STRATEGIC PLAN

2020/21 - 2024/25

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Phila
Inspired to live

2030
NDP

STRATEGIC PLAN
2020/21-2024/25

RP: 108/2020
ISBN: 978-0-621-48280-5

FOREWORD BY THE MINISTER OF HEALTH

On 31 July 2019, I had the privilege of introducing Parliament to a progressive piece of legislation meant to revolutionize our health system in South Africa: The National Health Insurance Bill.

The National Health Insurance will become a reality and we are committed to ensuring that our people get quality healthcare and are not discriminated on the basis of lack of affordability. We will fulfill our constitutional obligation to protect the right to health care for all.

The National Health Insurance will, at the very heart of it all, address the gross distortions that currently characterize our health care system and impede the ability to deliver on our constitutional mandate. In the past months we witnessed a thorough consultative process through public hearings and submissions by various stakeholders and ordinary members of the public. South Africans came out in their number to ensure that the final piece of legislation reflects their will.

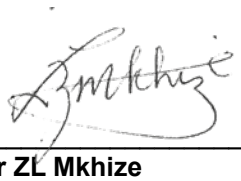
We thank all citizens who ensured that they contribute to the democratic process of determining legislation that is meant to improve their health and wellbeing.

As we prepare for the NHI, we want to ensure that we are ripe and ready for the year we are targeting for implementation: 2026. Our preparations will be driven by the Presidential Health Compact, which emanated from the Presidential Health Summit: a collaborative effort of multiple stakeholders who came together with the sole purpose of overhauling the health sector in its entirety. The Compact, anchored by nine pillars to realize the emancipation of the sector, will be coupled with the Quality Improvement Plan. These two programmes are action driven blueprints that clearly set out implementable, goal oriented activities for a unified, cohesive and efficient health care system.

The most important concept that binds all this activity together is that of multi-sectoral collaboration- particularly in the area of public-private- partnership.

The outcomes in the Strategic Plan for 2020/21-2024/25 targeted by the Department, ensure a comprehensive response to priorities identified by the nine pillars of the Presidential Health Compact. These outcomes also firmly respond to the impact statements of Priority 3: Education, Skills, and Health, as well as the interventions identified in government's Medium Term Strategic Framework for the period 2019-2024

We remain committed to providing stewardship to the National Health Insurance, working closely with the provincial members of the executive council for health , to deliver quality healthcare to all South Africans and as committed by our government, to improve their lives.



Dr ZL Mkhize
Minister of Health, MP

STATEMENT BY THE DIRECTOR-GENERAL

The health outcomes of South Africa reflect positively on the health system. Empirical evidence shows that Life expectancy continues the upward trajectory. Life expectancy at birth is currently at 64.7 years in South Africa, the highest it has ever been, exceeding the target of 64.2 years that was set by government 5 years ago. This increase is due to expansion of the HIV programme, as well as reductions in maternal, infant and child mortalities. However, it is of concern that neonatal mortality has seen just about no change in the past 5 years. This together with premature mortality due to non-communicable diseases, and trauma, violence, and injuries which are on the rise, and will require additional attention over the next 5 years.

The health system in South Africa remains divided, and maintains its 2-tier status more than 25 years into democracy. During 2019, the Lancet commission released a report on quality of health care in South Africa, with detailed diagnosis, and recommendations to improve the quality of health care in South Africa, and made a case that increase in coverage will not be sufficient to improve health outcomes. The Health Market Inquiry also released its final recommendations citing many challenges in the private health sector, and market failure.

The National Health Insurance (NHI) policy of government aims to dismantle the system and introduce several structural reforms. The consultation on NHI bill, which is led by the portfolio committee of health, will ensure that NHI fund is established and able to strategically purchase health services from public and private health providers once it is enacted by the President. Concurrently, the National Department DoH, in partnership with its provincial counterparts, aims to strengthen the health system of South Africa to achieve Universal Health Coverage. The NHI bill has prioritized health promotion (non-personal), prevention and treatment (personal) services for the population.

Over the next 5 years, the Department has set the target to increase Life Expectancy to at least 66.6 years, and to 70 years by 2030. Additionally, it aims to progressively achieve Universal Health Coverage, and financial risk protection for all citizens seeking health care, through application of the principles of social solidarity, cross-subsidization, and equity. These targets are consistent with the United Nation's sustainable development goals to which South Africa subscribes, and Vision 2030, described by the National Development Plan, that was adopted by government in 2012.

A stronger health system, and improved quality of care will be fundamental to achieve these impacts. The Department's Strategic Plan 2020/21-2024/25 is firmly grounded in strengthening the health system. In total, 12 of the 18 outcomes prioritized by the Department are geared to strengthen the health system, and improve quality of care, with the remaining 5 outcomes responding to the quadruple burden of disease in South Africa. Actions towards achieving these will help go a long way to ensure quality health services, and effective coverage are achieved.

We will join hands with our Provincial Departments of Health to achieve these outcomes. We will also collaborate with other government departments to reduce the impact of social determinants of health, and forge strong partnerships with social partners to improve community participation to ensure that the health system is responsive to their needs.

Dr A Pillay
Acting Director-General

TABLE OF CONTENTS

OFFICIAL SIGN OFF

It is hereby certified that this Strategic Plan.

- Was developed by the management of the National Department of Health under the guidance of Dr Z.L Mkhize
- Takes into account all the relevant policies, legislation and other mandates for which the National DoH is responsible
- Accurately reflects outputs which the National Department of Health will endeavor to achieve over the period 2020/21-2024/25.

Ms V Rennie
Manager Programme 1:
Administration

Mr I van der Merwe
Chief Financial Officer

Dr A Pillay
Manager Programme 2:
National Health Insurance

Mr G Tanna
Chief Directorate: Policy co-ordination and Integrated Planning

Dr Y Pillay
Manager Programme 3:
Communicable and Non-Communicable Diseases

pp

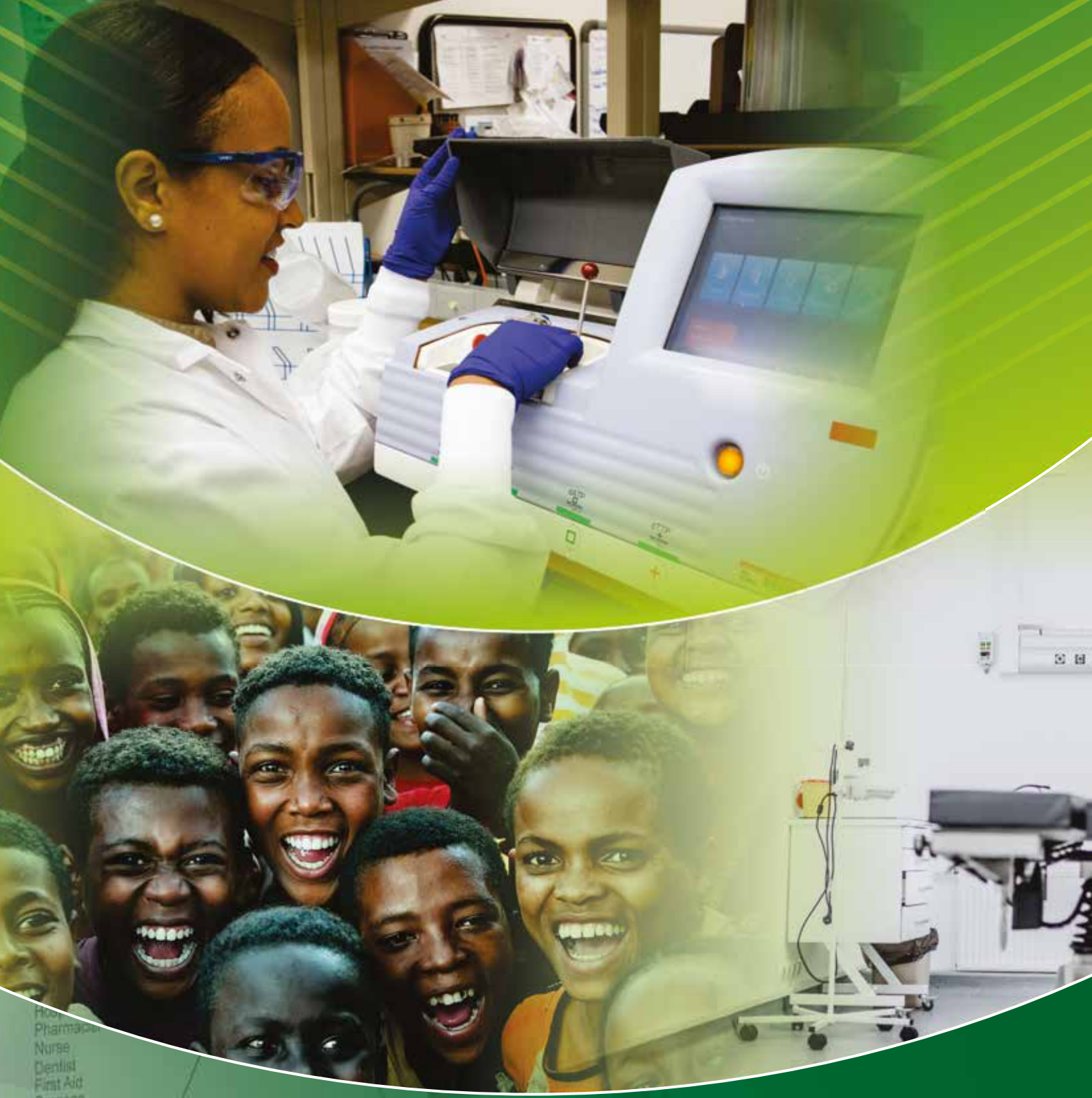
Ms J Hunter
Manager Programme 4:
Primary Health Care and Programme 5:
Hospital Systems

Approved by:

Dr A Pillay
Acting Director-General

Dr G Andrews
Manager Programme 6:
Health System Governance and Human Resources

Dr Z. L. Mkhize
Minister of Health, MP



PART A

OUR MANDATE

1. CONSTITUTIONAL MANDATE

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

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

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

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

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

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

(1) Everyone has the right to have access to:

  (a) Health care services, including reproductive health care;

  (b) Sufficient food and water; and

  (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and

(3) No one may be refused emergency medical treatment.

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

2. LEGISLATIVE AND POLICY MANDATES (NATIONAL HEALTH ACT, AND OTHER LEGISLATION)

The Department of Health derives its mandate from the National Health Act (2003), which requires that the department provides a framework for a structured and uniform health system for South Africa. The act sets out the responsibilities of the three levels of government in the provision of health services. The department contributes directly to the realisation of priority 2 (education, skills and health) of government's 2019-2024 medium-term strategic framework, and the vision articulated in chapter 10 of the National Development Plan.

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 77, 78, 79, 212 4(a) and 212 8(a) - Provides for forensic psychiatric evaluations and establishing the cause of non-natural deaths.

Child Justice Act, 2008 (Act No. 75 of 20080, Provides for criminal capacity of children between the ages of 10-14 years

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

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

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993) -

Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

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

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

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

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

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

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

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

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

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

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

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

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

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

3.1. National Health Insurance Bill

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

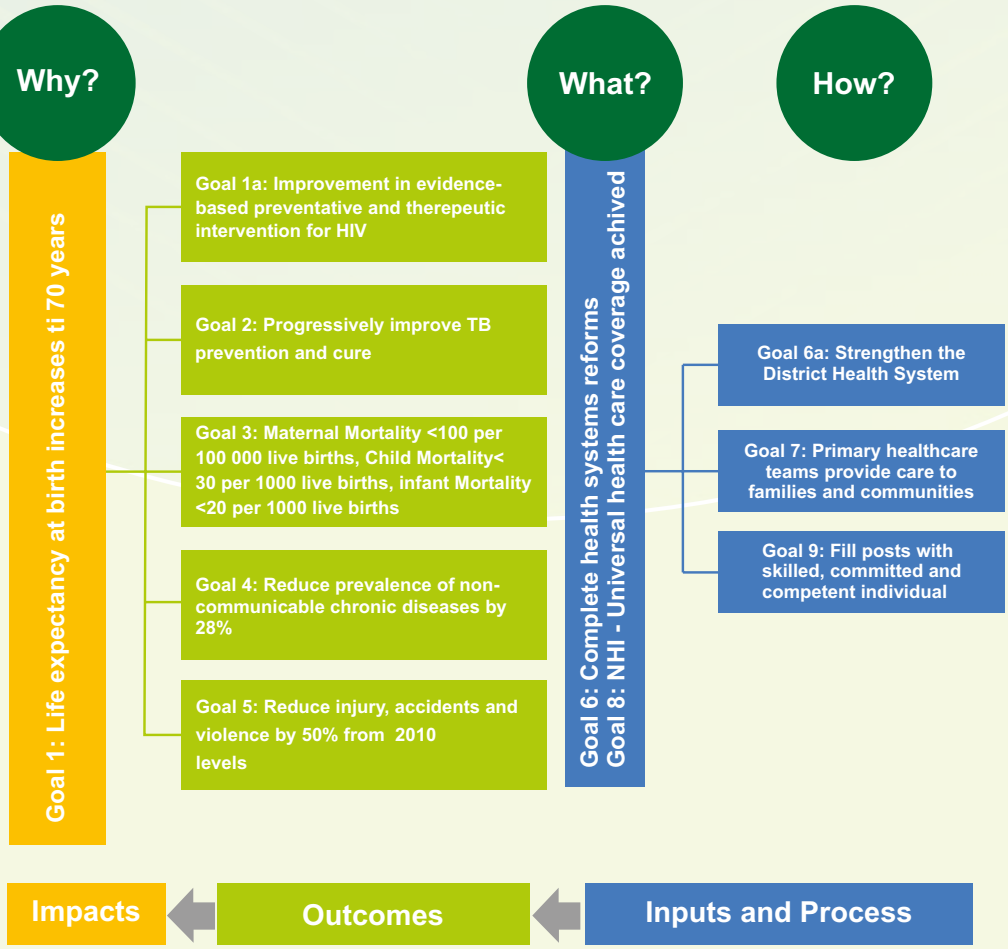
In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator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

