifeline and Pathways to Change) in five districts in order to strengthen services. Thuthuzela Care Centres operate in public hospitals close to communities where the incidence of rape is particularly high. They are also linked to sexual offences courts, which are staffed by skilled Prosecutors, Social Workers, Magistrates, NGOs and Police, and located in close proximity to the centres.

These centres provide the following services:

- provide medical care for survivors of sexual violence.
- offer counselling for survivors of sexual violence, including trauma containment and debriefing.
- provide access to the legal system and help survivors find justice in court.
- provide access to shelters or other safe places for survivors who are unable to return home.
- provide access to anti-retrovirals and ongoing HIV counselling.
- provide information on arrests, court dates, and bail decisions.
- assist survivors in preparing for court.
- refer survivors to other services that address family violence, drug rehabilitation, and HIV support.

The Thuthuzela Centres are premised under Forensic Unit but its programmes are funded by HAST Unit which works closely with the Change Management and Transformation on Gender Mainstreaming initiatives which include creating awareness and advocacy for employees in the Department. There are forums which were commissioned to deal with gender issues but their term has ended and new committee members have to be elected.

The Change Management and Transformation Unit has developed policies which advocates for GBVF-free environment for our employees such as Sexual Harassment in the Workplace and Dignity at Work.

SONA/SOPA 2025

The health sector wants a nation in which there is quality health care for all. This will be achieved by proceeding with the preparatory work for the establishment of the NHI. This includes developing the first phase of a single electronic health record, preparatory work to establish Ministerial Advisory Committees on health technologies and health care benefits, and an accreditation framework for health service providers.

The NHI will reduce inequalities in healthcare by ensuring everyone gets fair treatment. It will save many lives by providing a package of services that include, for example, maternal and newborn care and services for people living with HIV, those with TB, and those suffering from non-communicable diseases such as heart disease, cancer and diabetes. Our most immediate priority is to strengthen the health system and improve the quality of care.

A vital part of this is the modernisation, improvement and maintenance of existing health facilities and construction of new hospitals and clinics. A number of hospitals are under construction or undergoing revitalisation. To improve patient experience, we are putting more emphasis on reducing waiting times, cleanliness and staff attitudes in public health facilities. We are encouraged by the great progress the country has made towards ending HIV and AIDS as a public health threat. By the end of March 2024, 96 percent of people living with HIV knew their status, 79 percent of these were on antiretroviral treatment and 94 percent of those on treatment were virally suppressed. To ensure that we reach our target of 95-95-95, we will this year launch a massive campaign to look for an additional 1.1 million people who are not on treatment.

We are concerned about the potential impact of the decision by the United States government to suspend some of its funding for HIV and TB programmes in African countries for 90 days. This funding accounts for about 17 percent of our country's HIV spend. We have been able to provide funding from our fiscus for our HIV and TB programmes over the years. We are looking at various interventions to address the immediate needs and ensure the continuity of essential services.

9. MTEF BUDGETS

9.1 Overview of 2025/26 Budget and MTEF Estimates

MTEF BASELINE PRELIMINARY FOR 2024/25-2026/27

- Financial Year 2024/2025 – R 6 442 133 000
- Financial Year 2025/2026 – R 6 868 747 000
- Financial Year 2026/2027 – R 7 067 338 000

Key Assumptions

The following broad key assumptions were made while preparing the budget of the Department of Health for the 2025 MTEF:

- The assumption for the general CPI used for the current budget is based on the inflationary projections estimated at 4.4 per cent for 2025/26, 4.5 per cent for 2026/27 and 4.5 per cent for 2027/28.
- Improvement on Condition of Service carry through costs of the 2025 wage increase amounting to R36 691 million.
- Additional amount of R70 889 is allocated and earmarked to cushion 2024 ICS.
- Reversal of fiscal consolidation reduction amounting to R88.418 million in the equitable share allocation.
- Provision of 1.5 per cent for pay progression of the wage bill has been factored into the baseline of compensation of employees.
- A further once off allocation amounting R8.565 million as Social Sector Expanded Public Works Programme Incentive grant in order to sustain community healthcare workers' services.

Aligning departmental budgets to achieve government's prescribed outcomes

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

Improve health outcomes by responding to the quadruple burden of disease of South Africa

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

Over the next 5 years, the Provincial Department of Health's response is structured into impact statements and outcomes. These impact statements and outcomes are well aligned to the Pillars of the Presidential Health Summit compact.

Inter-sectoral collaboration to address social determinants of health

The World Health Organization (WHO) identifies Adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 – 19. This is a very critical stage in the development of a young person's life, as it is characterized profound physical, biological, social and emotional changes. It is a time in which identity formation begins, as individual's transition from childhood to adulthood, from dependence to independence. New attitudes, feelings, and risk taking behavior defines an individual's experience during adolescence, and potentially shapes a person's behavior.

Northern Cape showed the highest number of teenage pregnancy (19.3%) of all the provinces between April 2020 and March 2021 (2020/21 FY) 4.4 million children in South Africa are living with HIV (only those that have tested) majority coming from Black, Coloured and Indian communities. The Collaboration between the Social Cluster Departments like Department of Education, Social Development, Safety, Agriculture and other relevant sectors has since made the Department to perform at 17% in 2022/23 and 16,7% in 2023/24 third quarter respectively. There were interventions that were implemented amongst others:

Adolescent and Youth Friendly Services (AYFS) which is a standards driven approach to improve quality of care for adolescents and youth and Integrated School Health Programme, which focused on addressing both the immediate health problems of learners, including barriers to teaching and learning as well as implementing interventions that can promote their health and well-being during childhood and beyond.

Progressively achieve Universal Health coverage through implementation of National Health Insurance (NHI)

The District Health Services Strategy was reviewed and finalized in 2023 and seven goals have been identified below to give effect to this strategy**.**

i. Strengthen Leadership Development and Governance
ii. Optimize Comprehensive Health Service delivery to improve health outcomes.
iii. Improve Quality of Health services.
iv. Strengthen community involvement and social accountability:
v. Strengthen Inter-sectoral collaboration.
vi. Strengthen the sub-district for UHC and the NHI
vii. Strengthen System Capacity (systems, policies, processes, tools, and resources)

Improve quality and safety of care

The Department implemented CCMDD successful which is an initiative that seeks to improve Public Health Care service delivery, through centralised dispensing and distribution of medicines. The aim of this strategy is to decant stable patient from our health care facilities. The benefits of this initiative over a period of time has been to ensure that in improving quality of health care the department:

- Shortens patient waiting times
- Ensures convenient Pick up Points for patients (closer to home/work place)
- Nurses have more time for critical patients and improve quality of patients
- Reduces congestion at clinics
- Reduces risk of cross infections
- Relief work load for clinic staff
- Allows patients to take control/ownership of their health

The other intervention is the HPRS which is a foundational building block for successful NHI, Health Patient Registration System (HPRS) is developed by NDOH together with CSIR with the intention to:

- Create and allocates a Unique Health Patient Identification Number (from cradle to grave)
- In the **current phase**, each patient's demographic data is linked to this Unique Health Patients Identification number and stored on the system.
- The **next phases** of this programme will focus on linking the patients' Health Records to the number.
- Additional Benefits of the HPRS include:
  - Generate a *Patient File Number*
  - *Tracking of Patients* from one facility to another
  - *Lab Track functionality*
  - Appointment System

Improve and sustain the Ideal health facility status throughout the province

Ideal Clinic Realization and Maintenance:

The purpose of a health facility is to promote health and to prevent illness and further complications through early detection, treatment and appropriate referral. To achieve this, a clinic should function optimally thus requiring a combination of elements to be present in order to render it an “Ideal Clinic”.

An Ideal Clinic is a clinic with good infrastructure1, adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies, that uses applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community.
The Department of Health should cooperate with other government departments as well as with the private sector and non-governmental organizations to address the social determinants of health. Primary Health Care (PHC) facilities must be maintained to function optimally and remain in a condition that can be described as the “Ideal Clinic”.

