

---

# **NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA) 2010-2014**

**FOR OUTCOME 2: A Long and Healthy Life for All  
South Africans**

---

**RELEASED: OCTOBER 2010**

**UPDATED: NOVEMBER 2011**

## TABLE OF CONTENTS

1. INTRODUCTION.....	3
2. BROAD STATEMENT OF THE HEALTH SECTOR CHALLENGES .....	4
3. CHALLENGES RELATING TO SPECIFIC OUTPUT AREAS.....	5
3.1 INCREASING LIFE EXPECTANCY .....	5
3.2 MATERNAL, CHILD AND WOMEN'S HEALTH .....	7
3.3 COMBATING HIV, AIDS AND TB .....	10
3.4 STRENGTHENING HEALTH SYSTEM EFFECTIVENESS .....	11
4. ACTIVITIES THAT WILL BE UNDERTAKEN FOR EACH OUTPUT AREA .....	15
4.1 OUTPUT 1: INCREASING LIFE EXPECTANCY.....	15
4.2 OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY....	17
4.3 OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASES FROM TUBERCULOSIS.....	19
4.4 OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS .....	20
5. EVALUATION OF THE EXISTING LEGISLATIVE & REGULATORY ENVIRONMENT.....	26
6. IDENTIFICATION DELIVERY PARTNERS FOR EACH OUTPUT AREA.....	28
7. SIGNATORIES.....	46

## 1. INTRODUCTION

The Negotiated Service Delivery Agreement (NSDA) is a charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government. The Government has agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010 – 2014. Each outcome area is linked to a number of outputs that inform the priority implementation activities that will have to be undertaken over the given timeframe to achieve the outcomes associated with a particular output.

For the health sector, the priority is improving the health status of the entire population and to contribute to Government's vision of "**A Long and Healthy Life for All South Africans**". To accomplish this vision government has identified four strategic outputs which the health sector must achieve. These are:

- **Output 1:** Increasing Life Expectancy
- **Output 2:** Decreasing Maternal and Child mortality
- **Output 3:** Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
- **Output 4:** Strengthening Health System Effectiveness

Linked to these outputs are indicators and targets. Major targets include the following:

- Life expectancy must increase from the current 54.0 years for males and 59.0 years for females (2009 baseline) to 56.0 years for males and 61.0 years for females by 2014.
- South Africa's Maternal Mortality Ratio (MMR) must decrease from the estimated 310 per 100,000 live births to 270 (or less) per 100, 000 live births by 2014.
- The Child Mortality Rate must decrease from the current 56 per 1,000 live births to 40 deaths (or less) per 1,000 live births by 2014.

- The Infant Mortality Rate must decrease from 40 per 1,000 live birth to 36 per 1000 live birth.
- The TB cure rate must improve from 71.1 % in 2009 to 85% by 2014
- 80% of eligible pregnant women must be initiated on ART at a CD4 count of <350 antiretroviral treatment.

Re-engineering the health system to one that is based on a primary healthcare (PHC) approach, with more emphasis on promotive and preventive healthcare will underlie all interventions needed to achieve the outputs. Tangible improvements in the effectiveness of the health system must be attained and corroborated by empirical evidence that clearly links to the four output areas.

## **2. BROAD STATEMENT OF THE HEALTH SECTOR CHALLENGES**

South Africa currently faces a quadruple Burden of Disease (BoD) consisting of HIV and AIDS and TB; High Maternal and Child Mortality; Non-Communicable Diseases and; Violence and Injuries. In 2007, the South African population represented 0.7% of the world's population, but accounted for 17% (about 5.5 million people) of the global burden of HIV infections (The Lancet, August 2009). Life expectancy in South Africa has declined. South Africa is also one of only 12 countries in the world in which mortality rates for children younger than 5 years have increased since 1990 (The Lancet, August 2009).

Despite spending 8.7% of its GDP on health, and spending more on health than any other African country, the South African health care system has been characterised as fragmented and inequitable due to the huge disparities that exist between the public and private health sectors with regards to the availability of financial and human resources, accessibility and delivery of health services. A decision was taken in 1994 to implement a Primary Health Care Approach as the backbone of the healthcare system. Despite this, the service delivery structure still leans heavily towards a curative approach high-cost care with limited adherence to any referral system, which implies that many patients are seen at an inappropriate level, usually by specialists and in hospitals, and this contributes to cost escalation.

The inequity in the health system is exacerbated by the fact that access to health care is unequal with the majority of the population relying on a public health care system that has a disproportionately lower amount of financial and human resources at its disposal relative to the private sector. For instance, the per capita spend in the public sector is estimated at R1, 600 whilst in the private sector it is R9, 800 in nominal terms. Furthermore, the distribution of key health professionals between the two sectors is also skewed. In the public sector there are about 4,200 patients to a general doctor compared to 243 patients to a general doctor in the private sector.

While access in terms of reach has been achieved, more still needs to be done in terms of improving quality of care, human resources management, infrastructure and making services more available to all South Africans to ensure better health outcomes.

### **3. CHALLENGES RELATING TO SPECIFIC OUTPUT AREAS**

#### **3.1 Increasing Life Expectancy**

South Africa's life expectancy is affected by communicable diseases such as HIV, TB, malaria, respiratory infections and diarrhoeal diseases; high maternal and child mortality; increasing levels of non-communicable diseases such as hypertension, diabetes, cancer and cardio vascular diseases; as well as trauma related injuries. Maternal and child health and HIV and TB will be covered by outputs 2 and 3 and this section will address outputs on increasing life expectancy through non-communicable diseases, trauma related injuries and communicable diseases that are not part of HIV, AIDS and TB.

Malaria has contributed to reduction in life expectancy and more than 1 million deaths per annum associated with malaria occur in Africa and most are children under 5 years of age. Malaria constitutes a major barrier to social and economic development in the region and is mainly transmitted along the border areas of South Africa. Three of the nine provinces of South Africa, namely: Limpopo, Mpumalanga and KwaZulu-Natal are endemic for malaria and 10% of the population (approximately 4.9 million persons) is at risk of contracting the disease. Malaria

cases in South Africa have been steadily declining over the past 9 years. Between 2000 and 2008, morbidity was reduced by 88% (64,622 and 7796 cases respectively) and mortality by 90% (458 and 46 deaths respectively). Both morbidity and mortality as a result of malaria can be reduced further over the next few years. The country has the capacity to move towards malaria elimination.

Globalisation has contributed to increased international travel and trade, and the emergence and re-emergence of international communicable disease threats. These threats call for epidemic preparedness and the effective implementation of the International Health Regulations (IHRs). In terms of the IHRs, South Africa is required to develop minimum core public health capacities, and to develop, strengthen and maintain these by July 2012.

Non-communicable diseases contributed 28% of the total burden of disease measured by disability-adjusted life years in 2004. Cardiovascular diseases, diabetes mellitus, respiratory diseases and cancers contributed 12% of the overall burden while around 20% of all mortality is due to non-communicable diseases. The prevalence of mental disorders has been found to be 17%. The burden from Non-Communicable Diseases (NCDs) is two to three times higher than that in developed countries. According to Statistics South Africa, non-natural deaths accounted for 9% of all deaths and 44% of deaths in the 15-19 year age group in 2007.