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

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

3.2. National Development Plan: Vision 2030

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



Source: Adapted from National Development Plan 2030

3.3 Sustainable Development Goals

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

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

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

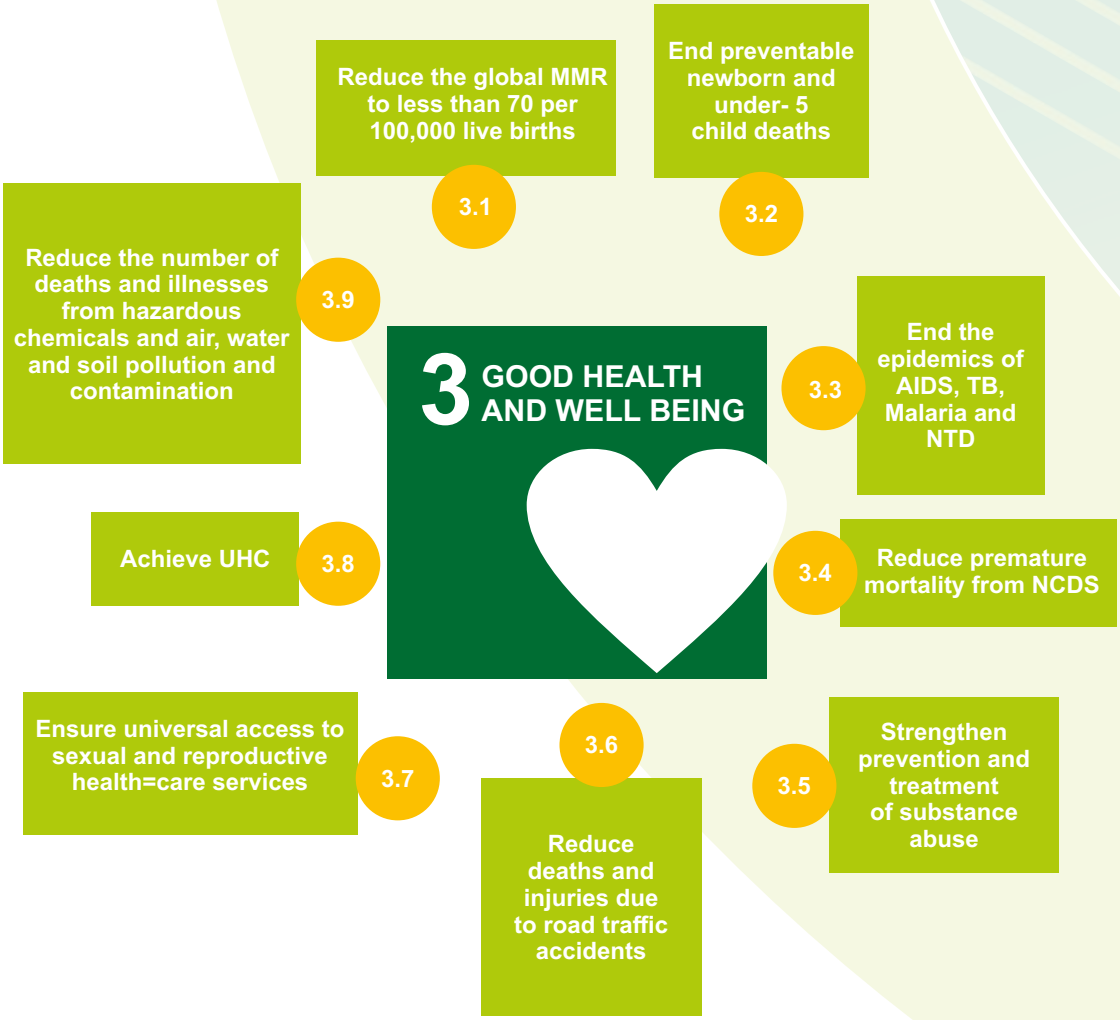
(3) 3.3 - By 2030, **end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases** and combat hepatitis, water-borne diseases and other communicable diseases

(4) 3.4 - By 2030, **reduce by one third premature mortality** from non-communicable diseases through prevention and treatment and promote mental health and well-being

(5) 3.5 - Strengthen the **prevention and treatment of substance abuse**, including narcotic drug abuse and harmful use of alcohol

(6) 3.6 - By 2020, **halve the number of global deaths and injuries from road traffic accidents**

(7) 3.7 - By 2030, **ensure universal access to sexual and reproductive health-care services**, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes



(8) 3.8 - Achieve **universal health coverage, including financial risk protection**, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

(9) 3.9 - By 2030, **substantially reduce the number of deaths and illnesses from hazardous chemicals** and air, water and soil pollution and contamination

(10) 3.a - Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

(11) 3.b - **Support the research and development of vaccines and medicines** for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

(12) 3.c - Substantially **increase health financing and the recruitment, development, training and retention of the health workforce** in developing countries, especially in least developed countries and small island developing States

(13) Strengthen the capacity of all countries, in particular developing countries, for **early warning, risk reduction and management of national and global health risks**

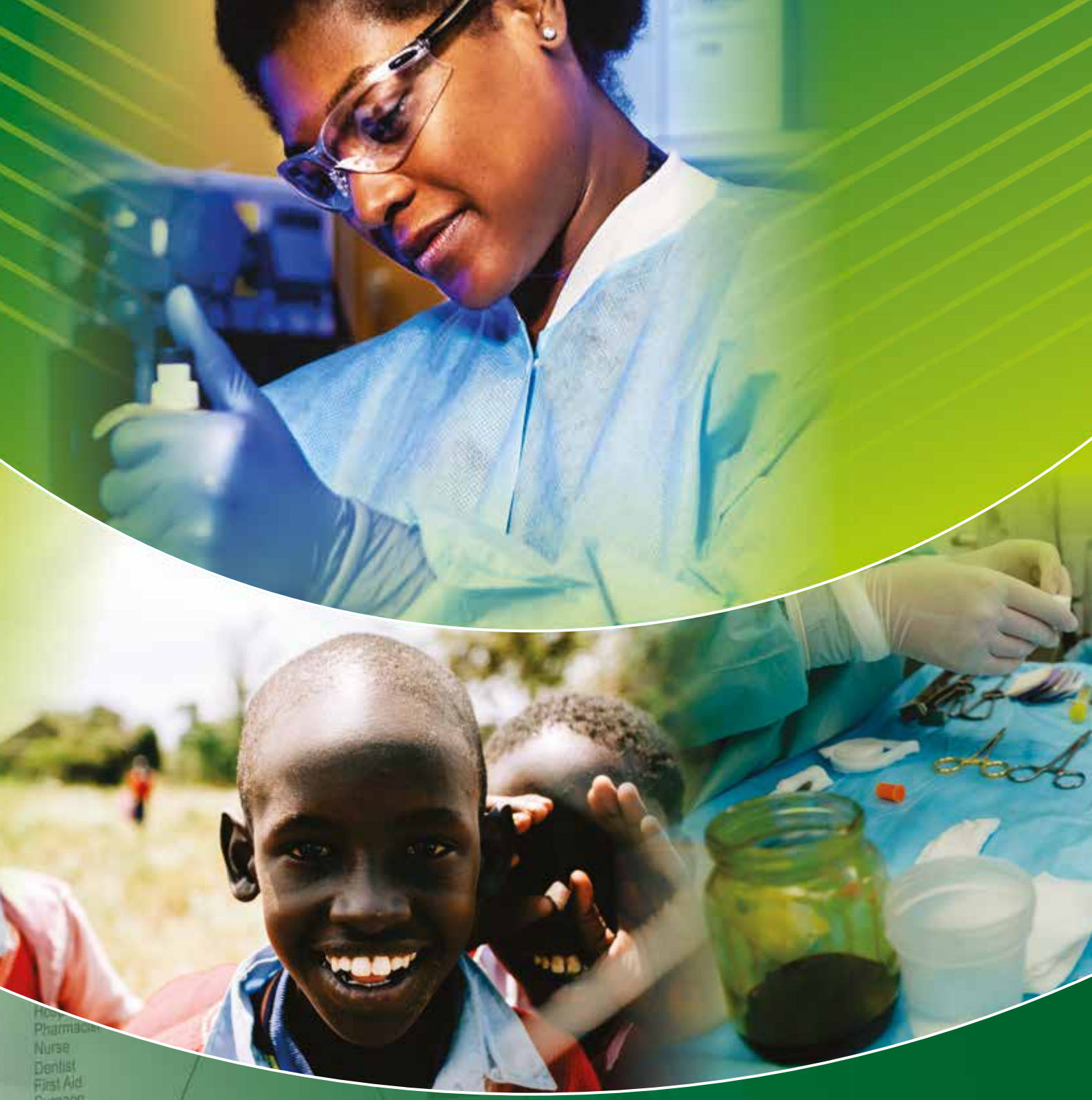
3.4. Medium Term Strategic Framework 2019-2024 and NDP Implementation Plan 2019-2024

The plan comprehensively responds to the priorities identified by the 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 National Department of Health's response is structured to deliver the MTSF 2019-2024 impacts, and the NDP Implementation Plan 2019-2024 goals. They are well aligned to the Pillars of the Presidential Health Summit compact, as outlined in the table below:

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
Survive and Thrive	Life expectancy of South Africans improved to 66.6 years by 2024, and 70 years by 2030	**Goal 1:** Increase Life Expectancy improve Health and Prevent Disease	• Improve health outcomes by responding to the quadruple burden of disease of South Africa • Inter sectoral collaboration to address social determinants of health	None
Transform	Universal Health Coverage for all South Africans progressively achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030 through the implementation of NHI Policy	**Goal 2:** Achieve UHC by implementing NHI Policy	• Progressively achieve Universal Health Coverage through NHI	**Pillar 4:** Engage the private sector in improving the access, coverage and quality of health services; and **Pillar 6:** Improve the efficiency of public sector financial management systems and processes
		Goal 3: Quality Improvement in the Provision of care	• Improve quality and safety of care	**Pillar 5:** Improve the quality, safety and quantity of health services provided with a focus on to primary health care.
			• Provide leadership and enhance governance in the health sector for improved quality of care	**Pillar 7:** Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
Transform	Universal Health Coverage for all South Africans progressively achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030 through the implementation of NHI Policy	**Goal 3:** Quality Improvement in the Provision of care	• Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health	**Pillar 8:** Engage and empower the community to ensure adequate and appropriate community based care
			• Improve equity, training and enhance management of Human Resources for Health	**Pillar 1:** Augment Human Resources for Health Operational Plan
			• Improving availability to medical products, and equipment	**Pillar 2:** Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery **Pillar 6:** Improve the efficiency of public sector financial management systems and processes
			• Robust and effective health information systems to automate business processes and improve evidence based decision making	**Pillar 9:** Develop an Information System that will guide the health system policies, strategies and investments
		Goal 4: Build Health Infrastructure for effective service delivery	• Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities	**Pillar 3:** Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities



PART B

OUR STRATEGIC FOCUS

4. VISION

A long and healthy life for all South Africans

5. MISSION

To improve the health status through the prevention of illness, disease, promotion of healthy lifestyles, and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

6. VALUES

The Department subscribes to the Batho Pele principles and values.

- **Consultation:** Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice regarding the services offered;
- **Service Standards:** Citizens should be told what level and quality of public service they will receive so that they are aware of what to expect;
- **Access:** All citizens have equal access to the services to which they are entitled;
- **Courtesy:** Citizens should be treated with courtesy and consideration;
- **Information:** Citizens should be given full, accurate information about the public services to which they are entitled;
- **Openness and transparency:** Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge;
- **Redress:** If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response; and
- **Value for money:** Public services should be provided economically and efficiently in order to give citizens the best value for money;"[1]

7. SITUATIONAL ANALYSIS

7.1. External Environmental Analysis

7.1.1. Demography

South Africa's population is expected to grow by about 6% (from 58.6m in 2019 to 63m by 2024) over the next 5 years, and by 15.9% over the next 11 years (58.6m in 2019 to 67.9m by 2030). There are absolute increases in population across all 9 provinces. However, the rate of absolute growth differs, and therefore its relative growth to South Africa differs.

Table 1 Population of South Africa

Province	2019		2024		2030		Absolute Growth (2019-2030)
Eastern Cape	6,533,465	11.1%	6,561,987	10.4%	6,589,924	9.7%	0.9% ↓
Free State	2,971,708	5.1%	3,051,270	4.8%	3,134,096	4.6%	5.5% ↓
Gauteng	15,099,801	25.8%	17,052,851	27.1%	19,399,066	28.6%	28.5% ↑
KwaZulu-Natal	11,503,917	19.6%	12,054,958	19.2%	12,628,832	18.6%	9.8% ↓
Limpopo	5,853,198	10.0%	6,097,030	9.7%	6,356,816	9.4%	8.6% ↓
Mpumalanga	4,598,333	7.8%	4,956,910	7.9%	5,374,970	7.9%	16.9% ↔
North West	4,045,179	6.9%	4,374,477	7.0%	4,758,442	7.0%	17.6% ↔
Northern Cape	1,240,254	2.1%	1,312,817	2.1%	1,398,257	2.1%	12.7% ↓
Western Cape	6,760,561	11.5%	7,456,724	11.9%	8,258,206	12.2%	22.2% ↑
South Africa	58,606,416	**100%**	62,919,025	**100%**	67,898,611	**100%**	15.9%

Source: Statistics South Africa, 2019

[1] *Service Charter, Government of South Africa, 2013*

It is projected that Gauteng will experience the largest absolute growth (28.5%), with lowest absolute growth in Eastern Cape (0.9%), against the average growth nationally projected to be at 15.9%. The change in growth differes significantly across all provinces:

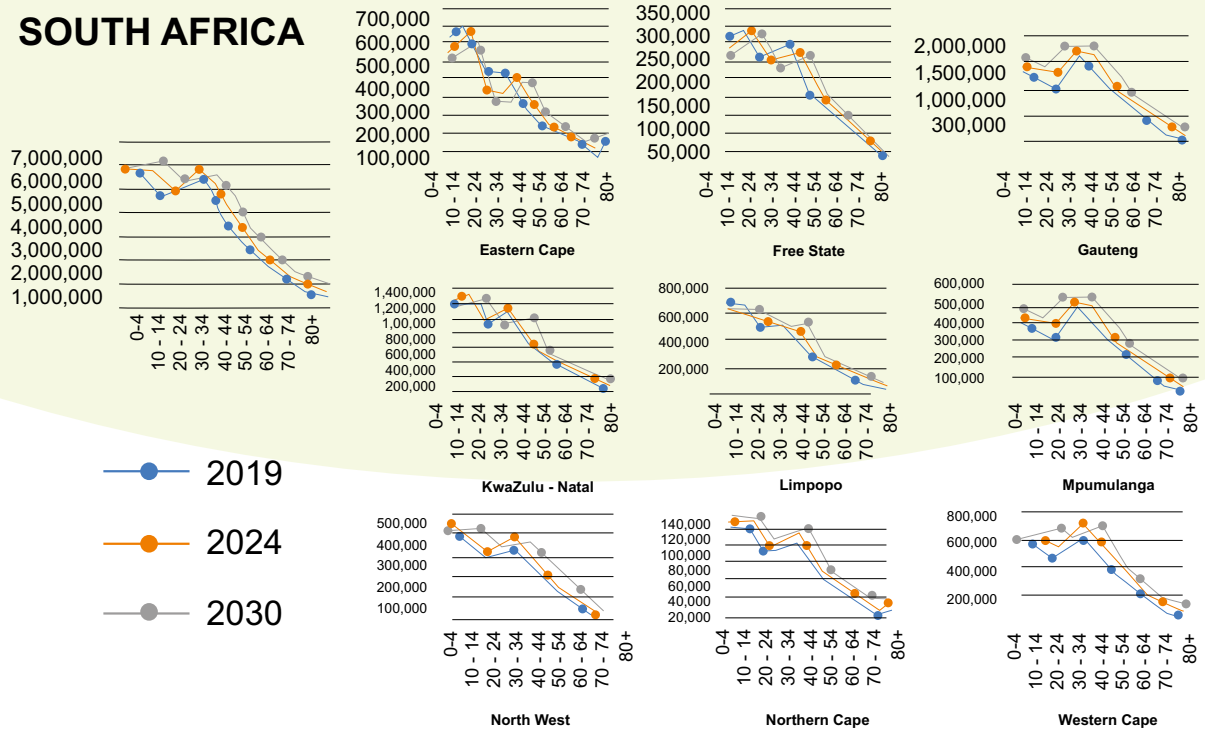
- The difference in population numbers between the two most populous provinces currently (ie. KZN and Gauteng) will almost double over the next 11 years (3.6m in 2019 to 6.7m to 2030), suggesting strong inter-provincial migration patterns.
- The provinces with largest population growth Western Cape (22.2%) and Gauteng (28.5%) currently account for approximately 30% of the population. In another 11 years, by 2030, Western Cape and Gauteng combined will represent 40% of South Africa's population.
- The population growth of Mpumalanga (16.9%) and North-West's (17.6%) is commensurate with that of South Africa (15.9%).
- Eastern Cape (0.9%), Free State (5.5%), Kwa-Zulu Natal (9.8%), Limpopo (8.6%), and Northern Cape (12.7%) all show much smaller increases relative to that of South Africa (15.9%)

The Demographic increases are also not uniform across age groups. The age-distribution patterns will significantly shift over the 11 years.