Provide leadership and enhance governance in the health sector for improved quality of care
Governance structures

Governance structures in line with national health policy and are intended to:

- Provide **oversight** on provision of quality healthcare services.
- Provide expression to the **principle of community participation** at a local and district level.
- Act as a **link** between communities and health services
- Provide a **platform for the health needs and aspirations of the communities** represented at local, districts, provincial and national levels.
- Ensure community participation that is nationally recognised for its potential in realising **good health outcomes**
- De-escalating potential community conflict

The Department through the Office of the MEC for Health has appointed Governance structures in all facilities which are Clinic Committees, hospital boards, mental health review board and the nursing college council. The department should ensure that all these boards are fully functional and accounts to the plight of communities

District Health Services

Resetting of the service delivery platform and reviewing the DHS strategy to strengthen service and enhance responsiveness to serice demands. Reconfiguration and reorganization of the operational capcity of the service platform to enhance effectiness and efficiencies of healthcare service delivery through:

- Expansion of operational hours.
- Operationalisation of theatres.
- 24-hour Operationalization of CHC.
- Classification of facilities.
- Access to underserviced and underserviced areas.

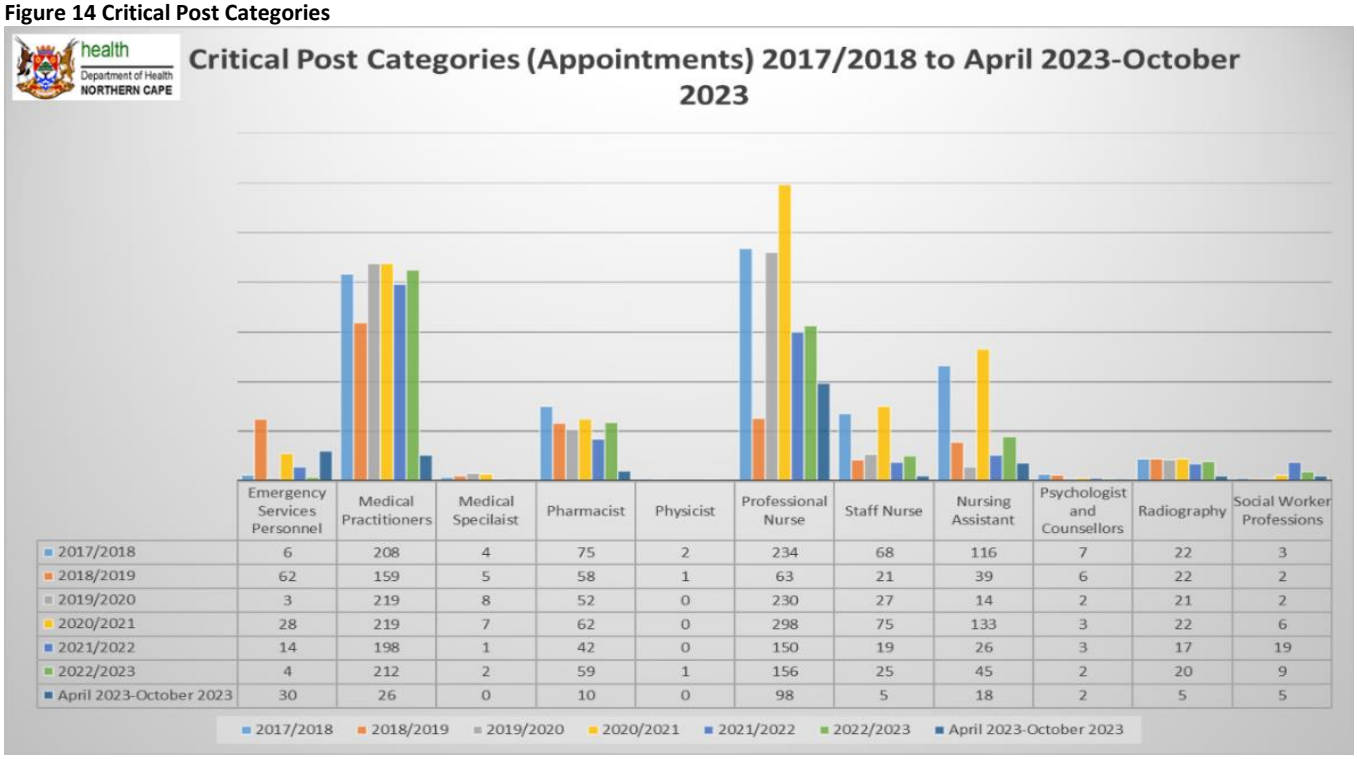
Improve equity, training and enhance management of Human Resources for Health

Without adequate and skilled health care workers, and their right skills mix, as well as their distribution in the right place, it is difficult to provide efficient, effective, good quality and equitable health care services for all South Africans. Most of the public health facilities in the province experience shortage of human resources for health, compared to their catchment population size and the burden of diseases within those communities.

Currently, the total number of fixed staff establishment is standing at 6 709. This was a 2.3% decrease from 2018, which was at 6866 total work-force (Clinical and support services). The department invested

a lot in filling scarce skills of which is a problem country wide, competing with the private sector that utilises our employees through a moon-lighting system.

Figure 14 Critical Post Categories



	Emergency Services Personnel	Medical Practitioners	Medical Specialist	Pharmacist	Physicist	Professional Nurse	Staff Nurse	Nursing Assistant	Psychologist and Counsellors	Radiography	Social Worker Professions
2017/2018	6	208	4	75	2	234	68	116	7	22	3
2018/2019	62	159	5	58	1	63	21	39	6	22	2
2019/2020	3	219	8	52	0	230	27	14	2	21	2
2020/2021	28	219	7	62	0	298	75	133	3	22	6
2021/2022	14	198	1	42	0	150	19	26	3	17	19
2022/2023	4	212	2	59	1	156	25	45	2	20	9
April 2023-October 2023	30	26	0	10	0	98	5	18	2	5	5

2017/2018 2018/2019 2019/2020 2020/2021 2021/2022 2022/2023 April 2023-October 2023

Improve community engagement and re-orient the system towards Primary Health Care through community-based health programmes to promote health

HIV Testing Services (HTS)

The HIV prevention programme managed to test two hundred and eighty-two thousand, six hundred and forty-eight (282 648) people for HIV against the quarterly target of two hundred and eighty-five thousand, seven hundred and fifty-five (285 755), which is a 99% achievement rate. This achievement was largely due to the following:

- Support from the Non-Governmental Organizations (NGOs).
- Build-up campaigns towards Sexual Reproductive Health week.
- TB World Day commemoration.

Additionally, despite some reports of stock outs late in the third quarter and early in the fourth quarter, due to inadequate stock from the service provider, there was better management of available HIV rapid test kits with rotation to ensure that no clients were turned away from facilities. In an attempt to mitigate the shortfall, the NDOH was engaged to assist and they tried to source test kits from the Gauteng Province, which could not materialise due to different ordering systems between Gauteng and Northern Cape. During the last quarter of the financial year orders on condoms were processed and the relevant service provider was able to deliver the HIV test kits.

Condom Distribution and Promotion

Condoms are effective at preventing Sexually Transmission Infections (including HIV) and unintended pregnancies, provided they are used consistently and that they are stored and transported correctly. The province and districts did not achieve the set targets in the 2022/2023 financial year. There is low male condom stock on hand while female condom is out of stock in four of the five Districts, which is due to the new RT tender that has affected service providers as they are waiting for shipment. This has attributed to non-achievement of the set target.

The National Department of Health conducted an assessment of the Provincial Distribution Sites (PDSs) across the province from the 16th to 20th May 2022. The purpose of the visit was to assess the conditions in which condoms are stored, stock on hand through bin cards, financial accountability through checking proof of delivery in the form of invoices, challenges and remedial actions. The findings were that most PDSs are non-existing or not in a good condition as condoms are in some instances not stored properly. The National Department of Health committed to support the Province with donation of stock while orders are placed.