More than half of women and three quarters of men requiring some intervention for hypertension and diabetes do not even know that they are suffering from these conditions (NIDS 2009). Only 14% of cases of high blood pressure reflect good management of the condition. Late detection results in increased costs and unnecessary suffering and possible death. Prevention, screening and early detection and effective management will improve life expectancy.

The contribution of violence and injuries to the burden of diseases declined from 17% in 1997 to 9% in 2005. However, this drop may be related to an increase in natural causes rather than drop in injuries. Intersectoral interventions to address the violence and injuries will be developed and implemented.

### **3.2 Maternal, Child and Women's Health**

The estimated maternal mortality ratio in South Africa is 310 per 100 000 live births. This ratio is much higher than that of countries of similar socio-economic development. The vision is to reduce the maternal mortality ratio to 270 per 100 000 live births or less through the implementation of Primary Health Care and a functional referral system to responsive support system of hospitals.

The National Committee on the Confidential Enquiry into Maternal Deaths (NCCEMD) report has identified community-based factors as some of the causes that lead to maternal deaths and include delay in seeking help at health facilities. Other factors that have contributed to increased maternal mortality include administrative and support shortcomings. The quality of care that is provided (clinical skills and competency), lack of transport in cases of emergency and delay in the initiation of Anti-Retroviral Treatment (ART) are some of the other factors that have resulted in preventable maternal deaths. The NCCEMD report has made recommendations that needed to be implemented to reduce maternal death in our facilities. However, implementation of these recommendations has been hampered by systemic challenges in the health system. The following are some of the causes of increased maternal and neonatal deaths:

#### ***HIV and AIDS***

The Saving Mothers Report shows that HIV is a major contributor to maternal deaths and maternal and child mortality remain high with an estimated 2,500 mothers and 52,600 children dying each year. The power imbalance between men and women, coupled with the socio-economic dependence of women has caused many women to be without choice in terms of pregnancy and protection from HIV infection. In addition, stigma still follows those diagnosed with HIV infection and women often present late for testing for HIV. Those that qualify for ARVs often have to wait for long periods before treatment is commenced. The HIV epidemic has also led to many women contracting tuberculosis and pneumonia in pregnancy.

### ***Hypertension***

Hypertension in pregnancy if not treated it may lead to fits (e.g. eclampsia) and death of the mother and/or the baby. It is often associated with poor foetal growth and may result in kidney and neurological malfunction in the baby. Hypertension must be diagnosed timeously and this requires appropriate technology and clinical management. Some facilities do not have the appropriately skilled human resources and the appropriate equipment to diagnose and manage this condition. When emergencies arise as a result of poor management and lack of technology, the consequence is often the death of the woman and/or her baby.

### ***Sepsis Post delivery***

The improper management of labour (parturition) associated with poor infection control measures often leads to sepsis and sometimes death. The presence of HIV further complicates the woman's response to infection, often not showing the traditional signs and symptoms of infection. It is for this reason that sepsis becomes difficult to detect early and once it reaches an advanced state, it is almost impossible to reverse. To prevent this, postnatal examination and care is essential but it is often not done in our facilities due to staff shortages and poor clinical management.

### ***Haemorrhage before and after delivery***

Excessive bleeding is a universal challenge for women in pregnancy and child birth. It is one of the major causes of death for many women related to pregnancy and statistics have shown that this has not improved since 1997. This condition is an emergency that results in death in a matter of minutes and the unavailability of transport and blood products further complicates the situation. Malnutrition in many women means that they go into labour with iron-deficiency and anaemic. Prevention of anaemia is a major step in helping women to survive moderate bleeding during and after delivery. However, this is often not done due to poor clinical management skills and lack of equipment for dealing with life-threatening bleeding.

### ***Unsafe Abortion***

Another major cause of death has been unsafe abortion. The Choice on Termination of Pregnancy Act has made unsafe abortion a less significant factor in maternal mortality. There has been a marked decrease in the number of women dying from

this cause since the passage the Choice on Termination of Pregnancy Act in 1996. However there has been a decrease in the number of facilities that offer surgical termination of pregnancy resulting in lack of access to safe termination of pregnancy. This has been partly due to conscientious objection to the procedure and the shortage of staff caused by burn-out among the few providers. The associated stigma to health workers and health facilities conducting termination of pregnancy contributes to this. With the attention being devoted to HIV, funding for the Sexual and Reproductive Health programmes and the health system suffered. Contraception services have been neglected. This has led to skills in contraception being lost and many women at high risk when pregnant to suffer complications and die from unplanned and high risk pregnancies.

### ***Prematurity***

Many newborns die from prematurity as a result of maternal illness such as hypertension during pregnancy and infections; and difficulties during labour and delivery. Newborns also die from infections and a hostile environment after being born as a result of shortages of neonatal nurses and poor infection control in our public health facilities.

### **Issues pertaining to Under 5 mortality are missing/lacking from the document**

The First Report of the Committee on Morbidity and Mortality in Children under 5 Years (CoMMiC) estimated that over 60,000 South African children between the ages of one month and five years die each year. This translates into an under-five mortality rate for South Africa of between 57.6 and 94.7 deaths per 1,000 live births and an infant mortality rate of between 42.5 and 59.1 deaths per 1,000 live births. These rates are highest in the Eastern Cape, KwaZulu-Natal, and Free State and lowest in the Western Cape, Gauteng and Northern Cape Province.

Major causes of childhood deaths are diarrhoeal disease, lower respiratory tract infections and perinatal conditions with HIV and AIDS and malnutrition contributing as both primary and underlying causes of child mortality. A need therefore exists to improve clinical care by strengthening the existing child survival programmes

adopted by the health sector, including the Community Health Worker (CHW) programme, the Integrated Nutrition Programme; Expanded Programme on Immunisation; Prevention of Mother to Child Transmission (PMTCT); Integrated Management of Childhood Illnesses (IMCI); Essential Drug List (EDL); and 10 steps for the management of severe malnutrition. Primary health care must also be strengthened by adopting and implementing the Household and Community component of IMCI (IMCI HHCC); introduction and roll out of standardized management and referral guidelines for general practitioners. Emergency referral and treatment capacity in all health facilities and districts should be strengthened through training in triage, assessment and resuscitation of critically ill children, and the development of suitable transport systems for the movement of critically ill children into and within the health system.

### **3.3 Combating HIV, AIDS and TB**

#### ***HIV and AIDS***

South Africa has the highest burden of HIV with an estimated 5.7 million people or 11.6% of the population infected. This is evidenced by the HIV prevalence rates among antenatal cases (ANC) which rose sharply over a few years where in some provinces such as Kwa-Zulu Natal the HIV ANC prevalence rose from 21.1% in 1995 to 38.7% in 2008. South Africa also has the highest burden of mother to child transmission with an estimated 300,000 infected mothers delivering each year.

Prevention of Mother to Child Transmission (PMTCT) is the corner stone of reducing deaths of newborns and children and more than 50,000 lives could be saved by 2015 if the maternal and child health interventions were implemented consistently for 95% of mothers and neonates. PMTCT alone is estimated to save 37,200 newborn lives each year if implemented effectively.

PMTCT coverage rose from 24% in 2006 to 80% in 2009, however lack of integration in maternal and child health services weakened the outputs of the programme. An acute shortage of beds results in mothers being discharged in 6 hours of normal delivery and poor obstetric care and HIV infection all contribute to negative outcomes for both the mother and the baby..