- **Children under 5** will decline 1.8% nationally (5.9m in 2019, compared to 5.8m estimated in 2030),
- **Youth population** (aged between 15 and 34) will increase by approximately 10% (20.6m in 2019 to 22.3m by 2030), but proportionally will only account for 33% of South Africa's population (compared to 35% currently).
- **Population of the working age** (between 15 and 64) will increase by approximately 20% (38m in 2019, to 45.6m by 2030), proportionally it will represent 67% of South Africa's population (compared to 65% in 2019).
- **Retired population** (aged 65 and older) will increase sharply from 3.3m in 2019, to 4.8m in 2030, reflecting an increase of 45%.

The population age-distributions are significantly different sub-nationally. There are large interprovincial variations in age-distributions that are masked by these national trends, as illustrated below in Figure 1.

Figure 1 Projected population age-distribution or South Africa



Source: Statistics South Africa, 2019

South Africa's under 5 population is projected to reduce by 1.8% over the next 11 years. However, this is masked by 16.8% increase projected in Gauteng, against declines in the rest of the 8 provinces (ranging between 15% in Eastern Cape and 0.4% Western Cape). Conversely, the population that is 65 years and older is projected to increase by 45% (with significant provincial variation that ranges between

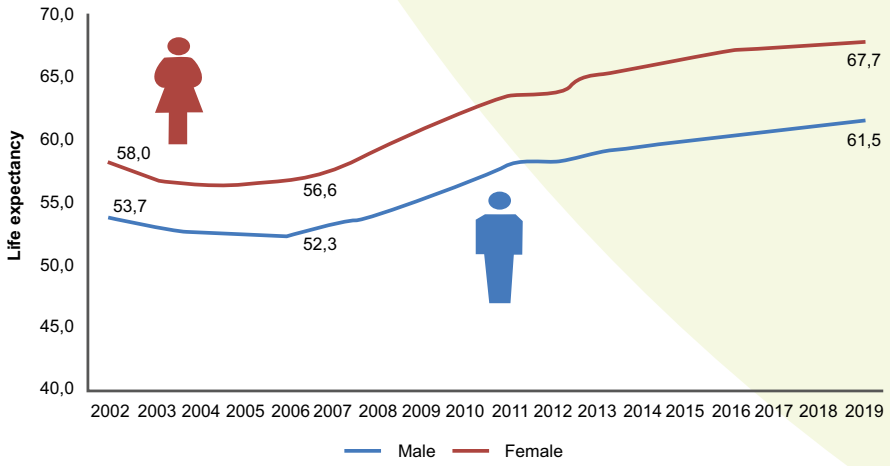
71% increase in Gauteng, compared to approximately 20% increase in Western Cape). South Africa will therefore experience a surge in the aging population. This will require the health system to pay much more attention to non-communicable diseases because the prevalence of two major risk factors (hypertension, diabetes, and cardiovascular diseases) increases with age. The change in demographic patterns will also require a significant expansion of rehabilitative and palliative care services in South Africa across all provinces.

The demand for care is thus expected to be commensurate with the growth in population numbers. It is likely that higher levels of demand will actually be experienced due to the rising incidence of non-communicable diseases.

7.1.2. Life Expectancy

The current life expectancy at birth for males are estimated at 61.5 years and females at 67.7 years, as can be seen in figure 2. The graph shows an increase in life expectancy for both males and females since 2007, which may be attributable to HIV interventions started in 2005 that increased the survival rates of children and infants. The percentage AIDS related deaths declined from 40.4% in 2007 to 23.4% in 2019.

Figure 2 Life expectancy trends for South Africa



Source: Mid-year Population estimates, StatsSA, 2019

7.1.3 Social Determinants of Health for South Africa

Person-centeredness requires adoption of the perspectives of individuals, families and communities, in order to respond to their needs in a holistic manner, by providing them with services required to improve their health status. Empirical evidence shows that socio economic status is a key determinant of health status in South Africa. Furthermore, social protection and employment; knowledge and education; housing and infrastructure all contribute to inequality. This affects the ability of vulnerable population groups to improve their health due to their social conditions.

Table 2 Employment Status across Provinces

Employment Status	ZA	EC	FS	GP	KZN	LP	MPU	NW	NC	WC
Head Unemployed	12%	11%	13%	13%	11%	13%	12%	12%	10%	10%
Head Employed	50%	34%	48%	64%	43%	36%	51%	49%	49%	60%
Head Discouraged work-seeker	4%	6%	4%	2%	5%	5%	4%	4%	4%	2%
Head Other but not economically active	34%	49%	36%	21%	40%	45%	32%	35%	37%	28%

Source: General Household survey, StatsSA, 2018

The high unemployment rate contributes to deprivation and ill health. Limpopo province has observed highest unemployment rate, followed by Eastern Cape and Kwa-Zulu Natal Provinces. The recent community survey (Table 3 below) show that in line with the high unemployment rates these provinces also have the highest rates of child; female and older (> 65yrs) headed households. Limpopo is the province with the highest percentage of households with no flush toilet connected to sewerage (82.8% vs 44% for South

Africa) and no access to refuse removal (79.6% vs 40.6% for South Africa). These factors increase the risk of contracting bacterial diseases. Free-State is the province with the highest percentage of households with no access to piped (tap) water (22.3%), with the country average at 8.7%.

South Africa has adopted person-centredness and a Life course approach for the delivery of social services[2]. The National Development Plan has identified at least three strategies to address social determinants of health. These are:

- "Implement a comprehensive approach to early life by developing and expanding existing child survival programmes"
- "Promote healthy diet and physical activity, particularly in the school setting".
- "Collaborate across sectors to ensure that the design of other sectoral priorities take impact on health into account".

Table 3 Social Determinants of Health for South Africa

Social Determinants of Health	ZA	EC	FS	GP	KZN	LP	MPU	NW	NC	WC
Female Headed Household	51.8%	59.4%	52.0%	44.7%	56.8%	58.4%	50.7%	50.8%	49.2%	45.4%
Child headed household	0.4%	0.6%	0.4%	0.3%	0.3%	0.8%	0.4%	0.4%	0.1%	0.2%
Household head older than 65 years	15.1%	20.0%	13.6%	11.1%	17.9%	18.3%	14.2%	15.1%	15.7%	11.2%
Informal dwelling	9.7%	5.2%	13.0%	14.2%	6.6%	3.8%	8.5%	14.6%	11.5%	12.6%
Traditional dwelling	9.7%	31.7%	1.7%	0.2%	22.9%	5.2%	3.4%	2.0%	2.1%	0.4%
Household with no access to piped (tap) water	8.7%	0.9%	22.3%	2.6%	2.2%	13.8%	8.8%	1.8%	12.4%	14.0%
Household with no electricity for lighting	8.7%	14.2%	5.6%	8.0%	12.5%	5.5%	8.0%	8.2%	8.9%	2.6%
Household with no flush toilet connected to sewerage	44.0%	60.9%	30.2%	14.0%	63.6%	82.8%	60.4%	56.7%	34.3%	7.8%
Household with no access to refuse removal	40.6%	61.4%	26.2%	11.9%	56.7%	79.6%	60.1%	42.1%	32.1%	8.3%
No schooling	14.7%	15.3%	13.3%	11.8%	16.4%	19.3%	17.6%	16.1%	14.7%	10.8%
Matric	21.1%	13.6%	20.2%	27.4%	21.7%	15.1%	21.1%	18.8%	17.9%	23.0%
Higher education	6.6%	4.4%	5.8%	10.2%	5.2%	5.0%	4.8%	4.3%	4.5%	8.2%

Source: Community Survey, StatsSA, 2016

7.1.4 Epidemiology and Quadruple Burden of Disease

Mortality and Morbidity

South Africa continues to face a quadruple burden of disease. The mortality patterns in South Africa are however changing, and deaths due to non-communicable diseases are now accounting for just under two thirds (~65%) of all natural causes of death[3]. Mortality due to tuberculosis has reduced by about 25% (39 695 in 2014 to 29 513 in 2016) in the past few years. The number of deaths due to HIV reduced significantly from 214 365 in 2009 (accounting for 35.4% of deaths), to 115 167 in 2018 (22% of total deaths)[4].

Deaths due to violence and injury

Non-natural causes of deaths in 2016 accounted for about 11.2% of all mortality, much higher than 9.9% in 2012. This is largely because the natural causes of death reduced from 446 324 in 2012 to 405 370 in 2016, compounded by a rise in non-natural deaths from 48 936 in 2012 to 51 242 in 2016[5]. Chapter 12 of the National Development Plan

[2] *NDP Implementation Plan 2019-2024 for Outcome 2 "A long and heal thy life for all South Africans"*
[3] *Mortality and Causes of Death in South Africa 2016, Statistics South Africa, 2018*
[4] *Mortality and Causes of Death in South Africa 2016, Statistics South Africa, 2018*
[5] *Mortality and Causes of Death in South Africa 2016, Statistics South Africa, 2018*

lists crime reduction as a strategic priority. There are three drivers of deaths due to violence and injury, which are (a) murder rate, (b) deaths due to Motor Vehicle Accidents, and (c) Gender Based Violence. The latest statistics released from the South African Police Service, 2019, indicate that Eastern Cape and Western Cape have the highest murder rates per 100,000 people, at 60.9% and 59.4% respectively. These murders are linked to gang related murders, especially under the youth population; with 83% of all gang related murders in South Africa recorded in the Western Cape.[6] As a country, inter-sectoral collaboration is imperative to address the underlying social determinants of health in these populations, in order to contribute to an increase the life expectancy and quality of life of the South African population.

Table 4: Murder Rates South Africa, 2018/2019

South Africa's provincial murder rates in 2018/19		
Province	**Number of murders**	**Murder rate per 100,000 people**
Eastern Cape	3,965	60.9
Western Cape	3,974	59.4
KwaZulu-Natal	4,395	39.1
Free State	1,000	34.5
Gauteng	4,495	30.5
Northern Cape	322	26.1
North West	961	24.4
Mpumalanga	996	21.9
Limpopo	914	15.6

Source: South African Police Service

Maternal, Infant and Child Mortality

Maternal mortality in South Africa stands at 122 per 100 000 live births[7], with significant inequalities among provinces, ranging between 195 per 100 000 in Free State and 75 per 100 000 in Western Cape. Hypertension, HIV and post-partum hemorrhage account for majority of the maternal deaths. The SDG 3 requires South Africa to reduce maternal mortality to below 70 per 100 000 live births by 2030. A reduction of 45.8% by 2030 is thus targeted, and this will require improvements in the timeliness, coverage and quality of antenatal care, management of high-risk pregnancies, and re-configuring the referral system to meet the needs of the patients. Antenatal care is a service provided to monitor the health of the mother and unborn child. Figure 4 shows that antenatal care before 20 weeks is improving to 68%.

Figure 3 Maternal and Reproductive Health 2009- 2018

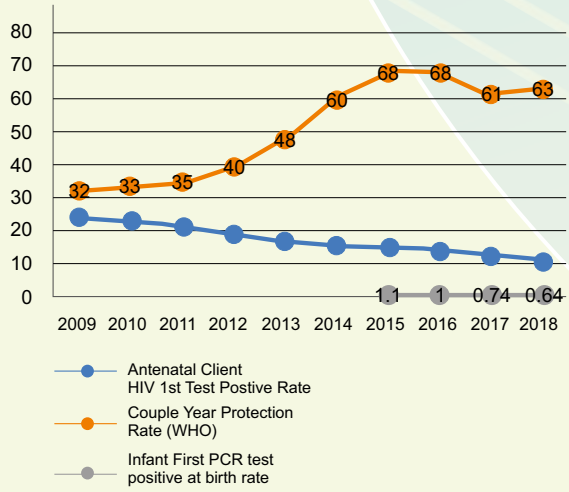
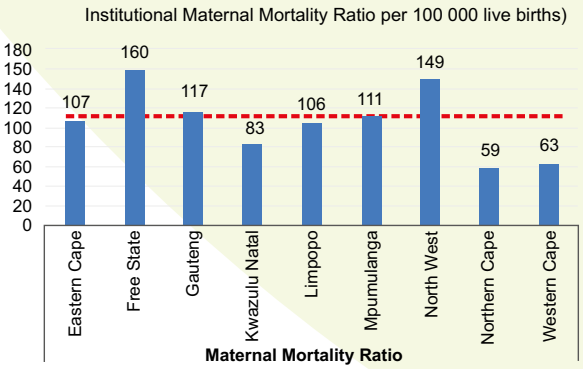


Figure 4 Maternal Mortality in South Africa

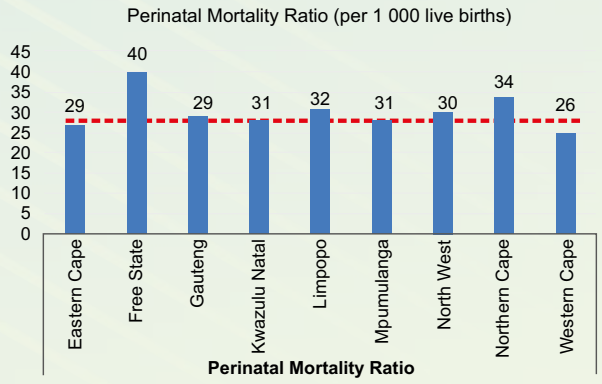


Source: DHIS Data, 2018

Perinatal mortality rate (PNMR) (a combination of **stillbirths** and **infants** that are born alive but die within the first 7 days after delivery - early neonatal deaths) in South Africa is high for a middle-income country. The PNMR currently stands at 30 per 1000 total births; stillbirths account for almost 21 per 1000 births and early neonatal deaths the remaining 9 per 1000 births. The ratio of stillbirths to early neonatal deaths is around 2:1, indicating *in-utero* deaths. This is a feature of the health care system that is not adequately able to detect high risk pregnancies early and institute interventions for at-risk pregnancies. Approximately half of perinatal deaths are potentially modifiable through interventions that are targeted at women before pregnancy and during antenatal care (e.g., provision of nutritional supplements and prompt treatment of sexually transmitted infections), and through provision of advanced antenatal care to detect and manage high risk obstetric conditions, including provision of timely caesarian sections and induction of labour when required.