Transport is also a challenge in all the Districts which has a negative impact on the condom distribution. Three single cab bakkies have been procured to assist with distribution. Lubricants and pallets will be procured for proper storage of condoms. Three SUVs have been procured and dispatched to the identified Districts to mitigate the shortage of transport for condom distribution. One NGO has been funded to further strengthen the distribution of condoms in the ZF Mgcawu and Pixley Ka Seme Districts.

Robust and efficient health management information systems to automate business processes and improve evidence based decision making

Voice Over IP (VOIP) Telephone System

The telephone system in the Department at all Hospitals and District Offices are currently finalized. This new system will assist in reducing costs and serve as a control measure in possible unofficial usage, however, there is a need to develop a system to control it, i.e. a Policy on official telephone usage.

Computer Aided Dispatch System(EMS)

The implementation of the Computer Aided Dispatch System includes the Call Centre Functionality, Ambulance Tracking and Monitoring. The Botshelo Application was launched and the system is currently functioning well

e-Submission

The implementation of the e-Submission system for an automated submission process is still gaining momentum as additional programmes are gradually being included. The following has been completed to date:

- Users created on the system for Districts and Hospitals
- Training completed for all users in the Districts
- Technicians trained in the Districts for support
- Final signatures to be uploaded on the system from Districts

Connectivity

Very small aperture terminal (VSAT) equipment is being delivered to the fourteen facilities identified within the JTG District. The following has been done to date:

- Fixed point to point connectivity completed in JTG District
- 14 VSAT Installations to be completed in JTG
- Facilities in Francis Baard and Pixley Ka Seme are currently being visited to resolve any issues encountered with the routers
- Pixley Ka Seme SA-Connect sites were identified with SITA and are being tested for functionality
- Provincial Office Networks Unit and District Technicians are currently attending to connectivity issues

Disaster Recovery and Business Continuity

The proposal for the Development of Disaster Recovery and Business Continuity Plan has been approved and SITA has been appointed as the Service Provider. This will enable the Department to be compliant with the Disaster Recovery Plan and Business Continuity Plan Policies.

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

Infrastructure Planning

Construction of New Nursing Main Campus
The Construction of new nursing college main campus Phase 2 is an ongoing project and expected to reach practical conclusion by end of March 2027.

New Schmitsdrift Clinic
The Schmitsdrift Clinic was planned for in 2024/ 25 financial year and was not completed and will be completed in the 2025/26 financial year

Upgrading and Refurbishment of Keimoes Hospital
The site was handed over in June 2024 and the final completion is expected to be done 2025/26 financial year

Frances Baard Forensic Mortuary
The project has been put on hold due to appointment of a service providers, however, process are in place to proceed in 2025/26 FY

9.2 Outlook for the coming financial year (2025/26)

The key priorities of the department include the following:

- Operationalization of theatres at district hospitals to increase theatre times as part of dealing with surgical backlogs.
- Investment in halfway houses to deal with psychiatric patients that requires further clinical care to limit hospital space.
- Monitoring and implementation of the organogram to ensure equitable share distribution of human resources for health.
- Improve the response time for emergency medical services through procurement of additional ambulances and improved call center management system.
- Improve access to tertiary services through the training of registrars especially in critical areas like oncology, psychiatry, anesthesia etc.

Reprioritisation

In the preparation of the 2025/26 MTEF budget, the department undertook the following decisions to reprioritise its budget:

- An amount of R16.941 million and R21.018 million for 2025/26 and 2026/27 respectively was reprioritized from goods and services budget to compensation of employees within programmes such as Programme 1: Administration, Programme 2: District Health Services, Programme 4: Provincial Hospital Services and Programme 5: Central Hospital Services to alleviate pressure and to ensure adequate provision of personnel costs.
- R35 million was also reduced from Programme 6: Health Science and Training to Programme 1: Administration, Programme 2: District Health Services, Programme 4: Provincial Hospital Services and Programme 5: Central Hospital Services to address spending pressures on goods and services and transfers as a result of contractual obligations, litigations as well as unplanned employee exits.

Procurement

The department plans to procure goods and services at an average of R2.522 billion over the MTEF period. This amount makes provision for a number of major purchases, including:

- Contractual obligations such as (Medical waste, Medical gas, SANBS, National Health Laboratory Services (NHLS) etc, property payments, security services, medicines and medical supplies amongst others.

- The department participates in transversal contracts to procure services where possible, and is in a process of reviewing all procurement contracts as a cost saving measure and procurement process improvement aligned to service delivery standards.
- Amongst the departments MTEF procurement plans is the refurbishment and construction of health facilities and procurement of health technology equipment to operationalize newly constructed facilities as well as the maintenance of machinery and equipment utilized by health facilities.
- The Framework for Infrastructure Delivery and Procurement Management FIDPM will facilitate infrastructure Procurement in line with Supply Chain Regulations and the support of the CIDB Standard for Uniformity in construction procurement. The department is committed to develop a procurement strategy for construction procurement.

9.3 Programme summary

Summary of payments and estimates by programme.

Table 16 Summary of payments and estimates by Programme

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2021/22	2022/23	2023/24		2024/25		2025/26	2026/27	2027/28
Programmes									
1. Administration	260 115	279 990	263 366	264 977	274 977	275 444	283 063	295 423	308 392
2. District Health Services	2 828 005	2 784 553	2 958 068	2 941 329	2 917 948	2 931 353	3 100 177	3 233 052	3 376 066
3. Emergency Medical Services	407 434	416 648	505 849	448 052	453 052	453 767	477 712	498 564	520 495
4. Provincial Hospital Services	470 233	453 601	520 064	522 479	510 427	513 580	558 497	582 880	608 443
5. Central Hospital Services	1 211 672	1 259 103	1 249 376	1 290 986	1 265 138	1 271 102	1 358 231	1 400 556	1 462 535
6. Health Sciences and Training	150 532	172 024	320 538	345 377	310 377	310 838	359 594	371 857	388 519
7. Health Care Support Services	175 488	133 467	126 486	143 938	149 673	149 928	153 793	160 507	167 547
8. Health Facilities Management	379 913	407 209	452 885	484 995	484 995	485 091	577 680	524 499	548 175
Total	**5 883 392**	**5 906 595**	**6 396 632**	**6 442 133**	**6 366 587**	**6 391 103**	**6 868 747**	**7 067 338**	**7 380 172**

The total budget allocation of R6.868 billion for the 2025/26 financial year shows an increase of R426.614 million or 6.6 per cent compared to the 2024/25 financial year. The allocations further increase to R7.067 billion in 2026/27 and R7.380 billion in 2027/28 at an average of 4.5 per cent over the MTEF.

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

Summary of economic classification

Table 17 Summary of provincial payments and estimates by economic classification

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2021/22	2022/23	2023/24		2024/25		2025/26	2026/27	2027/28
Current payments	**5 599 527**	**5 492 619**	**5 790 466**	**6 074 207**	**5 985 789**	**6 010 305**	**6 488 744**	**6 692 764**	**6 988 742**
Compensation of employees	3 352 535	3 410 157	3 573 083	3 740 702	3 740 702	3 765 219	4 012 851	4 192 996	4 399 578
Goods and services	2 233 655	2 066 688	2 195 800	2 333 505	2 245 087	2 245 086	2 475 892	2 499 768	2 589 164
Interest and rent on land	13 337	15 774	21 583	–	–	–	–	–	–
Transfers and subsidies to:	**49 072**	**72 898**	**96 722**	**46 851**	**46 851**	**46 851**	**48 478**	**50 577**	**52 854**
Provinces and municipalities	9 004	641	1 100	14 880	4 880	4 880	15 553	16 219	16 950
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	33	38	15	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	40 035	72 219	95 607	31 971	41 971	41 971	32 925	34 358	35 904
Payments for capital assets	**234 793**	**341 078**	**509 444**	**321 075**	**333 947**	**333 947**	**331 526**	**323 997**	**338 576**
Buildings and other fixed structures	169 934	242 660	356 548	132 210	132 210	132 210	138 133	143 659	150 124
Machinery and equipment	64 859	84 100	136 684	188 865	201 737	201 737	193 393	180 338	188 452
Heritage Assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	14 318	16 212	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification	**5 883 392**	**5 906 595**	**6 396 632**	**6 442 133**	**6 366 587**	**6 391 103**	**6 868 747**	**7 067 338**	**7 380 172**

The allocation for salaries and related costs of employees in the department accounts for 58 per cent of the total allocation of the department in the 2025/26 financial year.