## ***Tuberculosis***

The World Health Organisation (WHO) estimates that about 1% of South Africans (roughly 490,000) contracted Tuberculosis (TB) in 2008, giving an incidence rate of 949 TB cases per 100,000 population. The incidence is much higher in high risk concentrate settings such as the mines and prisons, with the former estimated at between 3,000 and 7,000 cases per 100,000 per population.

Tuberculosis is both a medical condition and a social problem and is linked to poverty related conditions. Problems of overcrowding and poor social conditions as well as environmental factors are contributory factors to its increased burden. It is important that the Human Settlement and Environmental Affairs Departments join forces with health to address the social determinants of health.

The current HIV/TB co-infection rate exceed 70%. Due to late detection, poor treatment, management and failure to retain TB patients on treatment, drug-resistant forms of TB (DR-TB) have increased significantly, with about 5,000 and 500 diagnosed respectively in 2009. Although the current policy by the Department of Health is that all DR-TB patients should be hospitalised until they are cured, there are about 2,000 beds available for DR-TB treatment and management. The combination of TB, HIV and DR-TB has led to a situation where TB is the number one common disease among diseased South Africans (13 out of every 100 deaths).

Although resources have been made available for TB control and management, the bulk of these are routed, as earmarked funds, through different programmes, particularly, districts systems development, drug supply and hospital management. As a result, a significant amount of the resources end up being utilised for other purposes than TB. It has also proven difficult to keep track of the allocations and expenditure of these funds.

### **3.4 Strengthening Health System Effectiveness**

A healthy life is the product of a mix of a functional and effective health system based on the use of cost-effective interventions that are rendered at an appropriate level of the health system coupled with the existence of reliable and equitable access

to decent housing, clean water, sanitation, nutrition and education (i.e. social determinants of health) which are all products of a number of stakeholders including interdepartmental collaboration. The primary health care approach has been the underlying philosophy of our health system for the past 15 years. Yet the health system remains focused largely on curative care, rather than on the promotion of health and prevention of illness. The following section will highlight some of the challenges the health system is facing with regards to performance and effectiveness.

### ***Primary Health Care***

The health system has not adequately facilitated community participation and inter-sectoral collaboration. The need for quality services at the primary level for the bulk of health problems, wherein efficient and timely referral for those patients requiring this is another critical aspect of the “primary health care approach”. The inadequate integration of the different levels of care, spheres of government and between public and private sectors imply that many patients get “lost in the system” resulting in poor access to health care and poor quality of care. The allocation of resources for primary health care between and within provinces has been variable and not related to population, health need or adequacy of infrastructure. The health system currently has no defined basket of services at household and community level that is responsive to community needs and links different actors at this level as can be achieved through a programme such as the Community Health Worker programme.

### ***Healthcare Financing and Financial Management***

The public health system has been under funded for several years which has contributed to the inability of the public health system to deliver a health service that is accessible and of high quality. Consequently Provinces have been overspending on their budgets resulting in high accruals, non availability of medicines/other critical items due to non-payment of suppliers. Additionally there is a lack of adequate

financial management, reporting and accountability processes as envisaged in the PFMA resulting in most Provincial Health Departments receiving qualified audits.

### ***Human Resources for Health***

The health system is also facing a challenge of inappropriate production and deployment of human resources for health (HRH) professionals associated with poor HRH planning and the absence of staffing norms and standards. Training institutions have not been producing the required number of healthcare providers to meet national service delivery needs. Training of nurses has been removed from hospitals to colleges and universities, which has resulted in decreased outputs and none responsiveness to service delivery needs. Funding of nursing training in the public sector is through both stipend and bursaries. In the private sector aspiring nurses have to pay exorbitant tuition fees. This impacts negatively in the size of student intake and prevents entry of those from poor backgrounds. The provincial bursary system has excluded many young people, the system is not institution based and the administrators often award the study grants inequitably. With regards to management, healthcare workers are incorrectly placed and unevenly distributed. While there are policies that govern management of human resources, these are not applied effectively. There is weak implementation HR policies and relevant statutes at all levels of the health system which translates to poor performance management and weak accountability.

### ***Quality of Health and Accreditation of Health Establishments***

The health system has not developed and adopted a uniform set of norms and standards for health establishments. As a consequence, different programmes on quality and human resources in the system have developed disparate sets of standards and norms with respect to how health services are structured and delivered. The consequence of this is that health facility managers and staff are not clear about what is expected of them. It also makes it impossible to measure the performance of different hospitals, districts and clinics are performing. Although our public health facilities operate guided by the Batho-Pele Principles, patient satisfaction with the services rendered in our facilities is low. One of the major

reason for patient dissatisfaction with the health services is that health personnel are not considered to be caring towards them or to their families.

Many of our health facilities are also not clean and tidy at all times and the patient waiting times are very long. The infection control mechanisms in our facilities have been found wanting, which could result in hospital acquired infections. There is no standard mechanism for monitoring clinical governance and quality improvement mechanisms in our facilities are also inadequate. In addition, our facilities have not been accredited to comply with norms and standards for acceptable quality.

### ***Health Infrastructure***

The current public health infrastructure (including Health Technologies) does not support service delivery adequately. The health system faces huge infrastructure backlogs with poor management of the numbers and quality of the infrastructure requirements, under spending and poor budget and expenditure forecasting, poor infrastructure maintenance, as well as poor risk management with regards to deficiencies in programme and project financial management. Technology planning is very poor and as a result, the distribution of health technology is not equitably distributed with high escalation of costs, high levels of wastage, poor maintenance with significant safety risk. This is also compounded by the fact that budget allocations for all infrastructure including Information Communication and Technology (ICT) are scattered in different budget lines and there are no relevant items in the Standard Chart of Accounts (SCOA).

### ***Information, Communication and Technology and Health Information Systems***

Although large sums of money have been used to procure health information, communication and technology (ICT) and health information systems (HIS) in South Africa in the past, the ICT and HIS within the public health system is not meeting the requirements to support the business processes of the health system thus rendering the healthcare system incapable of adequately producing data and information for management and for monitoring and evaluating the performance of the national health system. This results from the lack of technology regulations and a lack of policy frameworks.

## **4. ACTIVITIES THAT WILL BE UNDERTAKEN FOR EACH OUTPUT**

### **AREA**

The information provided in this section of the Health Sector NSDA is focused on identifying the innovative and enhanced activities that will be undertaken by the National and Provincial Departments of Health together with key stakeholders in achieving the results as agreed upon. The focus of the identified activities is not to keep doing things as usual, but to identify solutions and develop new strategies and approaches to effectively address the challenges in each particular output areas identified below:

- **Output 1:** Increasing Life Expectancy
- **Output 2:** Decreasing Maternal and Child mortality
- **Output 3:** Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
- **Output 4:** Strengthening Health System Effectiveness

#### **4.1 OUTPUT 1: INCREASING LIFE EXPECTANCY**

To ensure that we achieve the goal of increasing life expectancy, the Department will increase its focus on strategies aimed at the primary prevention of non-communicable and chronic diseases through educating individuals, households and communities on the benefits of healthy lifestyles. This will be proactively supported by a programme of community mobilization involving the utilization of community health workers through a re-engineered and integrated Primary Health Care system that promotes health promotion and prevention at the community level.