[6] *Crime Statistics, Western Cape, 2018, https://www.westerncape.gov.za/news/statement-minister-dan-plato-crime-statistics-2018, accessed 30 Oct 2019.*
[7] *NCCEMD, 2019 (2018 data)*

Figure 5 Perinatal mortality rate (PNMR);

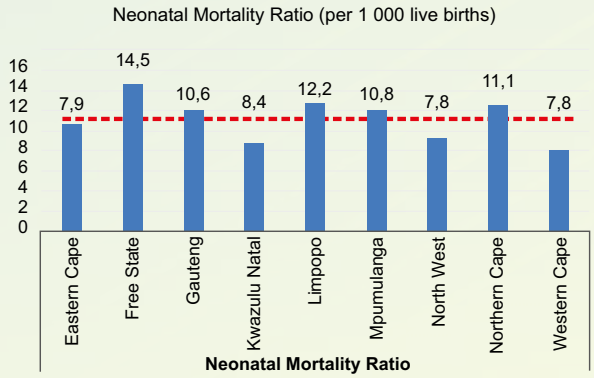


Source: DHIS Data, 2018

Neonatal mortality (child deaths within the first 28 days) in South Africa stands at 12 per 1 000 live births, and account for about half of infant mortality, and one third of child (under 5 years) mortality. This indicator has improved from 14 per 1 000 live births in 2014, but remained relatively static for the past few years at national and provincial level. South Africa has already achieved the SDG target of less than 12 per 1 000, but for a middle income country should aim to reach target of not more than 7 per 1000 by 2030. This translates to a two third reduction by 2030. This achievement will secure SDG and NDP targets for **Infant and child mortality t**hat stand at <20 per 1 000 live births (among infants), and <30 per 1 000 live births (among children).

Approximately 25% of all neonatal deaths are modifiable. This will require reducing deaths through prevention (reducing prematurity and improving antenatal care), managing complications during delivery (to prevent asphyxia) and improving the quality of newborn care (especially the management of infections). This will also need improving skills, facilities and equipment in neonatal units at all referral hospitals, to ensure high coverage and quality of antenatal care. First antenatal care visit by 20 weeks coverage varies between provinces, with a country average of 80% of pregnant women presenting for a 1st visit in a public facility for antenatal care. Eastern Cape (64%) and KwaZulu Natal (74%) have the lowest percentage of antenatal 1st visit coverage.

Figure 6 Neonatal Mortality Rate



Source: DHIS Data, 2018

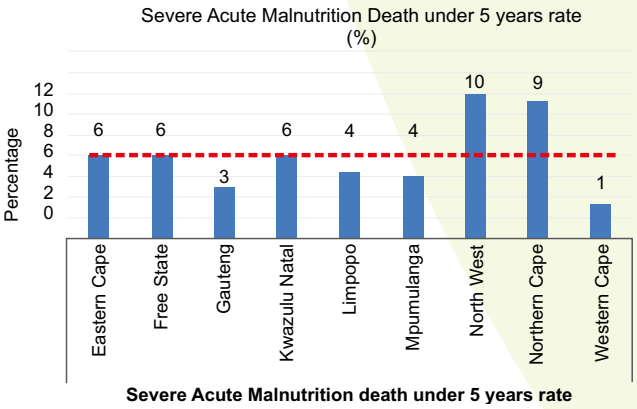
Child under 5 mortality Rate: South Africa is currently at 32 deaths per 1000 live Births[8] and aims to reduce deaths to 25 per 1000 live births by 2024. Minimizing exposure to poverty and improving nutritional status of children is critical because they lower cognitive performance. The first one thousand days in a child's life defines their life-long potential. By the age of 5, almost 90% of a child's brain is developed. These are the formative years where factors such as adequate healthcare, good nutrition, good quality childcare and nurturing, a clean and safe environment, early learning and stimulation will, to a large extent, influence his/her future."[9] The figure below indicate the percentage severe acute malnutrition death for under 5 years in South Africa. North West and Northern Cape are the worst performing provinces with 10% and 9% severe acute malnutrition death rate for under 5 years vs a country average of 5%. The health system's efforts are confined to immunization to ensuring infants are protected against vaccine preventable diseases and improving case management of diarhoea, pneumonia, and severe acute malnutrition in hospitals.

Table 5 Diarrhea, Pneumonia and Severe malnutrition deaths for under 5s

Indicator	Type	ZA	EC	FS	GP	KZN	LP	MP	NW	NC	WC
Immunisation coverage	%	82	72	76	83	91	74	96	70	86	82
Measles 2nd dose coverage	%	76	66.3	71.6	77.5	75.8	83.8	84.4	68.9	84.9	76.6
Diarrhoea case fatality < 5 years rate	%	2	3	1	2	2	2	2	3	2	0
Pneumonia case fatality < 5 years rate	%	2	4	2	3	3	3	3	3	2	0
Severe acute malnutrition death < 5 years rate	%	5	6	6	3	6	5	4	10	9	1

Source: DHIS, 2018

Figure 7. Severe Acute Malnutrition Death under 5 year's rate,



Source: DHIS, 2018

Communicable Diseases

The NDP has called for us to achieve a "generation free of HIV AIDS", while the SDG 3 has set the target to "end the epidemic of AIDS, Tuberculosis, and malaria" by 2030.

There are currently 7.5m **people living with HIV (PLHIV)** in South Africa, with approximately 4.9m people on Antiretroviral Treatment (ART). Number of AIDS-related deaths declined consistently since 2009 from 214 365 to 126 805 in 2019[10]. The HIV prevention interventions have resulted in a steady decline of HIV incidence. For 2019, an estimated 13.5% of the total population is HIV Positive of which 22.71 percent of women in age group 15-49 years are HIV positive. The rapid scale up of Antiretroviral Treatment (ART) services resulting in significant increases in the number of people receiving ART between 2011 and 2019. South Africa aims to continue to scale up ART by another 1.2 million by December 2020, to ensure that 90% of those who know their status, receive lifelong ART.

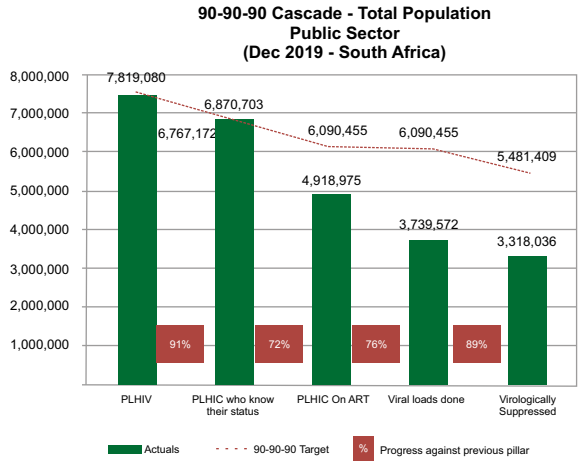
Table 6: HIV mortality, incidence estimates and the number of people living with HIV, 2009-2019

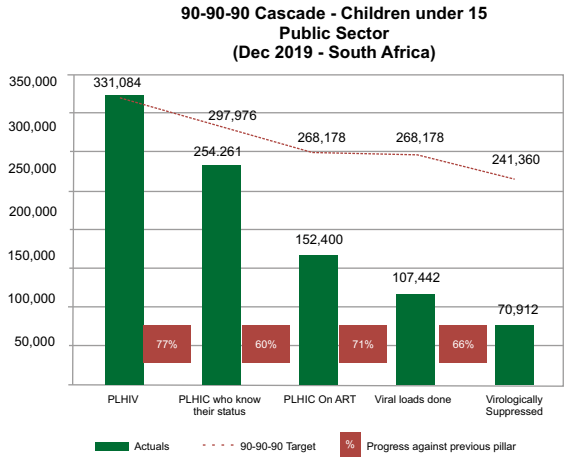
Year	Number of Births	Number of deaths	Number of AIDS related deaths	% of AIDS deaths
2009	1 203 938	602 288	204 120	33,9
2010	1 204 340	574 718	176 946	30,8
2011	1 192 472	551 597	153 284	27,8
2012	1 184 855	550 702	148 374	26,9
2013	1 180 634	535 958	137 542	25,7
2014	1 178 657	538 866	131 908	24,5
2015	1 177 000	532 761	133 951	25,1
2016	1 179 465	526 226	130 434	24,8
2017	1 178 754	530 210	132 544	25,0
2018	1 175 282	535 401	129 677	24,2
2019	1 171 219	541 493	126 805	23,4

Source: Mid-Year Population estimates, StatsSA, 2019

The number of AIDS related deaths would need to reduce by 41% (from 115 167 in 2018, to 68,301 by 2024 and 21 436 by 2030) for South Africa to reach its target of ending the HIV epidemic by 2030. The 90-90-90 strategy aims to reduce pre-mature mortality and onward transmission. The country is driving interventions to ensure that by 2020, 90% of all people with HIV know their status, 90% of those who know their status and are HIV positive are put on treatment and 90% of those on antiretrovirals are virally suppressed and by 2024/25 the targets are 95% for each cascade.

Figure 8: 90-90-90 HIV Treatment cascades for Total Population, Children under 15 years

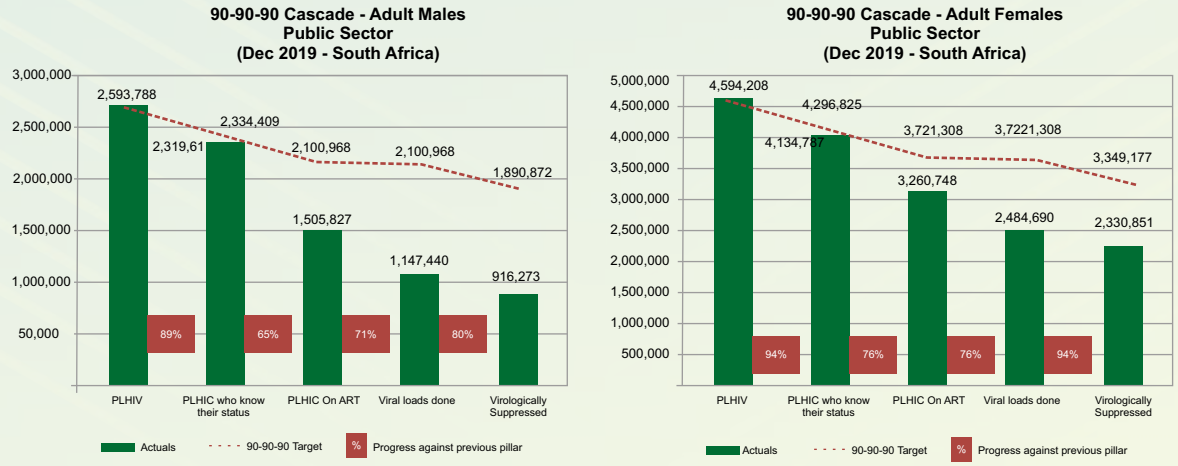




Source: DHIS, December 2019

[8] Rapid Mortality Surveillance 2017, MRC 2019 (published 2019)
[9] Early childhood development in South Africa 2016, StatsSA
[10] Mid year population estimates, StatsSA, 2019.
[11] Mid-year population estimates 2018, StatsSA

Figure 9 - 90-90-90 HIV Treatment cascades for Adult Males and Adult Females

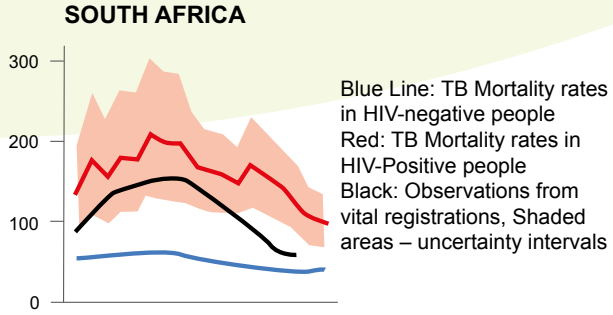


Source: DHIS, December 2019

South Africa is currently at 91-72-89 in terms of performance against 90-90-90 across its total population using data available in the public sector only. Results for each of the sub-populations vary, with adult females at 94-76-94, adult males at 89-65-80, and children at 77-60-66. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and would be addressed through focused interventions. To achieve 90-90-90 targets, South Africa must increase the number of adult men on ART by 595 141, the number of adult women on ART by 460 560, and the number of children on ART, by 115 778, by December 2020. Data available in the private sector indicates that an additional 4 789 Children, 190 515 Adult Females, and 112 472 Adult Males are receiving ART through private medical aid schemes.

The number of PLHIV are not evenly distributed in South Africa. Large urban metros (City of Johannesburg, City of Tshwane, Ekurhuleni, eThekwini, Mangaung, City of Cape Town, and Buffalo City) account for 37% of the HIV population, with 27 high burden districts accounting for approximately 79% of HIV population. Three Districts have reached 90-90-90 in South Africa. It is anticipated that a further 19 districts (John Taolo Gaetsewe; Umkhanyakude; Frances Baard; Ehlanzeni;Thabo Mofutsanyane; Mopani; Lejweleputswa; Pixley ka Seme; Harry Gwala; Zululand; uMgungundlovu; King Cetshwayo; Waterberg; eThekwini; Amajuba; City of Cape Town; Amathole; Sedibeng; City of Tshwane) could reach their 90-90-90 targets by end of March 2020, with the remaining 30 districts being supported to reach the 90-90-90 targets by December 2020.