Compensation of employees grows to R4.013 billion in the 2025/26 financial year from R3.741 billion in the 2024/25 financial year, this is a 7.3 per cent increase. The increase is attributable to earmarked allocation for the improvement of condition of service for 2025/26 financial year and the cushioning of the 2024 unfunded wage agreement. This growth is stable at 4.5 per cent and 4.9 per cent for the 2026/27 and 2027/28 respectively.

The allocation for goods and services grows to R2.476 billion in the 2025/26 financial year, which is a 6.1 per cent increase from R2.333 billion in the 2024/25 financial year. The budget further grows at a marginal rate of 1.0 per cent and 3.6 per cent over the 2025 MTEF.

Transfers and subsidies budget grows by 3.5 per cent to R48.478 million in the 2025/26 financial year compared to R46.851 million in 2024/25 and continues to grow at 4.3 per cent and 4.5 per cent over the MTEF.

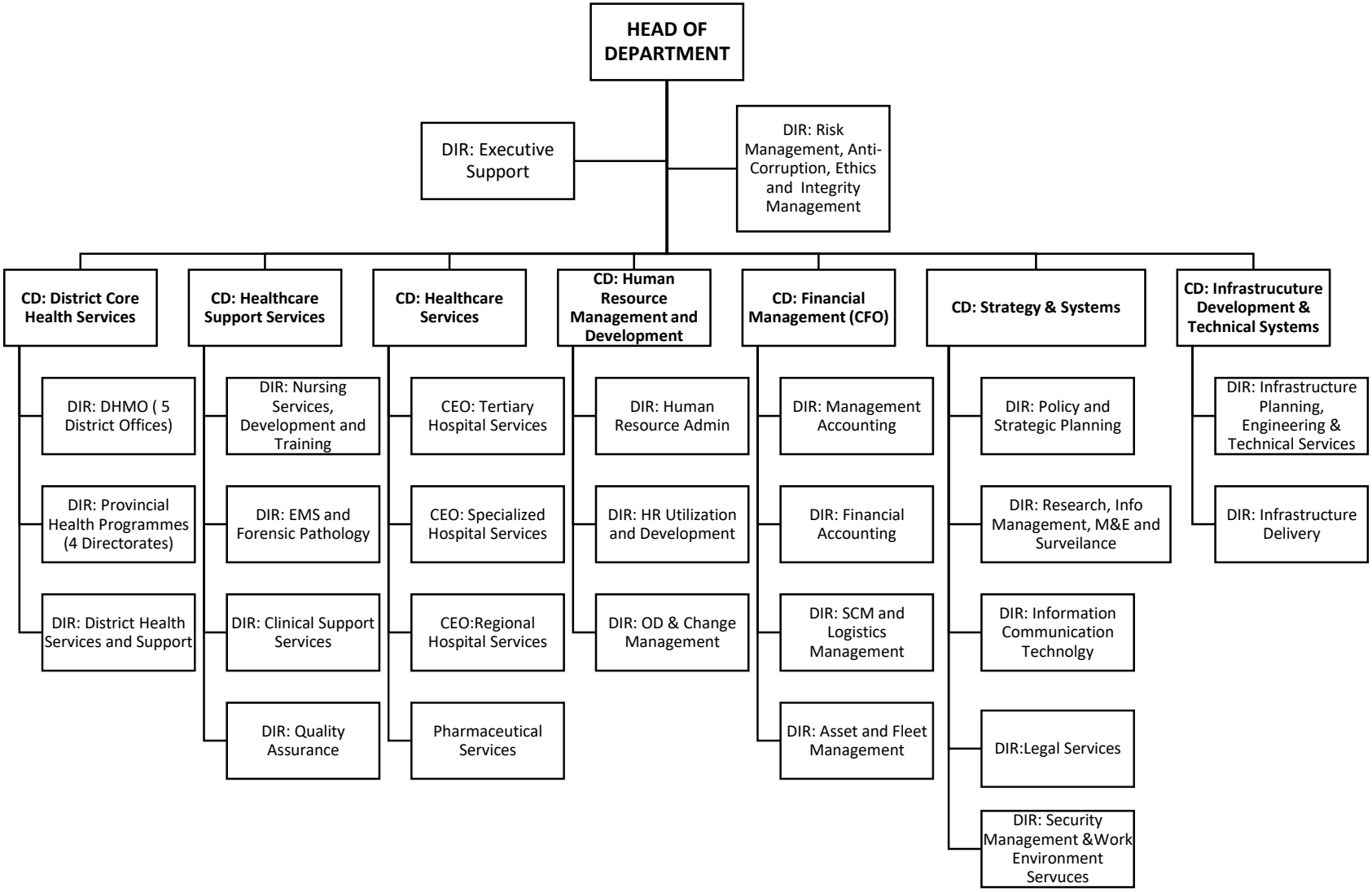
Payments for capital assets show growth of 3.3 per cent to R331.526 million in 2025/26 compared to R321.075 million in the 2024/25 financial year. A negative growth of 2.3 per cent and a growth of 4.5 per cent respectively in the outer years.

Table 18 Public Health Personnel in 2025/26

Categories	Number employed	% of total employed	Vacant Posts
Medical Officers	467	13.31%	58
Medical Specialist	38	1.08%	35
Dentists	38	1.08%	7
Dental Specialists	1	0.02%	1
Professional Nurses	1526	43.50%	418
Enrolled Nurses	214	6.10%	78
Pharmacists	146	4.16%	17
Physiotherapists	60	1.71%	10
Occupational Therapists	46	1.31%	20
Radiographers	88	2.50%	18
Emergency Medical Staff	712	20.29%	142
Dieticians and Nutritionists	63	1.79%	11
Allied Health Workers	109	3.10%	128
Total Health Workers	**3508**	**100%**	**865**

Source: Persal and Vulindlela- February 2025

10. INTERNAL ENVIRONMENT ANALYSIS: ORGANISATIONAL STRUCTURE



PROGRESS REPORT AND UPDATE ON THE APPROVED ORGANISATIONAL STRUCTURE FOR THE NORTHERN DEPARTMENT OF HEALTH

Implementation, Compliance, Monitoring and Reporting on the approved Organisational Structure

The Executive Authority approved the Organisational Structure on the 23rd January 2024 and the phased implementation of the approved Organisational Structure started on the 1st February 2024.
With the implementation of the Organisational Structure the department hopes to achieve the following objectives:

- Compliance with the Public Service Act, Public Service Regulations and the DPSA Directive on changes to the Organisational Structure by departments
- Ensure that the Organisational Structure is responsive to the mandate and vision of the department and contribute to the attainment of the strategic objectives of the department
- Promote value for money and achieve the envisaged impact in the manner in which the department is configured and capacitated.
- Strengthen compliance monitoring and reporting.
- Improve the alignment of Human and Financial (Budget) planning.
- Improved Human Resources allocation and Development of creditable HR policies

With the phased approach, the department has aligned the Persal post establishment to the approved Organisational Structure.

The District offices have been correctly reconfigured in line with the District Management Office (DHMO) generic structures to ensure uniformity across all the Districts.
Tertiary, Regional and Specialized Hospitals have been reconfigured in line with the DOH Guidelines for Organisational Structure for Hospitals

It is envisaged that full implementation of the Organisational Structure will take effect from 1st April 2025.

Monitoring and reporting of the implementation of the Structure is conducted in line with the PSR, PSA, PFMA and all legislative requirements and as per the norms and standards set out by the DPSA.

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12. ACKNOWLEDGMENTS

The Northern Cape Annual Performance Plan (APP) is a collective effort. This plan could not have been formulated without the substantial contribution of numerous individuals, budget programme managers and sub-programme managers who have been instrumental in the completion of the APP 2025/26.