New and innovative ways to increase early detection of non-communicable and chronic disease (NCDs) will be introduced. These activities will draw significantly on inter-sectoral initiatives such as those directed at reducing alcohol intake in communities (in collaboration with the Departments of Social Development and Trade and Industry) and ensuring that safe hygiene practices are appropriately followed at the household and community level. This includes active case-finding,

involvement of community health workers in identifying people at risk through understanding the risk factors and referral for assessments at health facilities; education programmes at schools (together with the Department of Basic Education) and within households; ensuring that people who attend health facilities are assessed for these diseases on a routine basis as part of the set of health care services that are offered particularly within PHC facilities for early detection purposes. This is a cost effective mechanism for effective disease surveillance and prevention.

Management of NCDs will be increased through greater monitoring of clinical conditions through a disease register and this will be used in developing and informing strategies for treatment at the community level. We are already engaged in a rigorous effort to prevent and manage non-communicable (NCD) conditions, including the screening of chronic diseases as a part of the HCT campaign. Disease surveillance mechanisms have already been put into place to draw on the health system's stakeholders with regards to detecting and responding in time to disease outbreaks and public health threats.

With regards to all chronic conditions, the focus is to improve the functioning of clinical services and extend care of all chronic diseases (both communicable and non-communicable) into communities. We will achieve this by integrating all chronic care services into a chronic care model and strengthening monitoring and evaluation systems within PHC facilities and communities. Community health workers are an important cadre for the implementation of the chronic care model.

In terms of communicable diseases like malaria, the target is to reduce the incidence of malaria in endemic provinces. Furthermore, the national malaria programme will be redirected towards malaria elimination through enhanced collaboration with countries like Botswana, Mozambique, Swaziland and Zimbabwe.

## **4.2 OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY**

A Primary Health Care approach that is designed as the foundation of the health system for promoting healthy lifestyles, prevention of diseases (including early detection), provision of early and quality ante- and post-natal services as well as essential infant and child health services and nutritional advice will be used in aggressively reducing the unacceptable high maternal and child mortality rates in the country.

Knowing the specific challenges that HIV poses in pregnancy, health worker initiated counselling and testing for HIV will be part of the screening in all ante-natal care at all levels of the health system. These services will be geared towards identifying problems early on in the pregnancy. Where appropriate, Prevention of Mother-To-Child Transmission (PMTCT) prophylaxis will start at 14 weeks of gestation, and the directive for qualifying women to have access to treatment, care and support within 2 weeks of diagnosis will be monitored.

The referral system for pregnant women, newborns and children with high risk conditions will be reviewed and strengthened to eliminate all delays and health care workers will be trained in the use and care of essential equipment to support a regime of quality care provision. A key activity is that an ambulance for emergency maternity and child cases will be available to avoid delays in getting medical attention (a common cause of maternal mortality). An ambulance must respond within one (1) hour of having been called to attend to an obstetric emergency. In remote areas, it is important for an ambulance to be stationed at each facility where deliveries are conducted. Some facilities will have to be redesigned such that maternity waiting homes/rooms are made available so that women do not have to travel far while in labour, especially those with complicated pregnancies. The facilities will also serve women with premature and sick newborns. Teams of experts/specialists in maternity and child health will provide supportive supervision to doctors, nurses and midwives in the management of pregnancy and child problems to reduce deaths, especially in under-resourced areas.

All maternity and neonatal facilities will have infection control measures in place and regular training will be provided to all health care workers on the best mechanisms for doing this. “Fire-drills” on dealing with haemorrhage will be conducted, together with perinatal and maternal mortality meetings in each facility. Facility will be supported to ensure that effective actions are taken to avert avoidable mortality.

Community Health Care workers linked to facilities will conduct post-natal care home visits at to identify problems with the mother and her baby and to assist in promoting appropriate feeding and prevention of neonatal sepsis.

Various strategies will be used to strengthen sexual and reproductive health to inter alia, ensure that contraceptives and other family planning methods are readily available. Health education and social mobilisation will be conducted regularly in conjunction with various partners within government, NGOs/CBs, the academic sector and developmental partners. Provision of termination of pregnancy services within the public sector will be strengthened with a focus on eliminating stigma associated with the use of such services.

Teams for primary health care consisting of a general practitioner, nurses and the community health workers will be assigned to a geographic area or to a number of families. The use of community health workers as part of the team of health workers (doctor, nurses, and community health workers) will improve access to health care. Social mobilisation will be strengthened, with basic public health education being the major community activity. In-service training of all health workers, especially nurses and Community Health Workers (CHWs) will be hands-on and community based. Community oriented training of doctors, midwives and nurses will also be used for effectiveness at primary care level. Task-shifting between and across different cadre of health care workers with relevant skills will also be undertaken to help redress the problem of scant resources. Advanced midwives and neonatal nurses will be trained in increased proportion. Currently, a number of mid-level workers are also being trained for improving maternal and child health, among others.

#### **4.3 OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASES FROM TUBERCULOSIS**

HIV, AIDS and Tuberculosis (TB) contribute a significant proportion to the burden of disease that is faced by the South African population, particularly among the poor and vulnerable groups. This is the primary reason why the government has decided to direct a huge amount of effort towards addressing the challenges of HIV and AIDS and TB in an integrated manner. The core of the strategies to effectively combat these diseases is encompassed in the HIV and AIDS Counselling and Testing (HCT) Campaign whose primary focus is to scale up the integrated prevention strategy based on behavioural change, use of barrier methods, provision of medical male circumcision, scale up syndromic management of STI and the early prophylaxes to prevent Mother-To-Child Transmission.

The HCT campaign is also aimed at making people know their status early by massively scaling up provider initiated HCT services in public and private health facilities, to reach people in their homes, work place and public spaces with messages that demonstrate the benefits of prevention and early access to treatment. It is also important for South Africans to know their status so that they can take responsibility to prevent new infections. In order to achieve this effectively, the Department of Health will work closely with social partners to promote and facilitate open dialogue among communities, civil society and social partners to address the social, cultural and political barriers to reduce stigma, address gender issues that put women at risk.

The Department of Health will simultaneously increase the number of people on Anti-Retroviral Therapy (ART). The focus of the health sector's ART programme will be to ensure that all eligible patients are put on ART through the use of quality and cost-effective drugs, the judicious use of laboratory services to improve patient care.

The focus of the health system's HIV, AIDS and TB programmes will be to provide health services within an integrated platform that will take advantage of the

re-engineered Primary Health Care (PHC) system that is community and household centred. Therefore, HIV, AIDS and TB services, irrespective of the level of the healthcare system at which they are rendered will be completely integrated with PHC services.

The HCT Campaign will be used as a base for key TB control, treatment and management interventions, including active case finding and contact tracing. This will be coupled with a strong focus on social mobilisation activities all partners to oversee a mechanism to ensure inter-departmental and inter-sectoral coordination for TB control, treatment and management in high risk concentrate areas, including the enforcement of compliance standards to infection control and clinical management protocols and regulations.

In strengthening its oversight over key health programmes, the Department of Health will proactively intervene in poor performing districts through enhanced supervision by the national TB control and management, working with Provincial Department of Health.