Tuberculosis (TB) Tuberculosis remains the leading cause of death amongst communicable diseases, however, there is a downward trend of mortality from 8.3% in 2014 to 6.5% in 2016. This is commensurate with the downward trends in TB morbidity. The 2019 Global WHO TB report indicates that South Africa's TB incidence rate has decreased from 1,000 cases per 100,000 in 2012, to 520 cases per 100 000 in 2018. TB case notifications have also declined significantly in the last decade. This is largely attributable to the improvement in Antiretroviral Treatment coverage and TB preventative care offered in the country for those people living with HIV. The country report published by WHO, reported the TB treatment coverage (notified/estimated incidence) for South Africa at 76% (with a confidence interval 57-110) for 2018.[12] South Africa aims to reach 90% by 2022/23.



Source: WHO Global TB Report

Improvements in case detection, and retaining patients in care will be essential to reduce premature mortality, and preventing MDR and XDR-TB. The global End TB strategy has called on WHO member states to reduce the number of deaths caused by TB

[12] *WHO TB Global report, 2018*

by 75% by 2025, and 90% by 2030, when compared against 2015 baselines. This translates to a target of not more than 8 510 deaths by 2025, and 3 404 by 2030, to ensure that South Africa achieves its SDG target of "ending the …TB… epidemic by 2030". This will require the health system to intensify case finding, and placing those diagnosed on treatment, and ensuring they successfully complete their treatment because TB is curable. Eastern Cape has the highest lost to follow up rate for the country with Western Cape the highest TB success treatment rate for Drug Sensitive TB Cases. Free State has the highest death rate for Drug-Sensitive TB cases in the country.

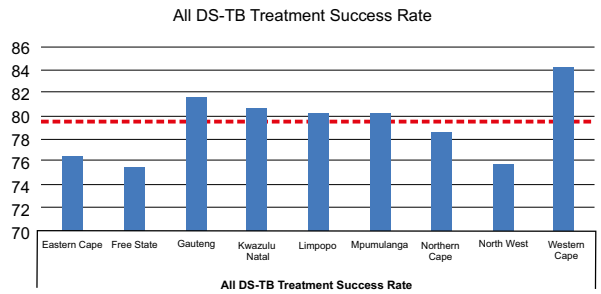
The public health facilities have progressively intensified case identification and case management for drug susceptible TB. The treatment success rate for South Africa was 79.2%. However, there is inter-provincial variation. The lowest (ie. 76.4%) was reported by Eastern Cape, and the highest (ie. 84.1%) in Western Cape. The TB death rate for South Africa stood at 7.7%, with the highest being in Free State, and the lowest in Western Cape.

Table 7 TB Outcome data for South Africa

Indicator		ZA	EC	FS	GP	KZN	LP	MPU	NC	NW	WC
All DS-TB lost to follow-up rate	%	10.2	12.5	9.5	10	9.6	7.1	8.9	10.1	10.7	9.3
All DS-TB treatment success rate	%	79.2	76.4	75.5	81.5	80.6	80.1	80.1	78.6	75.7	84.1
All DS-TB death rate	%	7.7	7.2	11.4	6.9	7	10.5	8.3	6.5	8.2	3.3

Source: DHIS for Q2 2018 cohort, 2019

Figure 9. TB Treatment Success rate, 2018



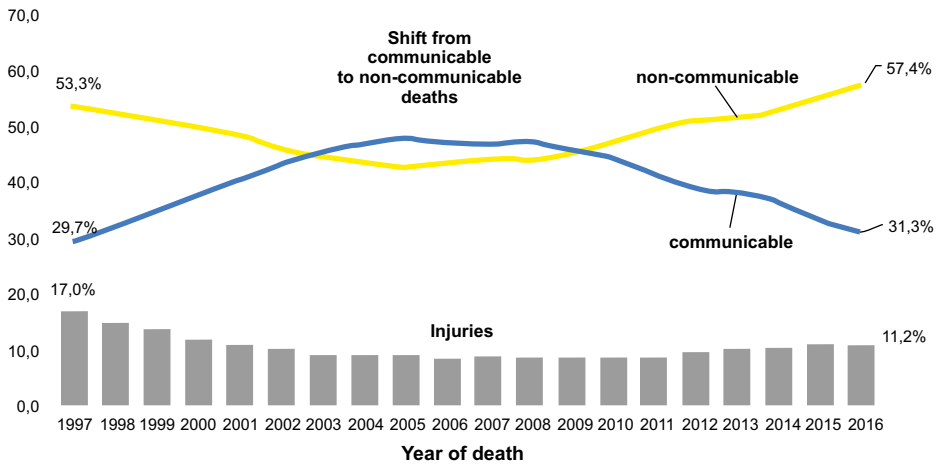
Source: DHIS Q2 2018 cohort, 2019

Malaria incidence was significantly reduced from 11.1 in 2000/01 to 2.1 total cases per 1,000 population at risk in 2010/11. There are 3 malaria endemic provinces in South Africa. There are Mpumalanga, Limpopo and KwaZulu Natal. South Africa is aiming for malaria elimination (zero malaria transmission) by 2023.This will require a multipronged response. A heightened surveillance system (all malaria cases reported within 24 hours), educating the population living in malaria endemic areas, implementation of key vector suppression strategies, and providing universal access to diagnosis and treatment in endemic and non-endemic areas.

Non-Communicable Diseases

The probability of premature mortality, between the ages of 30 and 70, due to selected NCDs including cardiovascular disease, cancer, diabetes and chronic respiratory diseases is 34% for males and 24% for females – total 29%. According to StatsSA, NCDs contribute 57.4% of all deaths[13], of which 60% are premature (under 70 years of age). Many of these deaths are preventable through evidence based promotive/preventive and control measures. The leading single cause of death from NCDs is cardiovascular disease, followed by cancer, diabetes and chronic respiratory disease.

Figure 10 : Deaths: Communicable; non- communicable and Injuries, 1997-2016



Source: Causes of Death Report, Stats SA, 2018

In South Africa, 46% of women and 44% of men aged 15 years and older have essential **hypertension**[14]. Since 1998 the prevalence of hypertension has nearly doubled, from 25% to 46% among women and from 23% to 44% among men. 22% percent of women and 15% of men report that they taking medication to lower their blood pressure. Overall, 9% of women are taking medication to control their blood pressure and have a normal blood pressure level, while 13% of women are taking medication to control their blood pressure are still hypertensive. Among men, 6% are taking medication to control their blood pressure and have normal blood pressure, and 9% are taking medication to control their blood pressure but are still hypertensive. In total, among those with hypertension, 80% of women and 87% of men have uncontrolled hypertension.

The SADHS has revealed that 13% of women and 8% of men are **diabetic** (HbA1c level of 6.5 or above). A significant percentage of women (64%) and men (66%) have an adjusted HbA1c measurement between 5.7 and 6.4 and are therefore classified as pre-diabetic. Diabetes type 2 prevalence increases with age with people over 45 at special risk. This is a major public health concern with the significant rise in aging population projected in South Africa.

Table 8 Non-Communicable Diseases (Hypertension and Diabetes)

Indicator		ZA	EC	FS	GP	KZN	LP	MPU	NW	NC	WC
Women age 15+ with hypertension	%	46	50	54	42	48	34	46	40	53	52
Men age 15+ with hypertension	%	44	47	48	40	48	29	46	37	52	59
Women age 15+ with diabetes[15]	%	13	18	14	9	17	15	12	9	12	12
Men age 15+ with diabetes[16]	%	8	10	8	7	9	10	7	4	7	13

Source: SADHS (2016), 2019

Overall, the leading **cancers** in South African men and women remain largely unchanged across a 13-year period from 2002 to 2014. In 2014, 74 577 new cases of **cancer** were registered with the National Cancer Registry. The most common female cancers sites were breast, cervix, colorectal, uterine and lung. **Breast cancer** is the leading cancer among women for all the race groups, except in black women where cervical cancer is the leading cancer. Top male cancers were prostate, colorectal, lung, bladder, and oesophageal. **Prostate cancer** remains the cancer with the highest incidence in South African men of all races.

Research in South Africa has shown that there is a strong correlation between mental disorders and HIV/AIDS.[17] Most **mental disorders** have their origins in childhood and adolescence with "approximately 50% of mental disorders begin before the age of 14 years."[18] The most prevalent mental health disorders are anxiety disorders, substance abuse disorders and mood disorders. The National Mental Health Policy Framework and Strategic Plan 2013-2020 adopted in July 2013 sets out key objectives and milestones that must be realised to transform mental health services in the country. The priorities are (i) improving detection rates and management of mental disorders especially in primary health care settings; (ii) improving mental health infrastructure capacity especially at community level; and (iii) improving the supply of and access to mental health professionals. Mental wellbeing also requires that multidimensional interventions be implemented with other sectors to address the socio-economic determinants of mental disorders.

Quality of care, health system improvement and Universal Health Coverage

The Lancet Global and South African commissions have argued that high coverage (or access to care) is necessary but not sufficient to shift morbidity and mortality patterns. Better health outcomes and impact can only be achieved by ensuring that a high proportion of people receive care (coverage) that is effective (delivered at high quality).[20] An effective health system is measured by its ability to provide reliable clinical care, and one that complies with norms and standards adopted by the system.

[13] *Mortality and Causes of Death in South Africa 2016, Statistics South Africa, 2018*
[14] *South African Demographic and Health Survey in South Africa,*
[15] *(% with adjusted HbA1c> and equal6.5%)*
[16] *(% with adjusted HbA1c> and equal6.5%)*
[17] *Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR et al. No health without mental health. Lancet 2007; 370:859-877*
[18] *WHO. Mental health: the bare facts. http://www.who.int/mental_health/en/ . 1-28-2010. Ref Type: Internet Communication*
[19] *High-quality health systems in the Sustainable Development Goals era: time for a revolution, Kruk, ME et al, 2018*
[20] *District Health Planning and Monitoring Framework, National Department of Health, Aug 2017*

Improving coverage and quality of care will require a system-wide action.

A quality health system is characterized by a system that offers reliable clinical care; that is compliant with the norms and standards set out the by the Office of Health Standards Compliance (OHSC); and one that is positively perceived by the patients:

Over the MTSF period, the health sector will ensure "Quality Improvement in the Provision of Care" - by providing integrated patient centred and respectful care that is well co-ordinated (across levels of care) and of high quality throughout the life course to build confidence in the public health system thereby ensuring public health facilities are the provider of choice under NHI".

The Department of Health aims to develop and implement a quality improvement programme, that harmonises all the quality improvement initiatives in the health sector. Over the MTEF, an integrated National Quality Improvement and clinical governance framework will be developed and implemented nationally.

7.1.5.1. Quality of Care from Patients Perspective:

The Department has implemented various tools to monitor patient experience of care. One of the systems is to track the resolution of patient safety incidents and patient complaints. The National Guideline for Patient Safety Incident (PSI) Reporting and Learning and the National Guideline for the Management of Complaints, Compliments and Suggestions (CCS) with the accompanying web-based information system was rolled out to provinces in November and December 2017. The implementation date for both Guidelines was 1 April 2018. A web-based information system was developed on the Ideal Health Facility website to assist facilities with the implementation of the two guidelines and to monitor the implementation thereof. Every complaint and patient safety incident should be captured on a form on the web-based information system. The data captured on the form is used to auto-generate registers and statistical data on the indicators and categories for PSI and CCS. The statistical data and categories should be used to improve patient safety and quality within every facility.

Table 9 Country and Provincial data on complaints logged for 2018 and 2019

Category	ZA	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	North West	Northern Cape	Western Cape
Waiting times	31%	27%	40%	25%	31%	8%	37%	32%	24%	32%
Patient care	29%	26%	28%	31%	26%	40%	24%	23%	30%	38%
Staff attitude	26%	25%	29%	28%	20%	20%	25%	31%	46%	31%
Other	13%	16%	11%	9%	15%	30%	15%	13%	13%	10%
Access to information	8%	4%	14%	9%	5%	13%	6%	7%	3%	10%
Safe and secure environment	5%	6%	4%	4%	5%	0%	7%	3%	9%	4%
Waiting list	4%	3%	2%	7%	2%	3%	3%	4%	0%	6%
Hygiene and cleanliness	3%	6%	3%	2%	3%	0%	5%	4%	2%	3%
Availability of medicines	3%	3%	3%	2%	3%	0%	2%	3%	3%	3%
Physical access	3%	2%	2%	5%	3%	0%	3%	3%	5%	1%

The results indicated that in South Africa the categories "waiting times"; "patient care" and "staff attitude" received the most complaints during the 2018/19 financial year.

7.1.5.2. Clinical Quality:

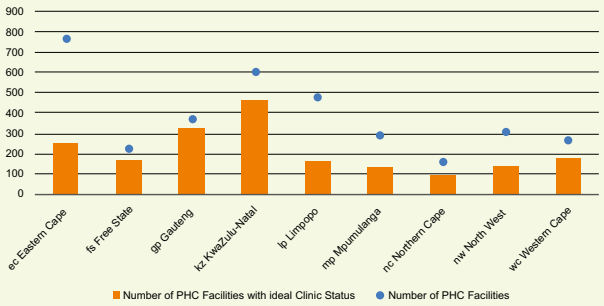
Modifiable factors contributing to mortality: According to the Lancet Commission report[21] the National Committee of Confidential Enquiry on Maternal Deaths (NCCEMD) has reported that about 60% of all maternal deaths had factors that were potentially modifiable. The modifiable factors are either due to delay in seeking care, inter-facility transport, or due to poor quality of clinical care. Clinical governance and clinical forums all play a vital role in ensuring quality from a clinical perspective. Part of the next 5 year initiatives to improve quality is to strengthen clinical governance through creation of a learning and collaborative culture (that empowers clinicians and administrative staff across levels of care to improve quality of care collaboratively).

Patient Safety Incidents:

7.1.5.3. Quality of the Health System:

Ideal Clinics In addition to the Ideal Clinic Realisation and Maintenance Programme, the Ideal Hospital Framework, is a tool that has been recently institutionalise and introduced to all Provincial Departments of Health, to ensure quality services is being rendered by hospitals.

Figure 11 - Ideal Clinics



Source: Ideal Clinic Software Information System, 2018/2019

Infrastructure. One of the NDP Implementation goals are to build health infrastructure for effective service delivery. The department will develop a 10 year national health infrastructure plan to improve health facility planning to ensure construction of appropriate health facilities on a need and sustainable basis. During the past financial year maintenance was completed in 225 facilities, 17 clinics and CHCs constructed or revitalised and 2 hospitals were constructed or revitalised.

The department is working with National Treasury to develop strategies to accelerate the delivery of infrastructure in the health sector for the implementation of national health insurance. Although the details of these proposals are still being finalised, they are likely to draw on the budget facility for infrastructure and the Infrastructure Fund to complement existing budgets for health infrastructure, such as the two conditional grants for this purpose. The direct *health facility revitalisation grant* is the largest source of funds for public health infrastructure with an allocation of R19.9 billion over the MTEF period, and is transferred to provincial departments of health through the *Health Facilities Infrastructure Management* subprogramme in the Hospital Systems programme. This subprogramme also houses the health facility revitalisation component of the *national health insurance indirect grant*, which is allocated R4.6 billion over the MTEF period and includes allocations for planning and building the Limpopo Central Hospital in Polokwane, which is planned to be completed in 2025/26.