These individuals are:

1. Office of the MEC under the guidance of Mr Maruping Lekwene
2. Office of the HOD under the guidance of Mr Mxolisi Mlatha
3. Office of the CFO under the guidance of Mr Amos Tsholo
4. Mr Mock Mocumi (Acting Director: Policy and Planning)
5. Ms Masego Manyetsa (Strategic Planning)
6. Ms Lorato Mooketsi (Strategic Planning)

PART C: MEASURING OUR PERFORMANCE

13 Institutional Programme Performance Information

MEASURING IMPACT

MTDP Priority 2: Reduce poverty and tackle the high cost of living	
Impact statement A	Life expectancy of the Northern Cape improved to 66.6 years by 2024, and 70 years by 2030
Impact statement B	Universal Health Coverage for all South Africans progressively achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030

MEASURING OUR OUTCOME

MTDP Outcome	Outcome	Outcome indicator	MTDP Period		
			Baseline 2023/24	Mid-year Target 2027	End of year 2030
Strengthen the primary health care (PHC) system by ensuring that home and community-based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative care services required for South Africa's burden of disease	Couple Year Protection	Couple Year Protection Rate	57.5%	50%	55%
	Prevent Adolescent Pregnancy	Number of Deliveries in 10-14 years in facility	-	70%	65%
	Increase percentage (80%) of pregnant women attend ANC before 20 weeks	Antenatal 1st visit before 20 weeks rate	57.2%	64%	65%
	Increase percentage (80%) of mothers attend postnatal care between 0-20 days	Mother postnatal visit within 6 days rate	65.2%	66%	68%
	Birth infant PCR positive at birth rate <0.4	Infant 1st PCR test positive at birth rate	-	≤1%	≤1%
	90% of children are fully immunised by one year of age	Immunisation under 1 year coverage	77.1%	75%	75%
	Death in children under five years of	Child under 5 years diarrhoea case fatality rate	2.1%	≤2.9%	≤2.9%

MTDP Outcome	Outcome	Outcome indicator	MTDP Period		
			Baseline 2023/24	Mid-year Target 2027	End of year 2030
	age from pneumonia, diarrhoea And Malnutrition are reduced 5% annually	Child under 5 years pneumonia case fatality rate	3.7%	≤2.8%	≤2.7%
		Child under 5 years severe acute malnutrition case fatality rate	5%	≤6%	≤6%
	Cervical cancer prevention	Cervical Cancer Screening Coverage	-	35%	40%
	95% of children receive two doses of measles containing vaccine	MR 2nd dose 1 year coverage	77.7%	75%	75%
	AIDS related deaths reduced by implementing the 95-95-95 strategy	HIV positive 5-14 years (excl ANC) rate	-	1%	<1%
		HIV positive 15-24 years (excl ANC) rate -	1.9%	≤2%	≤2%
		ART adult remain in care rate [12 months]	57%	95%	95%
		ART child remain in care rate [12 months]	72.49%	95%	95%
		ART adult viral load suppressed rate (below 50) [12 months]	65.3%	95%	95%
		ART child viral load suppressed rate (below 50) [12 months]	22.6%	95%	95%
	All DS-TB client Treatment Successfully completed treatment	All DS-TB client Treatment Success Rate *	74.4%	80%	80%
	TB RR-/MDR Successfully completed treatment	TB Rifampicin Resistant/Multidrug Resistant - treatment success rate	60.5%	65%	65%

MTDP Outcome	Outcome	Outcome indicator	MTDP Period		
			Baseline 2023/24	Mid-year Target 2027	End of year 2030
	RR-TB Notification	TB Rifampicin Resistant/ Multidrug treatment start	-	265	265
	DS TB Notifications	Number of DS TB – TB treatment start 5 years and older	-	8978	8978
		Number of DS-TB treatment start under 5 years	-	472	472
Strengthen the primary health care (PHC) system by ensuring that home and community-based services, as well as clinics and community health centres are well resourced and appropriately staffed	PHC Mental Disorders treated	PHC Mental Disorders Treatment rate new	-	2.5%	2.5%
Improve the quality of health care at all levels of the health establishments, inclusive of private and public facilities	Patient Experience of Care survey rate	Patient Experience of Care survey rate	-	80%	80%
	Audit outcome for regulatory audit expressed by AGSA for the previous financial year	Audit outcome for regulatory audit expressed by AGS	Qualified Audit Report	Unqualified Audit Outcome	Unqualified Audit Outcome
	Health facilities with completed capital infrastructure projects	Percentage of health facilities with completed capital infrastructure project	33%	100%	100%

13 KEY RISKS

Outcomes	Risks	Mitigation
Improved health management and leadership	Lack of functional structures to support leadership	Functional EMC and Extended EMC Acting HOD appointed and post advertised Hospital & Clinic boards in the process of being established, Nursing College Council in the process of being establish Provincial mental health review board established, district mental review boards requested District managers underwent training in? Alignment between functions of the executive done referring to organizational structure Limited Consequence management in place District CEOs appointed
	Failure to recruit and retain suitable calibre of staff into critical posts or to recruit scarce skills.	Requested authorisation to deviate moratorium processes from OTP to fill critical posts; Conditional Grants post exonerated from Moratorium;
Improved human resources for health care	Inadequate HR capacity at provincial and district level to and recruit critical staff;	Implemented contracted appointments of critical posts Updating of HR Plan on annual basis; MEC approved HR delegations;
	Delays in finalizing the organizational structure to be compliant with the 2016 MPSA directive	Reviewing Draft organogram; Data collection for WISN, Appointment of coordinator Proper consultative processes with stakeholders; Development of HR Plan Drafting of organogram Developed Retention/succession planning document(Draft)
Reduced health care costs	Inability to implement sound financial management and supply chain management by responsibility managers at all levels. / SCM	Centralisation HR and Financial delegations; Conducting budget bilaterals with Programme Managers; In-Year-Monitoring of revenue and expenditure; quarterly performance reviews; Consequence management in place; Training and awareness in sound financial management & SCM practices; District visits; Implemented budget pre-approval system;
Efficient health management information system developed & implemented for improved decision making	Lack of effective management information to support decision making	Monthly & quarterly cleaning of data; Continuous training of district information officers & data capturers; Training of clerical support staff on information management; Standardised tools for data collection; Implementation of daily capturing at selected facilities; Health Patient Registration System rolled out to 1 district; Rolled out WEB based (DDC) information

Outcomes	Risks	Mitigation
		management system; Appointment of data capturers & clerks through conditional grant;
Improved health facility planning and infrastructure delivery	Inadequate infrastructure to meet the service delivery needs of the department in the Province	Application of norms and standards for buildings (Building regulations & Infrastructure Unit Support Systems); Prioritise funding to address the needs; Conducting conditions assessment on facilities;
Improved quality of health care	Inadequate access to appropriate level of healthcare	Collaborating with strategic partners (local and district municipalities) to provide improved health care services (e.g. public health forums); Implementing Primary Health Care Re-engineering e.g. Ward Based Outreach Teams (WBOT); Integrated School health programme (ISHP); Central Chronic Medicine Dispensing & Distribution (CCMDD); Rendering outreach services to health establishments; Rendering of mobile services; Improving infrastructure; Availability of emergency & non-emergency patient transport; Governance structures established Fraud & corruption policy in place; Outreach programmes/mobile clinics/emergency vehicles (geo)
	Increased demand for health services	Social mobilization activities i.e. radio slots, Information Education & Communication (IEC) material, health education in communities; Collaborating with strategic partners (local and district municipalities) to provide improved health care services (e.g. public health forums); Implementing Primary Health Care Re-engineering e.g. Ward Based Outreach Teams (WBOT); Integrated School health programme (ISHP); Central Chronic Medicine Dispensing & Distribution (CCMDD)
Maternal, infant & child mortality reduced	An increase in morbidity & mortality due to - Communicable diseases (HIV/AIDS & TB) - Non-communicable disease (Diabetes, Heart diseases, and Cancer) - Maternal, infant and child deaths	BANC (Basic Ante-natal care), MSSN (Management of Sick & Small Neonates), HBB (Help Babies Breath) training; Established maternity waiting homes; Implementation of KMC (Kangaroo Mother Care); Established Human Milk Banks in district hospitals; ESMOE (Essential Steps in the Management Of Obstetric Emergencies) training; Tracing of patients; Awareness campaigns and community dialogues in collaboration with other stakeholders (e.g. NGOs, developmental