The programmes under this output area provide a platform for improving the level of integration and effectiveness of the health system in that as we conduct the HCT campaign to reach many South Africans so that they are able to know their status, we will also provide early treatment of pregnant women, infants and TB/HIV co-infected patients with a CD4 count  $\leq 350$  in order to contribute to reduction of disease progression, to improve quality of care and allow patients to improve their quality of life. We will scale up support and follow-up for all patients on TB treatment and ART to reduce the numbers of patients defaulting treatment which contributes to the development of drug resistance and poor patient outcomes.

#### **4.4 OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS**

To effectively strengthen the public health system, a number of parallel but equally important initiatives need to be undertaken by the Department of Health. The scope of these activities include the need to overhaul the health services delivery platform from one that is based on a largely curative care model to one that also promotes

cost-effective Primary Health Care delivered as close to the community and household as is possible, supported by strong enhancements in management and supervision.

#### ***Sub-Output 4.4.1: Re-Engineering the Primary Health Care System***

The service delivery platform of the health system will be changed from one that largely focuses on the delivery of curative health services to one that is also centred on Primary Health Care (PHC), which promote health promotion, prevention and community involvement. To do this, the Department of Health, in collaboration with key partners, will develop and implement a model for the delivery of PHC services that incentivises effective health promotion and disease prevention at the household and community level. All PHC facilities will be enhanced through the undergoing quality assessment and accreditation processes and the provision of effective health information system that is integrated across other government departments and agencies. The Department will develop a policy framework that clearly delineates the scope of services encapsulated within the PHC sphere and the scope of personnel that should form part of the PHC teams.

#### ***Sub-Output 4.4.2: Improving Patient Care and Satisfaction***

The matter of poor quality health services and poor satisfaction of patients is a common challenge for public health facilities. To ensure that patients don't face long waiting times, that they are treated with respect and dignity when they utilise health services and that the confidentiality of their information is protected the Department of Health will expedite processes and initiatives that have already been initiated and directed towards delivering quality healthcare services. The key focus will be the rapid and visible improvement of the physical infrastructure (including the provision of appropriate technology and equipment) that will assist with motivating staff and giving them (and our patients) the belief that they can change things for the better. This will be complemented with quality improvement, quality assurance and compliance programmes aimed to empower all staff with the requisite skills and methods to understand and measure their problems and to proactively test and implement improvements. To do this they will need training that is service oriented

and supported by mentoring as well as effective management and supervision. We will reduce risks of poor care by ensuring that basic systems are in place for sustained compliance with set standards and norms.

***Sub-Output 4.4.3: Accreditation of Health Facilities for Compliance***

There are a number of elements that need to be done differently under this component. Firstly, managers will be given a clearer description of expectations, preferably in a single, comprehensive and clear format and they need to know that they will be assessed on the basis of these standards and that there will be consequences for non-compliance, and that reports will be made public. The Department of Health will establish an Independent Body for Accreditation and Compliance that will be tasked with the development of a common set of national standards. These would also have a set of measurement tools, available to all for use in auditing by the independent regulatory entity.

The Department, through the Independent Body, will also establish standards to cover non-health establishments, Emergency Medical Services, General Practitioners, old age homes, as well as clinical standards. Clearly articulated mechanisms will be implemented to ensure that compliance with standards forms part of performance agreements of all managers (and staff where relevant), to ensure stipulated level of standards are met (both at the level of the facility and support level of district/province to meet target of compliant facilities). This requirement will be one of the pre-requisites for providing facility managers with increased autonomy/delegations for which there would also be incentives and regular reporting of selected quality surveillance information.

***Sub-Output 4.4.4: Improved Health Infrastructure Availability***

The public health sector has a reasonably large infrastructure backlog that needs to be addressed proactively to ensure equitable and sustained improvements in health services. The Department of Health will undertake organisational restructuring that is directed to better manage infrastructure maintenance and requirements including

health technology and ICT functions. We will exercise our stewardship function more strongly to pay greater attention and support to the infrastructure service delivery through building capacity at the national and provincial health departments as well as their implementing agents. We will develop and implement a national strategy to harness the value of technology in support of healthcare service delivery and this strategy will be managed in manner that ensures that we avoid the current costly and ineffective fragmentation.

Furthermore, we will create an enabling procurement and funding environment and ensure full utilization of Public Private Partnerships (PPP). We will also implement comprehensive mechanisms to manage our physical assets better, prioritizing the creation of an asset management information system.

#### ***Sub-Output 4.4.5: Improved Human Resources for Health***

In large part, the health workforce interventions that we have implemented in the past have been reactive, dealing with challenges as and when they arise, but largely leaving the existing institutional and financial impediments unaddressed. In re-evaluating the historical approach, and taking account of the inputs and recommendations provided to date, the following broad considerations are what we are going to implement as part of a proactive set of interventions central to a revised and urgent strategic refocus of the Department of Health's Human Resources for Health Plan to **Improve Human Resources for Health**:

- Strengthening clinical training: linking the resourcing of service and teaching platforms to ensure that the service levels of both meet with minimum norms and standards.
- Strengthen information on the workforce: Full implementation of the workforce-related information systems.
- Integrated planning: Service planning and workforce planning need to be integrated and form part of a single strategic costed plan that includes the Department of Higher Education and Training and the Training Institutions themselves.
- Determination of clearer targets: Explicit workforce attraction and retention strategies to be developed in relation to explicit targets that are linked to

attrition rates and the changes in the population demographic and epidemiological profiles.

- More consistent performance management implementation for clinical staff: a new strategic approach to maximizing workforce performance.
- Management of non-clinical staff: A revised strategic approach to maximizing the performance of non-clinical staff will be implemented.
- Renewed focus on delivery models and necessary staff configurations: a revised reporting framework for workforce planning will be implemented.
- A new strategic process for a renewed health workforce: a platform for integrated workforce planning and decision-making will be implemented.

With regards to the turnaround strategy for management, we will introduce mechanisms for a common competency framework for managers, together with standard delegation of responsibilities and functions. This has already started in the form of the assessment of the functionality, efficiency and appropriateness of the organisational structure and delegations for hospitals, in partnership with the Development Bank of Southern Africa (DBSA), the results of which will be used to finalise the framework as well as design training, support and performance management measures to address the identified challenges. We will introduce systems for rewarding good performance and ensure that poor performance is appropriately sanctioned. Equal focus will be directed at the service delivery and supervisory levels respectively through skills development programs, enhanced mentoring and monitoring and evaluation processes to ensure that deviations are detected early enough and acted upon immediately.

Community involvement in existing governance structures will be adequately resourced to ensure they have sufficient capacity and powers to hold management and frontline staff accountable on behalf of health service users they represent.

***Sub-Output 4.4.6: Strengthening Financial Management (Monitoring & Evaluation)***

The National Department of Health will implement a financial turnaround plan that is focused on setting up an internal financial expenditure monitoring unit to strengthen its oversight on expenditure patterns and financial sustainability of the 9 Provincial Department of Health's budgets. The purpose of the unit will be to monitor monthly provincial health spending and intervene where financial challenges are identified. This will ensure proactive and timely responses to the financial challenges in the provinces as they emerge and allow the Department to intervene before a crisis arises.