Human Resources for Health: To address the disparity in human resources of health a Ministerial Task Team was established that is drafting a HRH strategy that will be published by the end of the 2019/20 financial year. Over the next 5 years, the following sectoral priorities for health will be addressed as noted in the NDP Implementation Plan 2019-2024: addressed as noted in the NDP Implementation Plan 2019-2024:

a) Develop and implement a comprehensive strategy and operational plan to address the human resources requirements, including **filling critical vacant posts** for full implementation of universal health care.

b) Expand the primary health care system by strengthening the Community Health Worker Programme that consists of **50,000 community health workers** integrated into the public health system.

c) **Consolidate nursing colleges** – ensure one major nursing college per province with satellites campuses. These provincial facilities should orientate their curriculum towards more practical work at the patient's bedside.

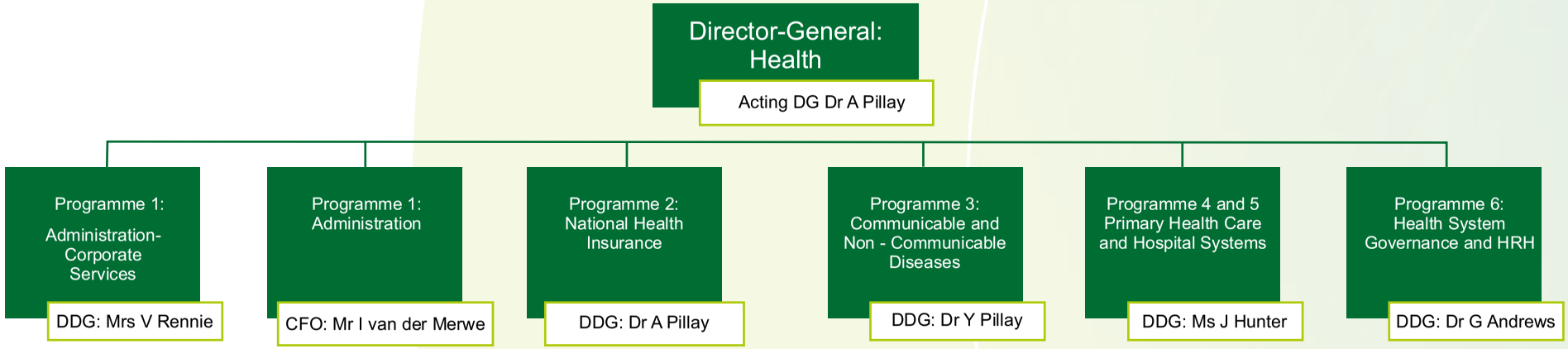
d) Strengthen and expand the **Nelson Mandela-Fidel Castro Programme** to supplement the production of much-needed medical practitioners and other health professionals. At the same time, expanding local capacity, and training platform at all levels of the health system with infrastructure, equipment and personnel to increase the intake of medical students for local training.

[21] *The South African Lancet National Commission, 2017*

Information Management and Health Information Systems: Strengthening information systems will be prioritized over the next 5 years. The department aims to develop a streamlined, integrated information system for decision-making in support of implementation that will remove duplication at all levels.

7.2. Internal Environmental Analysis

The budget programme structure shown below, depicts the transitional organizational structure of the National Department of Health. The Department's organisational structure, which was endorsed by DPSA in 2012, is currently under review. A new organisational structure will be determined during 2020/21 financial year, and implemented once approved by DPSA. Thereafter, the budget programme structure of the Department will also be reviewed, based on the approved organisational structure. This process will also ensure that the NHI office is provisioned within the National Department of Health while, the NHI Bill is bring publicly consulted by Parliament.



7.3 Personnel

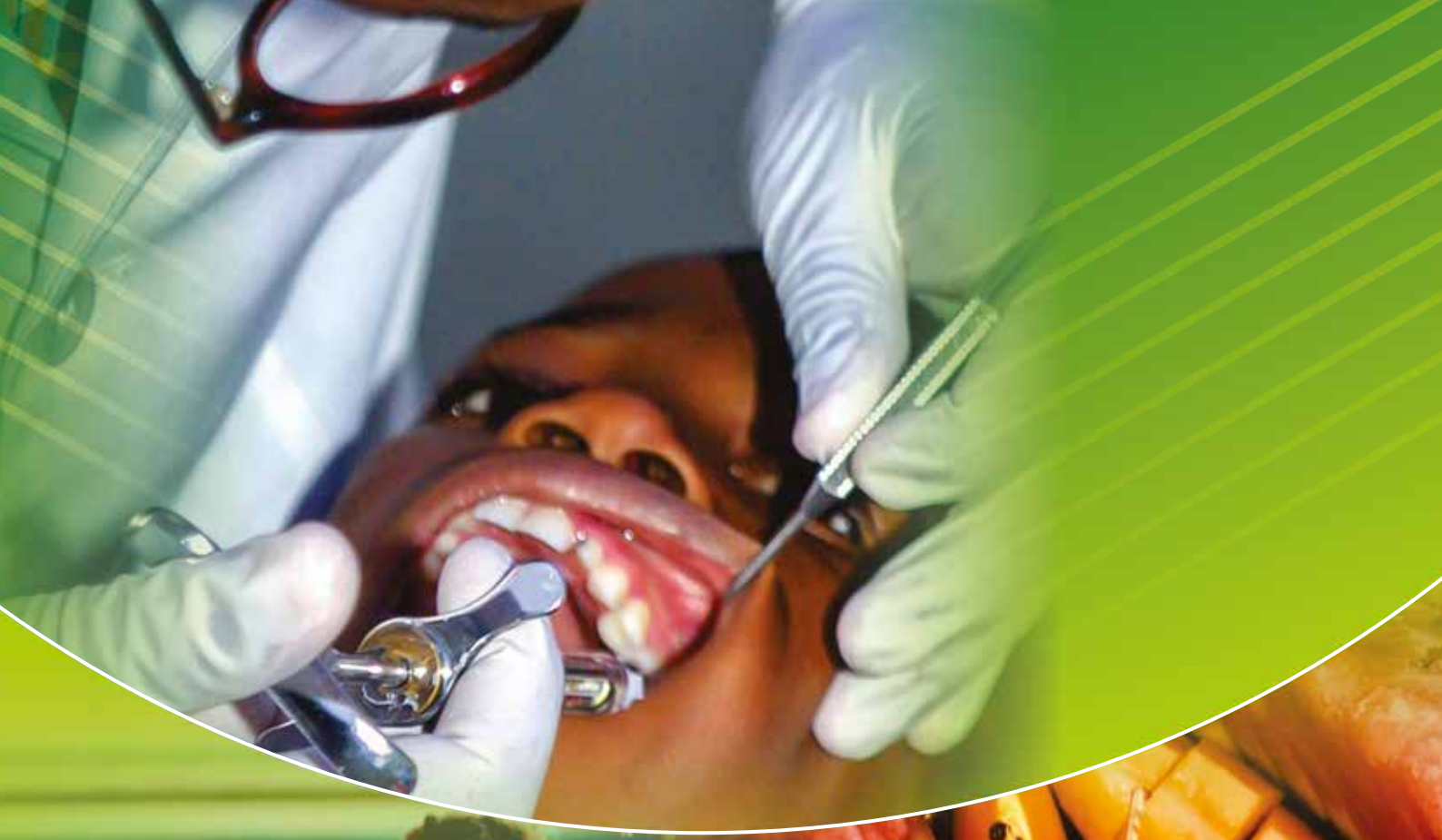
Table 18.4 Vote personnel numbers and cost by salary level and programme[1]

Programmes

1. Administration
2. National Health Insurance
3. Communicable and Non-communicable Diseases
4. Primary Health Care
5. Hospital Systems
6. Health System Governance and Human Resources

	Number of posts estimated for 31 March 2020		Number and cost[2] of personnel posts filled/planned for on funded establishment													Number	
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate							Av-erage growth rate (%)	Aver-age: Salary level/ Total (%)
			2018/19			2019/20			2020/21			2021/22			2022/23		
Health			**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**2019/20 - 2022/23**	
Salary level	**1,466**	**–**	**1,468**	**793.2**	**0.5**	**1,488**	**859.1**	**0.6**	**1,465**	**905.8**	**0.6**	**1,465**	**958.7**	**0.7**	**1,434**	**991.2**	**0.7**	**-1.2%**	**100.0%**
1 – 6	558	–	560	156.9	0.3	572	163.1	0.3	557	168.2	0.3	565	181.5	0.3	561	192.7	0.3	-0.6%	38.5%
7 – 10	634	–	634	334.9	0.5	636	362.8	0.6	646	399.4	0.6	642	422.9	0.7	626	439.4	0.7	-0.5%	43.6%
11 – 12	166	–	166	158.3	1.0	167	174.8	1.0	147	164.1	1.1	144	170.6	1.2	140	175.7	1.3	-5.7%	10.2%
13 – 16	106	–	106	138.3	1.3	111	153.5	1.4	113	168.9	1.5	112	178.2	1.6	105	177.4	1.7	-1.8%	7.5%
Other	2	–	2	4.8	2.4	2	4.9	2.5	2	5.2	2.6	2	5.5	2.8	2	5.9	2.9	–	0.1%
Programme	**1,466**	**–**	**1,468**	**793.2**	**0.5**	**1,488**	**859.1**	**0.6**	**1,465**	**905.8**	**0.6**	**1,465**	**958.7**	**0.7**	**1,434**	**991.2**	**0.7**	**-1.2%**	**100.0%**
Programme 1	469	–	471	239.8	0.5	483	252.9	0.5	470	268.5	0.6	457	282.5	0.6	450	297.0	0.7	-2.3%	31.8%
Programme 2	60	–	60	45.1	0.8	63	48.8	0.8	60	48.8	0.8	60	51.3	0.9	60	53.9	0.9	-1.6%	4.2%
Programme 3	221	–	221	122.7	0.6	233	176.7	0.8	224	181.7	0.8	220	191.3	0.9	218	201.2	0.9	-2.2%	15.3%
Programme 4	364	–	364	176.4	0.5	381	201.6	0.5	387	211.8	0.5	385	223.1	0.6	381	234.6	0.6	–	26.2%
Programme 5	47	–	47	21.1	0.4	48	25.8	0.5	55	31.3	0.6	55	32.9	0.6	56	34.5	0.6	5.3%	3.7%
Programme 6	305	–	305	188.0	0.6	280	153.3	0.5	269	163.7	0.6	288	177.8	0.6	269	169.9	0.6	-1.3%	18.9%

1. Data has been provided by the department and may not necessarily reconcile with official government personnel data.
2. Rand million.



PART C

MEASURING OUR PERFORMANCE

8. INSTITUTIONAL PROGRAMME PERFORMANCE INFORMATION

8.1. Impact Statements and Outcomes

MTSF Priority 3: Education, Skills and Health	
Impact A	Life expectancy of South Africans improved to 66.6 years by 2024, and 70 years by 2030
Impact 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

MTSF Priority 3: Education, Skills and Health	
Impact Statements	Outcomes
A. Life expectancy of South Africans improved to 66.6 years by 2024, and 70 years by 2030	1. Maternal, Child, Infant and neonatal mortalities reduced
	2. HIV incidence among youth reduced
	3. 90:90:90 targets for HIV AIDS achieved by 2020 and 95:95:95 targets by 2024/25
	4. Significant progress made towards ending TB by 2035 through improving prevention and treatment strategies
	5. Premature mortality from Non-communicable diseases reduced by 10%
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	6. An equitable budgeting system progressively implemented and fragmentation reduced
	7. Resources are available to managers and frontline providers, with flexibility to manage it according to their local needs
	8. Financial management strengthened in the health sector
	9. Management of Medico-legal cases in the health system strengthened
	10. Package of services available to the population is expanded on the basis of cost-effectiveness and equity
	11. Integrated services delivered according to the referral policy, at the most appropriate level, to ensure continuity of care
	12. Quality and safety of care improved
	13. Staff equitably distributed and have right skills and attitudes
	14. Community participation promoted to ensure health system responsiveness and effective management of their health needs
	15. Environmental Health strengthened by contributing to improved quality of water, sanitation, waste management and food services
	16. Financing and Delivery of infrastructure projects improved
	17. Adaptive learning and decision making is improved through use of strategic information and evidence
	18. Information systems are responsive to local needs to enhance data use and improve quality of care

8.2. Measuring our Outcomes

MTSF Priority 3:	Education, Skills and Health			
Impact A:	Life expectancy of South Africans improved to 66.6 years by 2024, and 70 years by 2030			
MTSF Intervention	Outcome	Outcome Indicator	Baseline (2018/19)	Strategic Plan Target 2024/25
Improve access to maternal health services; Protect children against vaccine preventable diseases; Improve the Integrated Management of Childhood Diseases services	Maternal, Child, Infant and neonatal mortalities reduced	Maternal Mortality Ratio (MMR)	129 per 100 000 live births[22]	<100 per 100 000 live births
		Neonatal (<28 days) Mortality Rate (NMR)	12 per 1 000 live births[25]	<10 per 1,000 live births
		Infant (<1 year) Mortality Rate (IMR)	23 per 1000 live births[25]	<20 per 1000 live births
		Child (<5 years) Mortality Rate (U5MR)	32 per 1,000 live Births[25]	<25 per 1,000 live births
Provide prompt treatment of HIV and other sexually transmitted infections	HIV incidence among youth reduced	Number of new HIV infections among youth	88 000	<44 000 by 2024/25
	90:90:90 targets for HIV AIDS achieved by 2020 and 95:95:95 targets by 2024/25	ART Client remain on ART at end of month	4.9m	6.1m by Dec 2020 7m by 2024/25
Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health	Significant progress made towards ending TB by 2035 through improving prevention and treatment strategies	TB Treatment Success Rate	84.7%	95% by 2024/25
		Number of TB Deaths	29 513[23] (2016)	8 510 deaths
Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health	Premature mortality from Non-communicable diseases reduced by 10%	Premature mortality due to NCDs (NCDs 40q30[24])	29%	26%

[22] *NCCEMD, 2018*
[23] *Leading causes of Mortality in South Africa 2016, StatsSA 2018*
[24] *Probability of a 30-year-old-person (both males and females) would die before their 70th birthday from non-communicable diseases (cardiovascular disease, cancer, diabetes, or chronic respiratory disease)*