Outcomes	Risks	Mitigation
		partners); Condom distribution; Social Mobilization through BLITZ approach for Male Medical Circumcision (MMC); Strengthened High Transmission Areas targeting key populations; Implementation of early information strategies e.g. MOM connect; Utilisation of obstetric vehicles; Rendering outreach services to health establishments; Availability of emergency/patient transport; Established maternity waiting homes in JTG, sponsored by Kumba; Support visits to facilities; Reporting of Perinatal & Child Problem Identification Programme in place; Conduct TB screening per headcount at facility level; Combination preventative approach (HIV/TB co-morbidity complications) in place;
Reduced health care costs	High rising impact of medico-legal cases on the department	Standard clinical processes in place; Clinical complaints review committee; Developed Management of Clinical Records Policy; Medico-legal unit established; Litigation strategy developed and implemented; Services of State Attorney terminated in high risk matters; Appointment of private attorneys for high risk matters; Participation in RAF contract; Conducted Medico-legal conference; Analysis of medico legal actions Review risk areas identified from analysis
Improved health management and leadership	Negative impact of audit findings (External, Internal Auditors, OHS, QA) on the department	Established Work streams for specific focus areas Developed AGSA rectification plan Developed action plans for IA findings
Improved health management and leadership (6)	Lack of functional structures to support leadership	Functional EMC and Extended EMC Acting HOD appointed and post advertised Hospital & Clinic boards in the process of being established, Nursing College Council in the process of being establish Provincial mental health review board established, district mental review boards requested District managers under went training in ? Alignment between functions of the executive done referring to organizational structure Limited Consequence management in place District CEOs appointed
	Failure to recruit and retain suitable calibre of staff into critical posts or to recruit scarce skills.	Requested authorisation to deviate moratorium processes from OTP to fill critical posts; Conditional Grants post exonerated from Moratorium;

Outcomes	Risks	Mitigation
Improved human resources for health care	Inadequate HR capacity at provincial and district level to and recruit critical staff;	Implemented contracted appointments of critical posts Updating of HR Plan on annual basis; MEC approved HR delegations;
	Delays in finalizing the organizational structure to be compliant with the 2016 MPSA directive	Reviewing Draft organogram; Data collection for WISN, Appointment of coordinator Proper consultative processes with stakeholders; Development of HR Plan Drafting of organogram Developed Retention/succession planning document(Draft)
Reduced health care costs	Inability to implement sound financial management and supply chain management by responsibility managers at all levels. / SCM	Centralisation HR and Financial delegations; Conducting budget bilaterals with Programme Managers; In-Year-Monitoring of revenue and expenditure; quarterly performance reviews; Consequence management in place; Training and awareness in sound financial management & SCM practices; District visits; Implemented budget pre-approval system;
Efficient health management information system developed & implemented for improved decision making (10)	Lack of effective management information to support decision making	Monthly & quarterly cleaning of data; Continuous training of district information officers & data capturers; Training of clerical support staff on information management; Standardised tools for data collection; Implementation of daily capturing at selected facilities; Health Patient Registration System rolled out to 1 district; Rolled out WEB based (DDC) information management system; Appointment of data capturers & clerks through conditional grant;

14 PUBLIC ENTITIES

The department does not have any Public Entities

Public-Private Partnerships (PPPS)

The department does not have any Public-Private Partnerships

Conclusion

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

15 TECHNICAL INDICATOR DESCRIPTION (TID) FOR STRATEGIC PLAN

1.	Indicator title	Couple year protection rate
	Definition	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4.5) +) + (Sub dermal implant x 2.5) + Male condoms distributed / 120) + (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10).
	Source of data	HC Comprehensive Tick Register Birth Register, Labour, Combined and Postnatal ward and Health Facility Registe
	Method of calculation/Assessment	Numerator: Couple Year Protection Denominator: Population 15-49 years females
	Means of verification	HC Comprehensive Tick Register Birth Register, Labour, Combined and Postnatal ward and Health Facility Register
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All Districts
	Calculation type	Cumulative (year-to-date
	Reporting cycle	Quarterly
	Desired performance	Higher numbers
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

2.	Indicator title	Number of deliveries 10-14 years in facility
	Definition	Number Deliveries to 10-14 years old.
	Source of data	Health Facility Register, DHIS
	Method of calculation/Assessment	Numerator: Number of Delivery 10-14 years in facility Denominator: N/A
	Means of verification	Health Facility Register, DHIS
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Females
	Spatial transformation	All districts
	Calculation type	Cumulative (year-end)
	Reporting cycle	Quarterly
	Desired performance	Lower rate indicates good performance
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

3.	Indicator title	Antenatal 1st visit before 20 weeks rate
	Definition	Women who have a first booking visit before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits.
	Source of data	PHC Comprehensive Tick Register, DHIS
	Method of calculation/Assessment	Numerator: Antenatal 1st visit before 20 weeks Denominator: Antenatal 1st visit total
	Means of verification	PHC Comprehensive Tick Register, DHIS
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Females
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher percentage indicates better uptake of ANC services
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

4.	Indicator title	Mother postnatal visit within 6 days rate
	Definition	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities
	Source of data	PHC Comprehensive Tick Register, Postnatal ward registers, Admission register, DHIS
	Method of calculation/Assessment	Numerator: Mother postnatal visit within 6 days after delivery Denominator: Delivery in facility total
	Means of verification	PHC Comprehensive Tick Register, Postnatal ward registers, Admission register, DHIS
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Females
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher percentage indicates better uptake of postnatal services
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

5.	Indicator title	Infant 1st PCR test positive at birth t rate
	Definition	Infants tested PCR positive for the first time at birth as proportion of infants PCR tested at birth
	Source of data	PHC Comprehensive Tick Register
	Method of calculation/Assessment	Numerator: Infant 1st PCR test positive at birth Denominator: Infant 1st PCR test at birth
	Means of verification	PHC Comprehensive Tick Register+H8+I8
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date
	Reporting cycle	Quarterly

	Desired performance	Lower infant PCR test positive rate reflects good performance
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

6.	Indicator title	Immunisation under 1-year coverage
	Definition	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year.
	Source of data	PHC Comprehensive Tick Register, Immunisation/Paediatric admission register, DHIS
	Method of calculation/Assessment	Numerator: Immunised fully under 1 year new Denominator: Population under 1 year
	Means of verification	PHC Comprehensive Tick Register, Immunisation/Paediatric admission register, DHIS
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher percentage indicates better immunisation coverage
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

7.	Indicator title	Child under 5 years diarrhoea case fatality rate
	Definition	Diarrhoea deaths in children under 5 years in Referral Hospitals
	Source of data	Ward register
	Method of calculation/Assessment	Numerator: Diarrhoea death under 5 years Denominator: Diarrhoea separation under 5 years
	Means of verification	Ward register
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year to-date)
	Reporting cycle	Quarterly
	Desired performance	Lower rate
	Indicator responsibility	Senior Manager-MCYWH & Nutrition; Chief Director- Health Programmes and manager provincial tertiary hospital services

8.	Indicator title	Child under 5 years Pneumonia case fatality rate
	Definition	Pneumonia deaths in children under 5 years under 5 years in Referral Hospitals
	Source of data	Ward register
	Method of calculation/Assessment	Numerator: Number of Pneumonia deaths under 5 years Denominator: Pneumonia separation under 5 years
	Means of verification	Ward register
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year to-date)
	Reporting cycle	Quarterly
	Desired performance	Lower number
	Indicator responsibility	Senior Manager-MCYWH & Nutrition; Chief Director- Health Programmes and manager provincial tertiary hospital services