***Sub-Output 4.4.7: Improving Healthcare Financing through Implementation of National Health Insurance***

The fundamental change that must be initiated in the health sector is to overhaul our current financing system and to introduce a health system financing mechanism that explicitly takes into account the health needs of the national population and utilises key indicators based on demographics and epidemiological profiles to make resource allocations to health facilities. The introduction of a National Health Insurance (NHI) within the South African health system founded on the Primary Health Care Approach provides an opportunity for the significant transformation of the existing institutional and organizational arrangements in the health system. This opportunity entails the transformation of the health system into one that is equitable and offers the national population universal coverage to a defined comprehensive package of services. It also implies a profound shift to a national health system that is financed through a prepayment-based mechanism that is based on the principles of universal coverage and social solidarity, the promotion of financial risk protection to protect the population, especially the poor, against catastrophic health-related expenditure.

#### ***Sub-Output 4.4.8: Strengthening Health Information systems***

We will develop a framework for a comprehensive and integrated Monitoring and Evaluation function with the necessary Health and Management Information System (HMIS). This will be followed by the development and enforcement of common standards, norms and systems across the country and defined roles for national, provincial, district and local levels in monitoring and evaluation.

We will strengthen the District Health Information System (DHIS) and progressively design and implement an appropriate Electronic Health Record for the country.

We will also ensure that the quality of data we produce is reliable so that we strengthen planning and implementation. We will also strengthen our oversight over sub-national levels through the use of levers such as supervisory visits and incorporating the DHIS requirements into manager's performance agreements at all levels. Evidence of analysis will also be required for accreditation purposes and ultimately for linking to the case-load and/or risk adjusted funding. Regular reports on the NSDA outputs will be tabled to the National Health Technical Implementation Forum and to the National Health Implementation Forum.

## **5. EVALUATION OF THE EXISTING LEGISLATIVE & REGULATORY ENVIRONMENT**

To ensure the effective stewardship of the national health system, a number of enabling legislations and supporting regulations have been enacted by Parliament to support the achievement of the vision of improved health status and longevity for all South Africans. The following is the list of all Acts for which the Minister of Health is the custodian of:

- The National Health Act
- The Choice of Termination of Pregnancy Act
- The Mental Health Care Act
- The Sterilisation Act
- The Nursing Act

- The Medical Schemes Act
- The Occupational Diseases in Mines and Works Act
- The Health Professions Act
- The Pharmacy Act
- The Allied Health Professions Act
- The Traditional Healers and Practitioners Act
- The Dental Technicians Act
- The Food, Cosmetics & Disinfectants Act
- The Medicines and Related Substances Act
- The Medical Research Council Act
- The National Laboratory Services Act
- The Human Tissue Act

There are also other acts that are part of government's legislative framework that have a direct or indirect bearing on the functioning and structure of the health sector currently. More importantly, these acts have a bearing on how some of the proposals indicated above can be undertaken more immediately. These acts include, but are not limited to:

- The Compensation for Occupational Injuries and Diseases Act
- The Road Accident Fund Act
- The Correctional Services Act
- The Competition Act
- The Consumer Protection Act
- The Local Government Municipal Structures Act
- The Protection of Personal Information Act
- The Municipal Systems Act
- Higher Education Act
- Public Service Act
- Labour Relations Act

To support the achievement of the four (04) outputs and related sub-outputs as stipulated in the NSDA, we have already undertaken a process to review some of the provisions of the National Health Act (Act No 61 of 2003).

The National Health Act as it currently stands places the compliance function within the national Department of Health, with implications for perceptions of independence. The Act will be amended to create an independent accreditation body, in order to ensure independence and enhance legitimacy and credibility of its findings, and with powers to inspect and obtain information (including patient information) where necessary to support its oversight and implementation functions. The National Health Act places responsibility for *“advising managers at all levels on strategies to enhance quality”* as well as providing regular reports on quality of care to the Minister of Health. This function will remain within the management support function of the National Department of Health when the compliance auditing function is removed through the creation of the independent office of standards compliance and accreditation.

The National Health Act provides the legislative background for the new categories of health professionals in South Africa. Under regulations relating to Human Resources in Chapter 7, Section 52 (c) and (d) of the Act, there is a need to develop regulations regarding Human Resources within the National Health System in order to create new categories of health care personnel to be educated or trained; identify shortages of key skills, expertise and competencies within the National Health System to be informed by the restructuring of the health system into one that is based on the PHC approach.

## **6. IDENTIFICATION DELIVERY PARTNERS FOR EACH OUTPUT AREA**

The improvement of the health status of all South Africans is a responsibility that cut across a number of sectors, both internal and external to the government systems and processes and not just the Department of Health. Health is determined by factors such as poverty (which contributes to malnutrition including obesity, unwanted pregnancy), lack of potable water (which contributes to diarrhoea, cholera,), stress (which may lead to lack of productivity, depression and suicide), lack of safety in the home and road (injuries, burns, poisoning of children), air pollution (chest conditions such as asthma, bronchitis), drugs (alcohol and domestic

violence, sexual indiscretion, child neglect) and moral degeneration (violence against women and children, interpersonal violence). Therefore, the Department of Health must engage with key partners within and outside government to ensure that it effectively implements the four required outputs of the NSDA 2010-2014.

In the table below, we provide a high level analysis of the key partners/stakeholders that are identified as the major role players in terms of achieving the four (04) outputs as listed in the NSDA.

**TABLE 1: KEY PARTNERS/STAKEHOLDERS IN THE IMPLEMENTATION OF THE NSDA 2010-2014**

<b>OUTPUT AREA</b>	<b>KEY PARTNERS/STAKEHOLDERS</b>
<b>Output 1: Increasing Life Expectancy</b>	<p>Departments of Social Development, Trade &amp; Industry, Justice and Constitutional Development, Correctional Services, Water Affairs, Environmental Affairs, Agriculture, Transport and the South African Police Force</p> <p>Provincial Departments of Health and Social Development</p> <p>NGOs &amp; Community Based Organisations</p> <p>South African Local Government Association</p> <p>International organizations such as the World Health Organisation, UNICEF and the Centres for Disease Control</p>
<b>Output 2: Decreasing Maternal and Child Mortality</b>	<p>Departments of Social Development, Justice and Constitutional Development, Correctional Services, Water Affairs, Environmental Affairs, Public Works, Transport and the South African Police Force</p> <p>Provincial Departments of Health and Social Development</p> <p>NGOs &amp; Community Based Organisations</p> <p>International organizations such as the World Health Organisation, UNICEF and the Centres for Disease Control</p>
<b>Output 3: Combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis</b>	<p>Departments of Mineral Resources, Labour, Correctional Services, Human Settlement, Environmental Affairs and Rural Development</p> <p>The Mining Companies (including the Chamber of Mines)</p> <p>Other partners including academic institutions, research and civil society organisations</p>

---

**OUTPUT AREA**

**Output 4:** Strengthening Health System Effectiveness

Sub-Output 4.1: Re-Engineering the Primary Health Care Approach

Sub-Output 4.2: Improving Patient Care and Satisfaction

Sub-Output 4.3: Accreditation of Health Services Facilities for Compliance

Sub-Output 4.4: Improved Health Infrastructure Availability

Sub-Output 4.5: Improved Human Resources for Health

Sub-Output 4.6: Strengthening Financial Management (Monitoring & Evaluation)

Sub-Output 4.7: Improving Healthcare Financing through Implementation of National Health Insurance