MTSF Priority 3:	Education, Skills and Health			
Impact 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			
MTSF Intervention	Outcome	Outcome Indicator	Baseline (2018/19)	Strategic Plan Target 2024/25
Enabling legal framework created for the implementation of NHI Bill	An equitable budgeting system progressively implemented and fragmentation reduced	Equitable share model for financing health care progressively reviewed and implemented	Allocations not adequately equitable	Equitable share model for financing health care progressively reviewed and implemented
		Conditional grants of the health sector progressively reviewed and implemented	Fragmented conditional grants	Conditional grants of the health sector progressively reviewed and implemented
Not Applicable	Resources are available to managers and frontline providers, with flexibility to manage it according to their local needs	Percentage of hospitals with increased decision making space	Inadequate and/or ineffective delegations	100% of the hospitals granted increased decision making space
		Centralized procurement through sector transversal contracts for core supplies and low value equipment implemented to reduce buy outs and derive economies of scale	Lengthy and cumbersome procurement system core supplies	Centralized procurement through sector transversal contracts for core supplies and low value equipment implemented to reduce buy outs and derive economies of scale
		Percentage of health facilities with no stock outs on essential medicines	74.4% health facilities with stock outs on essential medicines reported	100% (3830) health facilities
		Percentage of Health Facilities with cost-Centre accounting	PHC facilities not operating as cost centres in BAS	100% of PHC facilities and public hospitals operating as cost-centres
Not Applicable	Financial management strengthened in the health sector	Audit Outcome of National DoH	National DoH receiving unqualified audit opinion from Auditor-General	National DoH receiving Clean audit opinion from Auditor-General
		Audit Outcomes of Provincial DoH reporting to Minister of Health	1 Provincial DoH with unqualified Audit opinion, 1 Provincial DoH with clean Audit Opinion for 2018/19 FY	8 Provincial DoH with unqualified audit opinions and 1 Provincial DoH with Clean audit opinion for 2023/24 financial year
		Audit Outcomes Public entities reporting to Minister of Health	5 Public entities with unqualified audit opinion for 2018/19 FY	50% (3 of 6) public entities receiving clean audit opinions and the remaining 3 receiving unqualified audit opinions by 2023/24 Financial year

MTSF Priority 3:	Education, Skills and Health			
Impact 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			
MTSF Intervention	Outcome	Outcome Indicator	Baseline (2018/19)	Strategic Plan Target 2024/25
Develop a comprehensive policy and legislative framework to mitigate the risks related to medical litigation	Management of Medico-legal cases in the health system strengthened	Contingent liability of current medico-legal cases	Contingent liability at R90bn (March 2019)	Contingent liability of current medico-legal cases reduced to under 50% by 2021/22, and 80% by 2024/25 for all claims on the register
Enabling legal framework created for the implementation of NHI Bill	Package of services available to the population is expanded on the basis of cost-effectiveness and equity	NHI Fund purchasing services	NHI Bill in the parliamentary process	NHI Fund purchasing services by 2022/23
		UHC Service Index	68%	75%
	Integrated services delivered according to the referral policy, at the most appropriate level, to ensure continuity of care	Number of Districts with referral systems with care pathways defined and institutionalized	Final draft referral policy available	52 Districts with referral systems with care pathways defined and institutionalized

MTSF Priority 3:	Education, Skills and Health			
Impact 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			
MTSF Intervention	Outcome	Outcome Indicator	Baseline (2018/19)	Strategic Plan Target 2024/25
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for NHI; Improved quality of primary healthcare services through expansion of the Ideal Clinic Programme	Quality and safety of care improved	Percentage of public health facilities certified by OHSC	No PHC facilities certified by OHSC	100% of PHC facilities and 60% of hospitals
		Percentage of PHC facilities that qualify as ideal clinics	56% (1920) PHC facilities qualify as Ideal clinics	100% primary health care facilities qualify as Ideal Clinics
		Percentage of public hospitals obtaining 75% and above on food service quality assessments	Not Available	100% Hospitals obtain 75% and above on the food service quality assessments
		Percentage of traditional health practitioners offering high quality services	Draft policy on traditional medicine developed	80% (of 300 000) traditional health practitioners (who are registered) offering high quality services
		Percentage of people requiring preventive chemotherapy for schistosomiasis reduced	80%	50%
		Number of ports of entry where health services comply with international health regulations	15 Ports of entries compliant with international health regulations	All 44 Ports of entries compliant with international health regulations
		Number of provinces compliant with Emergency Medical Services Regulations	Baselines to be determined	All 9 provinces compliant with Emergency Medical Services Regulations
		Percentage of blood alcohol tests completed within normative period of 90 days	80% of blood alcohol tests completed within normative period of 90 days	98% of blood alcohol tests completed within normative period of 90 days

MTSF Priority 3:	Education, Skills and Health			
Impact 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			
MTSF Intervention	Outcome	Outcome Indicator	Baseline (2018/19)	Strategic Plan Target 2024/25
Establish provincial nursing colleges with satellite campuses in all 9 provinces	Staff equitably distributed and have right skills and attitudes	Number of public Nursing colleges accredited and registered to offer quality basic and specialist nursing programmes	7 public Nursing colleges accredited and registered to offer basic nursing programmes	9 public Nursing colleges accredited and registered to offer quality basic and specialist nursing programmes
Develop and implement a comprehensive HRH strategy 2030 and a HRH plan 2020/21-2024/25 to address the human resources requirements, including filling critical vacant posts		HRH Plan for 2020/21 – 2024/25 implemented	Draft HRH Plan for 2020/21 – 2024/25	HRH Plan for 2020/21 – 2024/25 implemented
Expand the primary healthcare system by integrating community health workers into the public health system.	Community participation promoted to ensure health system responsiveness and effective management of their health needs	Percentage of patients satisfied (positive experience) with their Experience of Care in public health facilities	76% patients satisfied (positive experience) with their Experience of Care in public health facilities	85% of patients satisfied (positive experience) with their Experience of Care in public health facilities
		Percentage of PHC facilities with functional Clinic Committees	Baselines not available	100% of PHC facilities with functional Clinic Committees
		Percentage of Hospitals with functional Hospital Boards	Baselines not available	100% of all Hospitals with functional Hospital Boards
		Percentage of households with low Socio Economic status visited by CHWs	Baselines not available	100% of households with low Socio Economic status visited by CHWs
Not Applicable	Environmental Health strengthened by contributing to improved quality of water, sanitation, waste management and food services	Number of metropolitan and district municipalities compliant with environmental norms and standards	20 metropolitan and district municipalities compliant with environmental norms and standards	52 metropolitan and district municipalities compliant with environmental norms and standards
Implement the costed infrastructure plan to improve efficiency and effectiveness of health services delivery	Financing and Delivery of infrastructure projects improved	Percentage of public health facilities refurbished, repaired and maintained	Baselines not available	80% of public health facilities refurbished, repaired and maintained

MTSF Priority 3:	Education, Skills and Health			
Impact 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			
MTSF Intervention	Outcome	Outcome Indicator	Baseline (2018/19)	Strategic Plan Target 2024/25
Public health facilities supplied with adequate ICT infrastructure to implement the Digital Health Strategy 2019-2024 of South Africa	Adaptive learning and decision making is improved through use of strategic information and evidence	National Health Research strategy developed, implemented and goals of the strategy achieved	Inadequate co-ordination of health research	National Health Research strategy developed, implemented and goals of the strategy achieved
		Performance dashboards implemented at National DoH; 9 x Provincial Head Offices, and 52x District Offices for adaptive learning and decision making	Fragmented dashboards	Performance dashboards implemented at National DoH; 9 x Provincial Head Offices, and 52x District Offices for adaptive learning and decision making
Public health facilities supplied with adequate ICT infrastructure to implement the Digital Health Strategy 2019-2024 of South Africa	Information systems are responsive to local needs to enhance data use and improve quality of care	Percentage of PHC facilities implementing priority interoperability use cases in patient information systems	Fragmented information systems in PHC facilities	100% of PHC facilities implementing priority interoperability use cases in patieWnt information systems
		Percentage of public health facilities using standardised diagnostic and procedure coding systems to record clinical care	Public health facilities without capacity and capabilities to record clinical codes for patient visits	50% of public health facilities using standardised diagnostic and procedure coding systems to record clinical care

9. KEY RISKS

Outcomes	Risks	Mitigation
1. Maternal, Child, Infant and neonatal mortalities reduced 2. HIV incidence among youth reduced 3. 90:90:90 targets for HIV AIDS achieved by 2020 and 95:95:95 targets by 2024/25 4. Significant progress made towards ending TB by 2035 through improving prevention and treatment strategies 5. Premature mortality from Non-communicable diseases reduced by 10% 6. An equitable budgeting system progressively implemented and fragmentation reduced 7. Resources are available to managers and frontline providers, with flexibility to manage it according to their local needs 8. Financial management strengthened in the health sector 9. Management of Medico-legal cases in the health system strengthened 10. Package of services available to the population is expanded on the basis of cost-effectiveness and equity 11. Integrated services delivered according to the referral policy, at the most appropriate level, to ensure continuity of care	Delays in finalisation and implementation of the NHI Bill/Act	• Sort Legal Opinion to address potential areas of Legal challenges • Address matters raised by Portfolio Committee of health and Provincial Legislatures
	Shortages of Human Resources in Critical positions Inadequate Capacity	• Development of a comprehensive strategy and plan to address human resource requirements, including filling of critical vacant posts • Expansion of Primary Health Care system by strengthening the community Health Workers Programme • Consolidate nursing colleges • Expand the Nelson Mandela-Fidel Castro Programme to supplement the production of much-needed medical practitioners and other health professionals.
	Shortages of Pharmaceuticals due to Ineffective Supply Chain Management processes	• Contracts with suppliers in place • Supplier performance management systems • Enforcement of penalty clauses on non compliance with the delivery terms.
	Inadequate Health Care Infrastructure (new or revitalisation of Old Hospitals and Clinics).	• Ensure effective Implementation of the 10 year National Health Infrastructure Plan to improve health facility planning in order to ensure construction of appropriate health facilities on a need and sustainable basis.
	Lack of adequate funding (in order to meet health delivery service needs)	• Continue to engage with National Treasury and other relevant Stakeholders e.g. Donor Funders for additional funds.
	Inadequate Health Prevention and Promotion	• Training of Community Health Workers (CHWs) for outreach programmes. • Health Promotion improved
	Inadequate Financial Management (which may lead to Irregular, fruitless/wasteful and unauthorised expenditure and negative Audit Outcomes)	• Financial management strengthened • Delegations and accountability framework implemented • South African Institute of Chartered accountants (SAICA) to strengthen financial capacity at Provincial Health departments in order to improve Audit Outcomes.
	Fraud and Corruption	• Fraud Prevention policy in place. • Conduct Fraud and Corruption awareness campaigns.

Outcomes	Risks	Mitigation
12. Quality and safety of care improved 13. Staff equitably distributed and have right skills and attitudes 14. Community participation promoted to ensure health system responsiveness and effective management of their health needs 15. Environmental Health strengthened by contributing to improved quality of water, sanitation, waste management and food services 16. Financing and Delivery of infrastructure projects improved 17. Adaptive learning and decision making is improved through use of strategic information and evidence 18. Information systems are responsive to local needs to enhance data use and improve quality of care	Inadequate Information, Communication, Technology (ICT) Infrastructure	• Adequate ICT infrastructure made available to public health facilities, through the implementation of Digital Health Strategy 2019-2024 • Development of a streamlined, integrated information system for decision-making, as required by the Digital Health strategy 2019-2024
	Escalating Medico-Legal Fraudulent claims	• Development of a Case Management system • Collaborate with Special Investigative Unit (SIU) to investigate alleged fraudulent claims

10. PUBLIC ENTITIES

Name of Public Entity	Mandate	Outcomes
Council for Medical Schemes	The Council for Medical Schemes was established in terms of the Medical Schemes Act (1998), as a regulatory authority responsible for overseeing the medical schemes industry in South Africa. Section 7 of the act sets out the functions of the council, which include protecting the interests of beneficiaries, controlling and coordinating the functioning of medical schemes, collecting and disseminating information about private health care, and advising the Minister of Health on any matter concerning medical schemes.	• The improvement of quality of care and the reduction of costs of in the private health care sector promoted • Effective risk pooling encouraged • Policy driven research, monitoring and evaluation of the medical schemes industry conducted
National Health Laboratory Service	The National Health Laboratory Service was established in 2001 in terms of the National Health Laboratory Service Act (2000). The entity is mandated to support the Department of Health by providing cost effective diagnostic laboratory services to all state clinics and hospitals. It also provides health science training and education, and supports health research. It is the biggest diagnostic pathology service in South Africa, servicing more than 80 per cent of the population, through a national network of 268 laboratories. Its specialised divisions include the National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry and the Anti-Venom Unit.	• Clinical effectiveness and efficiencies improved • high-quality and cost-effective laboratory services offered
South African Medical Research Council	The South African Medical Research Council (SAMRC) was established in terms of the South African Medical Research Council Act (1991). The SAMRC is mandated to promote the improvement of health and quality of life through research, development and technology transfers. Research and innovation are primarily conducted through funded research units located within the council (intramural units) and in higher education institutions (extramural units)	• Scientific excellence promoted to protect the reputation of South African health research; • Leadership in the generation of new knowledge in health provided; • Sustainability of health research in South Africa enhanced by funding and supervising the next generation of health researchers; and

Name of Public Entity	Mandate	Outcomes
Compensation Commissioner for Occupational Diseases in Mines and Works	The Compensation Commissioner for Occupational Diseases in Mines and Works was established in terms of the Occupational Diseases in Mines and Works Act (1973). The act gives the commissioner the mandate to: collect levies from controlled mines and works, to compensate workers and ex-workers in controlled mines and works for occupational diseases of the cardiorespiratory organs, and reimburse workers for loss of earnings incurred during tuberculosis treatment. The commissioner compensates the dependants of deceased workers and also administers pensions for qualifying ex-workers or their dependants.	• Management of the CCOD to administer the Mines and Works Fund strengthened
Office of Health Standards Compliance	The Office of Health Standards Compliance was established in terms of the National Health Act (2003), as amended. The office is mandated to: monitor and enforce the compliance of health establishments with the norms and standards prescribed by the Minister of Health in relation to the national health system; and ensure the consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner. The Minister appointed an ombudsman during 2016/17 financial year that makes it possible for patients to complain about public and private healthcare institutions in South Africa.	• Ensure inspections are conducted and norms and standards are effectively monitored for different categories of health establishments; • Quality of health care services are improved for the users of health services
South African Health Products Regulatory Authority (SAHPRA)	The South African Health Products Regulatory Authority is established in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), as amended. SAHPRA is the regulatory authority responsible for the regulation and control of registration, licensing, manufacturing, importation, and all other aspects pertaining to active pharmaceutical ingredients, medicines, medical devices; and for conducting clinical trials in a manner compatible with the national medicines policy.	• Financial sustainability enhanced through revenue generation and improving operational efficiencies; • Global best practices as the regulatory authority of health products by SAHPRA attained and maintained