9.	Indicator title	Child under 5 years Severe Acute Malnutrition case fatality rate
	Definition	Severe acute malnutrition deaths in children under 5 years in Referral Hospitals
	Source of data	Pediatric Ward register
	Method of calculation/Assessment	Numerator: Number Severe acute malnutrition Denominator: Severe acute malnutrition inpatient separation under 5 years
	Means of verification	Pediatric Ward register
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year to-date)
	Reporting cycle	Quarterly
	Desired performance	Lower rate
	Indicator responsibility	

10.	Indicator title	Cervical Cancer Screening coverage
	Definition	Cervical smears in women 30 years and older as a proportion of the female population 30-50 years (80% of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years)
	Source of data	PHC Comprehensive Tick Register ;OPD
	Method of calculation/Assessment	Numerator: Cervical cancer screening done Denominator: [(80% women aged 30-50yrs/10)+(20% women aged 20 years and above /3)
	Means of verification	DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	N/A
	Spatial transformation	All districts
	Calculation type	Cumulative (year to-date)
	Reporting cycle	Quarterly
	Desired performance	Lower rate
	Indicator responsibility	

11.	Indicator title	MR 2nd dose 1 year coverage
	Definition	Children 12 months old who received MR 2nd dose, as a proportion of the 1 year population
	Source of data	PHC Comprehensive Tick Register, Immunisation register/ Paediatric admission register
	Method of calculation/Assessment	Numerator: MR 2nd dose Denominator: Target population 1 year
	Means of verification	PHC Comprehensive Tick Register , Immunisation register / Paediatric admission register
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher coverage rates indicates greater protection against measles
	Indicator responsibility	Director-MCYWH & Nutrition; Chief Director- Health Programmes

12.	Indicator title	HIV positive 5-14 years (excl ANC) rate
	Definition	Children 5 to 14 years who tested HIV positive as a proportion of children who were tested for HIV in this age group
	Source of data	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net, DHIS
	Method of calculation/Assessment	Numerator:HIV positive 5-14 years (excl ANC) Denominator: HIV test 5-14 years (excl ANC)
	Means of verification	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net, DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Lower rate
	Indicator responsibility	Manager: HAST

13.	Indicator title	HIV Positive 15-24 years (excl ANC) rate
	Definition	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of Adolescents and youth 15 to 24 years who were tested for HIV in this age group
	Source of data	HTS Register (HIV Testing Services) or HTS module in TIER.Net,
	Method of calculation/Assessment	Numerator: HIV test positive 15-24 years female (excl ANC) + HIV test 15-24 years' male Denominator: Total HIV test 15-24 years female (excl ANC) + HIV test 15-24 years male
	Means of verification	HTS Register (HIV Testing Services) or HTS module in TIER.Net, DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Adolescents and youth
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Lower positivity rate reflects good performance in terms of preventing new HIV infections

14.	Indicator title	ART adult remain in care rate (12 months)
	Definition	ART adult remain in care at 12 months- total as proportion of ART adults start minus cumulative transfer out.
	Source of data	ART clinical record captured in TIER.Net; DHIS
	Method of calculation/Assessment	Numerator: ART adult on first-line regimen + ART adult on second-line regimen + ART adult on third-line regimen + ART adult stop treatment] care at 12 months] Denominator: SUM [ART adult start minus cumulative transfer out]
	Means of verification	ART clinical record captured in TIER.Net; DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities

	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher rate of adult remaining in care reflects good performance
	Indicator responsibility	Manager: HAST

15.	**Indicator title**	**ART child remain in care rate (12 months)**
	Definition	ART child remain in care - total as a proportion of ART child start minus cumulative transfer out at 12 months
	Source of data	ART clinical record captured in TIER.Net; DHIS
	Method of calculation/Assessment	Numerator: ART child on first-line regimen + ART child on second-line regimen + ART child on third-line regimen + ART child stop treatment in care at 12 months Denominator: ART child start minus cumulative transfer out
	Means of verification	ART clinical record captured in TIER.Net; DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher rate of children remaining in care reflects good performance
	Indicator responsibility	Manager: HAST

16.	**Indicator title**	**ART adult viral load suppressed rate-below 50 (12 months)**
	Definition	ART adult viral load under 50 as a proportion of ART adult viral load done at 12 months
	Source of data	ART clinical record captured in TIER.Net; DHIS
	Method of calculation/Assessment	Numerator: ART ART adult viral load done (at 12 months) adult viral load under 50 (at 12 months) Denominator: SUM ART adult viral load done (at 12 months)
	Means of verification	ART clinical record captured in TIER.Net; DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher rate reflects good performance
	Indicator responsibility	Manager: HAST

17.	Indicator title	Art child viral load suppressed rate-below 50 (12 months)
	Definition	ART child viral load under 50 as a proportion of ART child viral load done at 12 months
	Source of data	ART clinical record captured in TIER.Net; DHIS
	Method of calculation/Assessment	Numerator: ART child viral load under 50 (at 12 months) Denominator: ART child viral load done (at 12 months)
	Means of verification	ART clinical record captured in TIER.Net; DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Children
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher rate reflects good performance
	Indicator responsibility	Manager: HAST

18.	Indicator title	ALL DS-TB Client Treatment Success rate
	Definition	All DS-TB clients who started drug susceptible tuberculoses (DS-TB) treatment 12 months ago and have successfully completed treatment
	Source of data	Patient Blue file, TIER.Net
	Method of calculation/Assessment	Numerator: All DS-TB client successfully completed treatment Denominator: All DS-TB treatment start
	Means of verification	Patient Blue file, TIER.Net
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher treatment success rate reflects good performance
	Indicator responsibility	Manager: HAST

19.	Indicator title	TB Rifampicin resistant/Multidrug- Resistant treatment success rate
	Definition	TB Rifampicin Resistant/Multidrug Resistant clients successfully completed treatment as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment
	Source of data	DR-TB patient clinical record, DR-TB Register, EDR.web
	Method of calculation/Assessment	Numerator: TB Rifampicin resistant/Multidrug Resistant successfully completed treatment

		Denominator: TB Rifampicin Resistant/Multidrug Resistant client started on treatment
	Means of verification	DR-TB patient clinical record, DR-TB Register, EDR.web
	Assumptions	Accuracy dependent on quality of data submitted health facilities
	Disaggregation of Beneficiaries	Women, Youth and persons with disability
	Spatial transformation	All districts
	Calculation type	Cumulative (Year to date)
	Reporting cycle	Quarterly
	Desired performance	Higher treatment success rate reflects good performance
	Indicator responsibility	Manager: HAST

20.	**Indicator title**	**TB Rifampicin resistant/Multidrug-Resistant treatment start**
	Definition	TB Rifampicin Resistant/Multidrug- Resistant clients started on treatment
	Source of data	EDR Web
	Method of calculation/Assessment	Numerator: TB Rifampicin Resistant/Multidrug Resistant confirmed start on treatment Denominator: N/A
	Means of verification	EDRWeb
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	N/A
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher treatment success rate reflects good performance
	Indicator responsibility	Manager: HAST

21.	**Indicator title**	**Number of DS-TB treatment start 5 years and older**
	Definition	DS-TB Client 5 years and older started on DS-TB Treatment
	Source of data	DHIS
	Method of calculation/Assessment	Numerator: TB client 5 years and older start on treatment Denominator: N/A
	Means of verification	DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher numbers
	Indicator responsibility	TB Programme Manager

22.	**Indicator title**	**Number of DS-TB treatment start under 5 years**
	Definition	DS-TB Children under 5 years started on DS-TB Treatment
	Source of data	DHIS
	Method of calculation/Assessment	Numerator: TB client under 5 years start on treatment Denominator:
	Means of verification	DHIS

	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Quarterly e
	Desired performance	Higher numbers
	Indicator responsibility	TB Programme Manager