Sub-Output 4.8: Strengthening Health Information systems

**KEY PARTNERS/STAKEHOLDERS**

Departments of Public Works; Water Affairs; National Treasury; Trade & Industry; Higher Education & Training; Science & Technology; Public Service & Administration, Corporative Governance & Traditional Affairs; Other partners include:

- Eskom and relevant municipalities
- The Development Bank of South Africa (DBSA)
- Colleges of Medicine
- Statistics SA
- South African Local Government Association
- Academic Institutions
- Regulatory Bodies
- Medical Device Industry
- Community Based Organizations
- Non-Governmental Organizations
- Statutory Health Councils
- Professional Associations
- Labour Organizations
- International Agencies (WHO and ILO)

## **MONITORING AND EVALUATION FRAMEWORK FOR THE NSDA 2010-2014**

The health sector will implement a results-based Monitoring and Evaluation (M&E) system to track progress towards the implementation of the NSDA 2010-2014. Unlike the traditional M&E approach, which focuses on issues of implementation, namely inputs, activities, process and outputs, the results-based focuses on the impact of the programmes or projects implemented<sup>1</sup>. In fact, it starts with the desired outcomes and works backwards to identify the inputs, activities and outputs required to achieve these outcomes.

The key strategy going forward will be to focus on a very small set of strategic indicators, which will focus on outcomes. The main goal will be to generate good quality, reliable and timeous data to assess the impact of the interventions outlined in the NSDA on the health status of South Africans.

As indicated in the foregoing sections, the four outputs that the health sector will be tracking are:

- (1) Increasing Life Expectancy;
- (2) Decreasing Maternal and Child Mortality;
- (3) Combating HIV and AIDS and STIs; and,
- (4) Decreasing the Burden Of Disease from Tuberculosis, and Enhancing Health Systems Effectiveness

The health sector has enhanced measures for monitoring and reporting on the NSDA 2010-2014. In October 2010, the National DoH established the Health Data Advisory and Coordination Committee (HDACC) to improve the quality and integrity of data on key health outcomes. The HDACC consists of scientists, researchers and academics from outside government, as well as experts from key government departments.

The HDACC produced its final report in November 2011, which reflected more accurate baselines and realistic targets for Life Expectancy; Maternal Mortality Ratio (MMR); Infant Mortality Rate (IMR) and the Under-5 Mortality Rate (U5MR).

---

<sup>1</sup> Kusek, J.Z and Risk, R.C (2010): *Ten Steps to a Result-Based Monitoring and Evaluation System* in A Handbook for Development Practitioners, World Bank, Washington DC.

## ***Life Expectancy***

With regard to increasing Life Expectancy, the HDACC concluded that the overall baseline Life Expectancy of South Africans is 56.6 years. This is 54 years for males and 59 years for females. The Committee further recommended that the target for 2014/15 should be to increase the overall Life Expectancy from 56.6 years to 58.5 years, which is an increase of two years. With respect to males and females, this implies that the Life Expectancy of males should increase from 54 years to 56 years, and that of females from 59 years to 61 years.

## ***Maternal Mortality Ratio (MMR)***

The HDACC also acknowledged the huge uncertainty associated with measuring the Maternal Mortality Ratio (MMR), which is a challenge internationally. Based on its review of empirical evidence, the Committee concluded that the baseline MMR of South Africa (2008 data) is 310 per 100,000. The Committee recommended that the target in the Health Sector's NSDA 2010-2014 should be to reduce the MMR to not more than 270 per 100,000 (i.e. 10% reduction). With the rapid implementation of the policy to initiate Antiretroviral Treatment at a CD4 count of 350, further decreases in maternal mortality rates should be achieved.

The MMR of 310 per 100,000, although still high, is significantly lower than the baseline figure of 625 per 100,000 reflected in Millennium Development Goal (MDG) Country Report 2010 and the NSDA 2010-2014.

## ***Infant Mortality Rate (IMR)***

The HDACC confirmed in its November 2011 Report that:

- (a) The baseline Infant Mortality Rate (IMR) for South Africa is 40 per 1,000 live births.
- (b) The target for 2014 should be to decrease the IMR to 36 per 1,000 live births (10% reduction).

## ***Under-5 Mortality Rate (U5MR)***

The HDACC further stated in its November 2011 Report that:

- (a) The baseline Under-5 Mortality Rate (U5MR) of South Africa is 56 per 1,000 live births. This is lower than the 104 per 1,000 reflected in the MDG country Report 2010.
- (b) The realistic target for 2014 should be to reduce the U5MR from 56 per 1,000 live births to 50 per 1,000 live births (a 10% reduction).

The implications of the results of the work of the HDACC are that:

- (a) The Life Expectancy of South Africans is somewhat higher than originally estimated.
- (b) The Maternal Mortality Ratio; Under-5 Mortality Rate and Infant Mortality Rate of South Africa are actually lower than the original estimates.
- (c) The baselines reflected in the original health sector NSDA 2010-2014 of October 2010, need to be revised to enhance their accuracy. Similarly, targets should be made more realistic.

The revised baseline figures and targets reflected in the HDACC Report will enable government to track more reliably progress towards implementing the NSDA 2010-2014, which seeks to reverse the quadruple burden of diseases that afflicts South Africans.

The HDACC report also identifies data sources and agencies that will be used in future to track the impact of health interventions and social support in improving health outcomes required in terms of the NSDA 2010-2014. The work of the Health Data Advisory Committee also improves systems for measuring progress towards the health related Millennium Development Goals (MDGs).

The focus of the M&E Plan of the revised NSDA 2010-2014 will be on the 36 high-level indicators produced by the HDACC, which are reflected in **Table 2** below. These will be used to track progress towards the four (4) outputs of the NSDA 2010-2014.

**TABLE 2: HEALTH SECTOR OUTPUTS, INDICATORS, BASELINES, TARGETS AND DATA SOURCES**

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUENCY</b>
<b>1. INCREASING LIFE EXPECTANCY</b>	1.1. Life Expectancy at Birth	56.5  54.0 years for males  59.0 years for female	58.5  Males 56.0 years  Females 61.0 years  (an increase of 2 years)	DHA (deaths from population register)  Population estimates from ASSA2008	MRC/NDoH(with task team including StatsSA, and Care)	Annually
	1.2. Adult Mortality Rate	46%  Male 52%  Female 40%	43%  Male 48%  Female 37%  (10% reduction)	DHA (deaths from population register)  Population estimates from ASSA2008	MRC/NDoH(with task team including StatsSA, and Care)	Annually

OUTPUT	INDICATOR	BASELINE 2009	TARGET 2014/15	SOURCE OF DATA	AGENCY	FREQUENCY
<b>2.DECREASE MATERNAL AND CHILD MORTALITY</b>	2.1 Under -5 Mortality Rate (U5MR)	56 per 1,000 live births	50 per 1,000 live births (10% reduction)	Death from the national population register  Birth estimates from ASSA2008	MRC/NDoH(with task team including StatsSA, and Care)	Annually
	2.2 Infant Mortality Rate	40 per 1,000 live births	36 per 1,000 live births (10% reduction)	Death from the national population register  Birth estimates from ASSA2008	MRC/NDoH (with task team including StatsSA, and Care)	Annually
	2.3 Maternal Mortality Ratio	310 per 100,000 live births	270 per 100,000 live births (reverse increasing trend and achieve 10% reduction)	Vital registration data  Birth estimate from ASSA2008	MRC/NDoH(with task team including StatsSA, and Care)	Annually