PART D

TECHNICAL INDICATOR DESCRIPTION (TID) FOR STRATEGIC PLAN

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Maternal Mortality Ratio (MMR)	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	Reports produced by the National committee of Confidential Enquiry into Maternal deaths (NCCEMD)	Maternal death in facility	Live births known to facility	Not Applicable	Females	All Districts	Lower	Chief Directorate: Maternal Health
Neonatal (<28 days) Mortality Rate (NMR)	Neonates (0-28 days) who died per 1000 live births	Annual Rapid Mortality surveillance report published by MRC	Neonatal deaths (under 28 days)	Live births in facility	Not Applicable	Not Applicable	All Districts	Lower	Chief Directorate: Maternal Health
Infant (<1 year) Mortality Rate (IMR)	Children under 1 years who died as a proportion of all live births	Annual Rapid Mortality surveillance report published by MRC	Infant deaths (under 1 year)	Live births in facility	Not Applicable	Not Applicable	All Districts	Lower	Chief Directorate: Child and Youth Health
Child (<5 years) Mortality Rate (U5MR)	The proportion of children who died before the age of 5 years	Annual Rapid Mortality surveillance report published by MRC	Child (under 5 year) deaths	Live births in facility	Not Applicable	Not Applicable	All Districts	Lower	Chief Directorate: Child and Youth Health

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Number of new HIV infections among youth*	Number of new HIV infections among youth as confirmed by population based surveys	Population based Survey reports	Number of new HIV infections among youth	Not Applicable	Not Applicable	Youth	All Districts	Lower	Chief Directorate: HIV and AIDS
ART Client-remain on ART at end of month	Total patients that are receiving Antiretroviral Therapy (ART) at the end of the reporting period	TIER.Net System	ART adult and child under 15 years remaining on ART end of month	No Denominator	Not Applicable	Youth; Women; Children	All Districts	Higher	Chief Directorate: HIV and AIDS
TB Treatment Success Rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently successfully completed treatment as a proportion of all those in the treatment outcome cohort	DS-TB Clinical Stationery; TIER.Net	All DS-TB client successfully completed treatment	All DS- TB patients in treatment outcome cohort	Accuracy dependent on reliability of data submitted by health facilities	Not Applicable	All Districts	Higher	Chief Director: TB
Number of TB Deaths	Total number of deaths due to TB	StatsSA, Causes of Death Reports	Number of TB Deaths	Not Applicable	Accuracy dependent on reliability of data from Home Affairs	Not Applicable	All Districts	Lower	Chief Director: TB
Premature mortality due to NCDs	Death before time due to non-communicable diseases	Rapid Mortality Surveillance reports	Not Applicable	Not Applicable	Accuracy of Report	Not Applicable	All Districts	Lower	Chief Director: Non-communicable Diseases

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Equitable share model for financing health care progressively reviewed and implemented	A holistic review and recalibration of provincial health budgets through amendment of the equitable share model	A report reflecting the new equitable share model	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Chief Financial Officer
Conditional grants of the health sector progressively reviewed and implemented	Conditional grants reviewed to reduce fragmentation and improve effectiveness of spending	A report reflecting the review of the conditional grants	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Chief Financial Officer
Percentage of hospitals with increased decision making space	Percentage of hospitals with increased decision making space	Delegation letters	Sum of hospitals compliant with increased decision making space in four domains	Total Tertiary, Regional and Specialized hospitals	Provincial DoH would provide adequate delegations to Hospital CEOs	Not Applicable	Not Applicable	Higher	Chief Director: Hospital Services
Centralized procurement through sector transversal contracts for core supplies and low value equipment implemented to reduce buy outs and derive economies of scale	A centrally facilitated procurement system through sector transversal contracts for core supplies and low value equipment implemented to reduce buy outs and derive economies of scale	Transversal Tender documents	Not Applicable	Not Applicable	Not Applicable	Not Applicable	All Districts	Higher	Chief Financial Officer

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of health facilities with no stock outs on essential medicines	Percentage of health facilities with no stock outs on essential medicines (ie meeting the 90% threshold for all essential meds at any given time)	Dashboard report from National surveillance centre	Sum of health facilities with no stock outs (ie. 90% of essential medicines in stock throughout the reporting period)	Total number of health facilities	All health facilities reporting stock availability at national surveillance centre	Not Applicable	All Districts	Higher	DDG: National Health Insurance
Percentage of Health Facilities with cost-centre accounting	Percentage of Health Facilities that are set up as cost-centres on BAS	BAS report confirming cost-centres	Number of Health Facilities with cost-centre accounting	Total Number of health facilities	None	Not Applicable	All Districts	Higher	Chief Financial officer
Audit Outcome of National DoH	Audit opinion from Auditor General for National Department of Health	Auditor General's Report confirming audit outcome	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Chief Financial Officer
Audit Outcomes of Provincial DoH	Audit opinion from Auditor General for Provincial Departments of Health	Auditor General's Report confirming audit outcome	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Chief Financial Officer
Audit Outcomes Public entities reporting to Minister of Health	Audit opinion from Auditor General for public entities reporting to Minister of Health	Auditor General's Report confirming audit outcome	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Higher	Director: Public Entities Management

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Contingent liability of current medico-legal cases reduced	The reduction liability by the government due to medical litigation	Report from medico-legal case management system	Not Applicable	Not Applicable	Active use of the medico-legal case management system by Provincial DoH to manage medico-legal claims	Not Applicable	All Districts	Lower	DDG: Corporate Services
NHI Fund purchasing services	NHI Fund purchasing services on behalf of the population from accredited public and private health providers	Copies of agreements signed with health providers	Not Applicable	Not Applicable	Subject to NHI Bill enacted into law by the president after it has been processed by National Assembly and NCOP	Not Applicable	Not Applicable	Not Applicable	DDG: National Health Insurance

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
UHC Service Index	Proxy indicator to measure Coverage of essential health services (based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access; among the general and the most disadvantaged population)	South African Health Review publication by HST	Not Applicable	Not Applicable	South African Health Review 2018, based on: World Health Organization, International Bank for Reconstruction and Development / The World Bank	Not Applicable	All Districts	Higher	DDG: National Health Insurance
Number of Districts with referral systems with care pathways defined and institutionalized	Number of Districts with an integrated referral system and mapped out care pathways for all levels of care	Approved referral system for Districts	Sum of Districts with referral systems with care pathways defined and institutionalized	No Denominator	Provincial DoHs will approve referral system for their districts once they are developed	Not Applicable	All Districts	Higher	Chief Director: District Health Services
Percentage of public health facilities certified by OHSC	Percentage of public health facilities certified by the Office of Health Standards Compliance against the regulated norms and standards	Annual Report OHSC	Not Applicable	Not Applicable	OHSC would have the capacity to assess and certify health facilities	Not Applicable	All Districts	Higher	Director: Quality Assurance

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of PHC facilities that qualify as ideal clinics	Percentage of Primary Health Care facilities that qualify as ideal clinics	Report generated from the Ideal clinic software system	Sum of PHC facilities that quality as ideal clinics	Total number of PHC facilities	The assessments are done annually, and assume to be correct at the time of inspection.	Not Applicable	All Districts	Higher	Chief Director: District Health Services
Percentage of public hospitals obtaining 75% and above on food service quality assessments	Percentage of public hospitals obtaining 75% and above on food service quality assessments	Assessment reports from Hospitals	Sum of public hospitals compliant on food service quality assessments	Total number of public hospitals (391)	Accuracy of reporting	Not Applicable	All Districts	Higher	Chief Director: Health Promotion and Nutrition
Percentage of traditional health practitioners offering high quality services	Percentage of traditional health practitioners offering high quality services as determined by the to be developed policy on traditional medicine	Reports from traditional medicine practitioners	Sum of traditional health practitioners (who are registered) offering high quality services	Total number of traditional health practitioners	policy on traditional medicine in conjunction with the norms and standards for health establishments would specify the standards that determines quality service	Not Applicable	All Districts	Higher	Directorate: Traditional Medicine

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of people requiring preventive chemotherapy for schistosomiasis	Percentage of people requiring preventive chemotherapy for schistosomiasis	Survey confirming the population requiring preventive chemotherapy for schistosomiasis	Sum of people identified to preventative chemotherapy for schistosomiasis	Total number of people assessed with schistosomiasis	Funding for a survey would be available to assess the reduction	Not Applicable	All Districts	Lower	Chief Director: Communicable Diseases
Number of ports of entry where health services comply with international health regulations	Number of ports of entry where health services comply with international health regulations	Annual assessment Reports	Sum of ports of entry where health services comply with international health regulations	No Denominator	The assessments are annually conducted and therefore assume the status is maintained until the subsequent assessment is completed	Not Applicable	All Districts	Higher	Chief Director: Environmental Health and Port Health Services
Number of provinces compliant with Emergency Medical Services Regulations	Number of provinces compliant with Emergency Medical Services Regulations	Annual assessment Reports	Sum of provinces compliant with Emergency Medical Services Regulations	No Denominator	The assessments are annually conducted and therefore assume the status is maintained until the subsequent assessment is completed	Not Applicable	All Districts	Higher	Director: EMS

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of blood alcohol tests completed within normative period of 90 days	Percentage of blood alcohol tests completed within normative period of 90 days Percentage of blood alcohol tests completed within normative period of 90 days from the time the test was submitted to FCL	Report from LIMS (Laboratory Information Management System)	Sum of Blood Alcohol test completed within normative period of 90 days	Total number of blood alcohol tests received for analysis	Accuracy of reporting	Not Applicable	Not Applicable	Higher	Director: Forensic Chemistry Laboratories
Number of public Nursing colleges accredited and registered to offer quality basic and specialist nursing programmes	Total number of public Nursing colleges accredited and registered to offer quality basic and specialist nursing programmes	Accreditation and registration certificates of all nursing colleges to offer quality basic and specialist nursing programmes	Sum of public nursing colleges accredited and registered to offer basic and specialist nursing programmes	No Denominator	Not Applicable	Not Applicable	Not Applicable	Higher	Chief Nursing Officer
HRH Plan for 2020/21 – 2024/25 implemented	HRH Plan for 2020/21 – 2024/25 implemented	Quarterly monitoring reports produced against milestones and actions in the HRH plan 2020/21 – 2024/25	Not Applicable	Not Applicable	Capacity for HRH Policy development, Planning and monitoring available	Not Applicable	All Districts	Not Applicable	Chief Director: Human Resources for Health

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of patients satisfied (positive experience) with their Experience of Care in public health facilities	The percentage of patients that had a positive experience as measured by a survey to assess their experience of care in public health facilities	General Household survey report from StatsSA	Sum of patients satisfied with their experience of care in public health facilities	Total number of people participating in the survey	Sample size surveyed by StatsSA is representative of total population accessing public health services	Not Applicable	All Districts	Higher	Director: Quality Assurance
Percentage of PHC facilities with functional Clinic Committees	Percentage of PHC facilities with functional Clinic Committees (meet regularly, represent the interest of its community, and provide adequate oversight)	Monitoring reports as required by the, to-be developed monitoring system	Sum of PHC facilities with functional Clinic Committees	Total number of PHC facilities	Monitoring system to be developed	Not Applicable	All Districts	Higher	Chief Director: District Health Services
Percentage of Hospitals with functional Hospital Boards	All Hospitals with functional Hospital Boards (meet regularly, represent the interest of patients, and promote good governance)	Monitoring reports as required by the, to-be developed monitoring system	Sum of hospitals with functional Hospital Boards	Total number of hospitals	Monitoring system to be developed All Hospitals with trained hospital boards	Not Applicable	All Districts	Higher	Chief Director: Hospital Services

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of households with low Socio Economic status visited by CHW	Percentage of population with low Socio Economic status visited by CHW to offer health services	Reports from the Electronic system used by CHWs to capture household visits	Sum of households with low Socio status Economic visited by CHW	Sum of households with low Socio status Economic in South Africa	Low socio economic status households are those living in Q1 and Q2 Districts	Not Applicable	All Districts	Higher	Chief Director: District Health Services
Number of metropolitan and district municipalities compliant with environmental norms and standards	Number of metropolitan and district municipalities compliant with environmental norms and standards	Annual assessment reports	Sum of metropolitan district municipalities compliant with environmental norms and standards	Not Applicable	The assessments are annually conducted and therefore assume the status is maintained until the subsequent assessment is completed	Not Applicable	All Districts	Higher	Chief Director: Environmental Health and Port Health Services
Percentage of public health facilities refurbished, repaired and maintained	Percentage of all public health facilities maintained, repaired and/or refurbished	Practical completion certification	Sum of public health facilities (Clinics, Hospitals, nursing colleges, EMS base stations) maintained, repaired and/or refurbished	Total number of public health facilities	Once the infrastructure project is completed, it is assumed that the facility will remain in the state of maintainance	Not Applicable	All Districts	Higher	Chief Director: Health Facilities and Infrastructure Planning

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
National Health Research strategy implemented and goals of the strategy achieved	National Health Research strategy implemented and goals of the strategy achieved	National Health Research strategy; and quarterly progress reports against the targets in the strategy	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Director: Health Research
Performance dashboards implemented at National DoH; 9 x Provincial Head Offices, and 52x District Offices for adaptive learning and decision making	Integrated Performance dashboards with indicators that measure health outcomes implemented at National DoH; 9 x Provincial Head Offices, and 52x District Offices for adaptive learning and decision making	Performance Dashboards	Not Applicable	Not Applicable	Performance dashboards for national, provincial and district levels completed and access provided	Not Applicable	All Districts	Not Application	Chief Director: Health Information Research, Monitoring and Evaluation
Percentage of PHC facilities implementing priority interoperability use cases in patient information systems	Percentage of PHC facilities implementing priority interoperability use cases in patient information systems	Interoperability reports from PHC facilities	Number of Health facilities with interoperable Health Information Systems	Total number of PHC facilities	Policy on the use of HPRN for public health facilities adopted	Not Applicable	All Districts	Higher	Chief Director: NHI Information Systems

Indicator Title	Definition	Source of Data	Method of Calculation/Assessment		Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Desired performance	Indicator Responsibility
			Numerator	Denominator					
Percentage of public health facilities using standardised diagnostic and procedure coding systems to record clinical care	Percentage of public health facilities (PHC facilities and hospitals) using standardised diagnostic and procedure coding systems to record clinical care	Reports from information systems confirming use of diagnostic and procedure codes	Sum of public health facilities (PHC and hospitals) electronically recording clinical codes for patient visits	Sum of PHC facilities and Hospitals	clinical coding framework finalized and adopted for national use	Not Applicable	Not Applicable	Higher	Chief Director: Health Information Research, Monitoring and Evaluation

RP: 108/2020 | ISBN: 978-0-621-48280-5

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

National Department of Health
Private Bag X 828, Pretoria, 0001
Republic of South Africa