23.	Indicator title	PHC Mental Disorders Treatment rate new
	Definition	Clients treated for the first time for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide attempt, developmental disorders, behavioural disorders and substance abuse/addiction disorders) as a proportion of total PHC headcount
	Source of data	PHC Comprehensive Tick Register, DHIS
	Method of calculation/Assessment	Numerator: PHC client treated for mental disorders - new Denominator: PHC Headcount - Total
	Means of verification	DHIS
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts
	Calculation type	Cumulative (year to-date)
	Reporting cycle	Quarterly
	Desired performance	Higher detection of new mental cases in the PHC setting
	Indicator responsibility	Senior Manager –NCD; Chief Director-Health Programmes

24.	**Indicator title**	**Patient Experience of Care survey rate**
	Definition	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities
	Source of data	Patient Surveys
	Method of calculation/Assessment	Numerator: Facility PEC Survey done Denominator: Fixed PHC clini+H36
	Means of verification	Fixed PHC clini+H36
	Assumptions	Accuracy dependent on quality of data submitted by health facilities
	Disaggregation of Beneficiaries	Women, Youth and people with disabilities
	Spatial transformation	All districts
	Calculation type	Cumulative (year-to-date)
	Reporting cycle	Annually
	Desired performance	Higher satisfaction survey rate
	Indicator responsibility	Quality Assurance

25.	**Indicator title**	**Audit Outcome for regulatory audit expressed by AGSA**

	Definition	Audit opinion for Provincial Departments of Health for financial performance
	Source of data	Auditor General's report, Management Report
	Method of calculation/Assessment	Numerator: Audit outcome for regulatory audit expressed by AGSA for 2023/24 financial year
	Means of verification	Auditor General's report, Annual Report
	Assumptions	The departmental financial statements are true and fair in accordance with the financial reporting framework
	Disaggregation of Beneficiaries	None
	Spatial transformation	None
	Calculation type	Non-cumulative
	Reporting cycle	Annually
	Desired performance	Unqualified Audit Opinion from the Auditor General reflects good performance
	Indicator responsibility	Senior Manager Finance

26.	**Indicator title**	**Percentage of health facilities with completed capital infrastructure project**
	Definition	Number of existing health facilities where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management contract projects only) have been completed (excluding new and replacement facilities) as a proportion of total number of health facilities Rebuild is considered where refurbishment cost is >70% of estimated replacement value
	Source of data	Project management Information Systems (PMIS)
	Method of calculation/Assessment	Numerator: Total number of health facilities with completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) issued Denominator: Total number of health facilities planned to have completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) planned to be issued
	Means of verification	Project management Information Systems (PMIS)
	Assumptions	Health facilities are dilapidated
	Disaggregation of Beneficiaries	None
	Spatial transformation	All districts

	Calculation type	Non-cumulative
	Reporting cycle	Annually
	Desired performance	Higher percentage reflects good performance
	Indicator responsibility	Manager: Infrastructure and Technical Management

16 ACRONYMS

ADMIN	**Administration**
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Client
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immuno Deficiency Syndrome
APP	Annual Performance Plan
ART	Antiretroviral Therapy
ARV	Anti-Retroviral
BAS	Basic Accounting System
BANC	Basic Antenatal Care
CCMDD	Central Chronic Management Dispensing and Distribution
CCTV	Closed-Circuit Television
CDC	Communicable Disease Control
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CFR	Case Fatality Rate
CHC	Community Health Centres
CHS	Community Health Services
CHW	Community Health Workers
CPIX	Consumer Price Index
DBE	Department of Basic Education
DBSA	Development of SA
DCST	District Clinical Specialist Teams
DHIS	District Health Information System
DHS	District Health Services
DIP	District Implementation Plan
DOH	Department of Health
DRG	Diagnosis Related Grouper
DRPW	Department of Roads and Public Works
DR-TB	Drug Resistant Tuberculosis
DSD	Department of Social Development
DTap IPV	Diphtheria, Tetanus, Pertussis and Polio Vaccine
EDR	Electronic Drug Resistance
EML	Essential Medicine List
EMS	Emergency Medical Services
EPI	Extended Programme Immunisation
EPMDS	Employee Performance Management Development System
ESMOE	Essential Steps in Obstetric Emergencies
ETR	Electronic TB Register
FDC	Fixed Dose Combination
GCCN	Government Central Core Network
GDP	Gross Domestic Product
GIAMA	Government Infrastructure Asset Management Act
HAI	Hospital Acquired Infections
HAST	HIV & AIDS, STI and Tuberculosis
HBB	Help Babies Breathe
HCSS	Health Care Support Services
HCT	HIV Counselling & Testing
HEP	Hepatitis
HFM	Health Facilities Management
HFRG	Health Facility Revitalisation Grant
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HOD	Head of Department

HPCSA	Health Professions Council of South Africa
HPV	Human Papilloma Virus
HR	Human Resources
HRP	Hospital Revitalisation Programme
HRP	Human Resource Plan
HST	Health Science and Training
HVAC	Heating, Ventilation, Air-Conditioning and Cooling
ICT	Information Communication and Technology
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPC	Infection Prevention Control
IPT	Isoniazid Preventative Therapy
IRM	Infrastructure Reporting Model
ISHP	Integrated School Health Programme
IUCD	Intra Uterine Contraceptive Device
IYM	In-Year Financial Monitoring
JTG	John Taolo Gaetsewe
KbPS	Kilobits Per Second
LOGIS	Local Government Information System
LP	Liquid Petroleum (Domestic Gas)
LTF	Lost to Follow-up
MbPS	Megabits Per Second
MCWH & N	Maternal, Child, and Women's Health and Nutrition
MDG	Millennium Development Goals
MDR	Multi Drug Resistant TB
MEC	Member of the Executive Council
MMC	Medical Male Circumcision
MMR	Maternal Mortality Rate
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
MTT	Ministerial Task Team
N / No.	Number
N/A	Not Applicable
NCD	Non-Communicable Disease
NCDOH	Northern Cape Department of Health
NCS	National Core Standards
NDOH	National Department of Health
NDP	National Development Plan
NET	Network
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NICD	National Institute Communicable Disease
NIHE	National Institute of Higher Education
OHH	Outreach Household
OHS	Occupational Health and Safety
OPD	Out Patients Department
OSD	Occupational Special Dispensation
P1	Priority One
PCA	Provincial Council on AIDS
PCR	Polymerase Chain Reaction
PDE	Patient Day Equivalent
PDP	Personal Development Plan
PEP	Post Exposure Prophylaxis
PERSAL	Personnel and Salary Administration System
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care

PHS	Primary Healthcare Services
PHS	Provincial Hospital Services
PMDS	Performance Management and Development System
PMTCT	Prevention of Mother to Child Transmission
PSP	Provincial Strategic Plan
PSS	Patient Satisfaction Survey
PT	Provincial Treasury
PTB	Pulmonary Tuberculosis
QA	Quality Assurance
R254	One Year Nursing Programme
R425	Two Year Nursing Programme
R683	Four Year Nursing Programme
R	Rand / Rate
RV	Rota Virus
SA	South Africa
SACTWU	Southern African Clothing and Textile Workers' Union
SAPS	South African Police Service
SLA	Service Level Agreements
SMS	Senior Management Structure
SPLUMA	The Spatial Planning and Land Use Management Act
SONA	State of the Nation Address
SOP	Service Operating Procedures
SRH	Sexual and Reproductive Health
STATS SA	Statistics South Africa
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
STP	Service Transformation Plan
TB	Tuberculosis
TFI	Transfer in
TFO	Transfer out
THS	Tertiary Hospital Services
TIER	Three Integrated Electronic Registers
TMMC	Traditional Medical Male Circumcision
TROA	Total Client Remaining on ART
U5MR	Under Five Mortality Rate
U-AMP	User Asset Management Plan
UNAIDS	United Nations Programme on HIV and AIDS
VIZ	Videlicet
vs	Versus
VMMC	Voluntary Medical Male Circumcision
WBPHCOTs	Ward Based Primary Health Care Outreach Teams
WEH	West End Hospital
WHO	World Health Organisation
XDR	Extensive Drug Resistant

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