<b>2. DECREASE MATERNAL AND CHILD MORTALITY</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUENCY</b>
	2.4 Neonatal Mortality Rate (<28 days)	14 per 1,000 live births	12 per 1,000 live births (10% reduction)	Death from population register Birth estimates from ASSA2008	MRC/NDoH(with task team including StatsSA, and Care)	Annually
	2.5 . Prevalence of underweight among children $\leq 59$ months	No baseline	5% reduction (1% per year)	SANHANES	HSRC	Annually
	2.6. Prevalence of stunting among children $\leq 59$ months	No baseline	5% reduction (1% per year)	SANHANES	HSRC	Annually

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE E 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUENCY</b>
<b>3. COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASES FROM TUBERCULOSIS</b>	3.1. Estimated incidence of HIV in 15-49 year old women	1.3%	Evidence of consistent downward trend	Modelled from HIV prevalence in 15-49 years old pregnant woman reported by annual antenatal HIV and syphilis survey. Model calibrated using HSRC household survey results	NDoH/ HSRC/ HSRC/ CARE	Annually
	3.2. Mother- to- Child transmission rate of HIV <2 months of age	2010: 3.6%	<2%	PMTCT surveillance system (PCR positive/Elisa positive at <2 months of age)	Medical Research Council (MRC)	Annually
	3.3. Proportion of eligible HIV positive pregnant women initiated on ART	22%	80% (of eligible pregnant women to be initiated on ART at a CD4 count of <350	Numerator: DHIS data element #271 (ANC client initiated on ART) Denominator calculated as follows: (*38.9%) Deliveries in public sector facilities +BBAs) * ANC seroprevalence) – antenatal client on HAART at 1 <sup>st</sup> visit) *38.9% - antenatal client on HAART at 1 <sup>st</sup> visit)	NDoH/ HSRC/ HSRC/ CARE	Quarterly

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE NE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUENCY</b>
<b>3. COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASES FROM TUBERCULOSIS</b>	3.4. Total number of patients (adults and children) on ART	1,1 million (estimate based on ever initiated on ART)	2.5 million on treatment	Three tier data system to be set up nationally and to report from June 2012  National DoH CCMT reports.	NDoH	Quarterly
	3.5. Medical male circumcisions	2010:  100 000 (estimate)	500 000 adolescent and adult males per annum	Information needs to be added to NIDS so that the age breakdown can be collected routinely in DHIS	NDoH	Quarterly
	3.6. Proportion of TB Treatment Success among <u>all</u> TB cases	73,9%	85%	ERT. net Report: Summary Treatment outcome summary: All TB cases	NDoH	Quarterly
	3.7. TB Defaulter rate at the end of TB treatment among <u>all</u> TB cases.	7,9%	<5%	ERT. net Report: Summary Treatment outcome summary: All TB cases	NDoH	Quarterly

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE E 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUENCY</b>
<b>3. COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASES FROM TUBERCULOSIS</b>	3.8. Percentage of HIV-TB co-infected patients who are on ART on completion of TB treatment	20%	85%	ETR. net: TB/HIV Report	NDoH	Quarterly
	3.9. Percentage of diagnosed MDR-TB patients who are enrolled in a TB treatment programme	Not available	75%	MDR treatment register	NDoH	Annual

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUE NCY</b>
<b>4. RE-ENGINEERING PHC SYSTEM</b>	4.1. Primary Health Care utilisation rate	2.5 visits per person per annum	3.5 visits per person per annum	DHIS	N DoH	Quarterly
	4.2. OPD clinic new case not referred rate	55%	30%	DHIS	N DoH	Quarterly
	4.3. School health programme coverage	No baseline (new programme)	95% of all Quintile 1 School & 95% of all all Quintile 2 School	PHC re-engineering M&E	NDoH / DBE /DSD	Annual
	4.4. PHC outreach team coverage	No baseline new programme	30% population covered at target level of 1 team per 7660 persons or 1619 households	PHC re-engineering M&E	NDoH	Annual

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUENCY</b>
<b>4. RE-ENGINEERING PHC SYSTEM</b>	4.5. CHWs	65,000 various categories (2011 audit)	45, 000 formally trained and Placed to meet target of 1 per 270 households	QRS / Annual report	NDoH / DSD	Quarterly / Annual
	4.6. Specialist Clinical Team Coverage	No baseline	80% of total districts with gynaecologist in special team & 100% of NHI pilot district	PHC re-engineering M& E	NDoH	Annual
<b>Improve patient care and satisfaction</b>	4.7. Percentage of users of public Health services highly satisfied with with the service received	54% (Public)	70%	General Household Survey	STATSSA	Annual

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUEN CY</b>
<b>Improve patient care and satisfaction</b>	4.8. Office for Health Standard Compliance established	No baseline	Established by 2012	NDoH Annual Report	NDoH	Annually
	4.9. Certification of health Facilities ( public and private)	None	20%	NDoH Annual Report	NDoH	Annually
<b>Improve Human Resource for Health</b>	4.10. Hospital managers meeting competency criteria	No baseline	100%	Competency Assessment Survey	NDoH	Biannual
	4.11. Intake of medical students	1,309 (2008)	Additional 1,053 per annum	NDoH Annual Report	NDoH/DHE	Annual
	4.12. Intake of pharmacy students	No baseline	Double intake	NDoH Annual Report	NDoH/DHE	Annual
	4.13. Intake of nursing Students (professionals nurses)	5,621 (2010)	Additional 5,000 per year	SANC	NDoH/DHE	Annual

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUEN CY</b>
<b>Strengthening Financial Management</b>	4.14. Number of Health Departments Receiving unqualified Audit From Auditor – General	3/10 (2009/10) (1 National and 2 Provincial DoHs)	9/9 Provincial DoHs 1 National DoH	Auditor- General's Report on the Annual Financial Statements of Government Departments.	Auditor- General.	Annual
	4.15. Spending on infrastructure Maintenance	10% under spending	5% by 2012/14 2% by 2014/15	Auditor- General's Report on the Annual Financial Statements of Government Departments.	Auditor- General.	Annual
<b>Building blocks of NHI within the DoH</b>	4.16. Policy and legislation framework	No baseline	Green paper 2011, White paper, Act and Regulations	NDoH Annual Report	NDoH	Annual
	4.17. NHI pilot districts	No baseline	10 pilot districts	NDoH Annual Report	NdoH	Annual

<b>OUTPUT</b>	<b>INDICATOR</b>	<b>BASELINE 2009</b>	<b>TARGET 2014/15</b>	<b>SOURCE OF DATA</b>	<b>AGENCY</b>	<b>FREQUEN CY</b>
<b>Strengthening Health Information Systems</b>	4.18. Integrated M&E Framework for Health	No baseline	Integrated framework for SA by 2012	NDoH	NDoH	Annual
	4.19. 5-year HMIS strategy for SA	No baseline	5-year strategic plan by 2013	NDoH	NDoH	Annual

## **7. SIGNATORIES**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2010

Minister of ..... Date: \_\_\_\_\_ 2010

Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2010

Minister of .....

Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2010

Minister of .....

Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2010

Minister of .....

Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2010

MEC for .....

Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2010

Mayor of .....