STRATEGIC PLAN

2025-2030

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

STRATEGIC PLAN 2025 - 2030

STATEMENT BY THE MINISTER OF HEALTH

Dr PA Motsoaledi, MP
Minister of Health

The 7th Administration provides an opportunity to accelerate the universal health coverage reforms in line with the priorities of the Medium-Term Development Plan for 2024-2029. During this term the health sector with introduce various interventions to address the inequities and financial hardships in accessing quality health care.

As we slowly approach the year 2030, which marks a significant period for the National Development Plan Goals and the Sustainable Development Goals, the department and sector remain committed towards the attainment of the targets we ought to achieve. In the period 2025-2030, the sector's key interventions will be geared towards health system strengthening reforms with focus on optimizing human resources and infrastructure to facilitate the delivery of care as well as strengthening Primary Health Care as a vehicle for the implementation of the National Health Insurance (NHI).

One of the key interventions is the implementation of an integrated electronic health record, which introduces a single medical record for every patient which will enable real-time access to patient information across health care facilities and as result will improve the quality of patients' records, reduce the risks associated with manual record keeping and facilitate continuity of care as patients navigate through the health system throughout the course of life. Additionally, patient information systems will be integrated in a manner that enables improved monitoring of patients' outcomes for all strategic health programmes across all the levels/spheres.

The National Development Plan 2030 goal for an improvement in average life expectancy of 70 years by 2030, requires the sector to make significant progress in reducing the burden of disease with interventions targeted at; reducing maternal, child and neonatal mortalities, reduce prevalence of non-communicable diseases, progressively improve TB prevention and cure as well as ensuring that the generation of under-20s is largely free of HIV.

Dr PA Motsoaledi, MP
Minister of Health

STATEMENT BY THE DIRECTOR GENERAL

Dr SSS Buthelezi
Director-General: Health

I am pleased to present the National Department of Health's Strategic Plan for 2025 -2030 which reflects the focus of the department for the medium term. The introduction of the 7th Administration has provided an opportunity for the sector to reflect on the progress made in the previous Administration with a focus on strengthening integrated planning to enable effective implementation of sector interventions.

The country has made significant progress towards achieving the HIV and AIDS 95-95-95 targets for the UNAIDS, with current performance at 96-79-94. Several strategies have been put in place to address the gap in the second '95' which is currently at 79, to increase demand for HIV testing, and treatment services and intensifying social and behavioural community communication to trace and link men, children and the youth to care.

The department remain committed to driving improving quality of care through the expansion of the ideal clinic realization to all public health facilities and to strengthen the alignment of quality initiatives to ensure that health facilities deliver the standards that meet the accreditation requirements for the national health insurance. To improve patients' experience of care, our focus will be on reducing waiting times, improving the cleanliness of facilities and instilling a positive staff attitude. The primary healthcare platform has been strengthened to improve access to community-based services through the Ward Based Primary Health Care Outreach Teams (WBPHCOTs).

The rights of vulnerable groups have been promoted by improving equitable access to services, including Sexual and Reproductive Health for women and especially young girls in light of the increase in cases of teenage pregnancies as well as Human PapilloVirus (HPV) screening for cervical cancer for women and HPV vaccination for young girls. Furthermore, targeted progammes are in place to ensure that young children survive and thrive through Immunization Programme and Integrated School Health Programme.

One of the key priorities for the 7th Administration is to pursue progressive achievement of universal health coverage to address inequity and financial hardship. Our most immediate priority which is a critical enabler for the NHI is the modernization, improvement and maintenance of existing health facilities and construction of new hospitals and clinics to ensure that health infrastructure is fit for purpose for service delivery.

We recognize that health system challenges are compounded by financial constraints and economic stagnation. As a sector we are continuously exploring opportunities to promote efficiencies and alternative funding opportunities to support critical activities. The Strategic Plan for 2025-2030 elevates interventions that are imperative to facilitate universal health coverage.

Dr SSS Buthelezi
Director-General


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OFFICIAL SIGN OFF

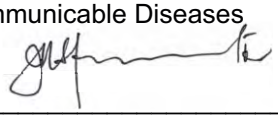
It is hereby certified that this Strategic Plan:

- Was developed by the management of the National Department of Health under the guidance of Dr A. Motsoaledi, MP
- Consider all the relevant policies, legislation and other mandates for which the Department of Health is responsible.
- Accurately reflects the Impact, Outcomes and Outputs which the National Department of Health will endeavour to achieve over the period 2025-2030

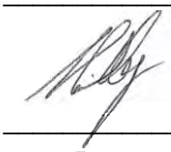
Mr. P Mamogale Signature: 
Acting Manager Programme 1: Administration

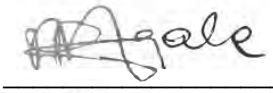
Prof. N Crisp Signature: 
Manager Programme 2: National Health Insurance

Mr R Morewane Signature: 
Acting Manager Programme 3: Communicable and Non-Communicable Diseases

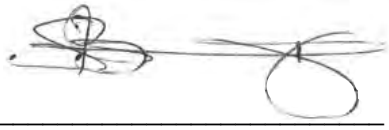
Ms J Hunter Signature: 
Manager Programme 4: Primary Health Care

Dr P Mahlati Signature: 
Manager Programme 5: Hospital Systems

Dr A Pillay Signature: 
Manager Programme 6: Health System, Governance and Human Resources

Mr P Mamogale Signature: 
Chief Financial Officer

Ms K Sebanyoni Signature: 
Head Official responsible for Planning

Dr SSS Buthelezi Signature: 
Director-General

Approved by:

Dr A Motsoaledi, MP Signature: 
Minister of Health

Part A:
Our Mandate

PART A: OUR MANDATE

1. Constitutional Mandate

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

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

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

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care. People also have the right to access information if it is required for the exercise or protection of a right. This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and this right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively.

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

(1) Everyone has the right to have access to: (a) Health care services, including reproductive health care;(b) Sufficient food and water; and(c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

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

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

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

2. Legislative and Policy Mandates

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 towards Strategic Priority 2 of the Medium-Term Development Plan 2024-2029 which focus on the reducing poverty and tackling the high cost of living 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 recognised 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.

understood alongside other laws and policies which relate to health in South Africa.

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

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.

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.

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

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.

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.

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

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.

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.

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.

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 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.

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.

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.

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

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.

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.

2.2. Other legislation applicable to Sector

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.

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.

Child Justice Act, 2008 (Act No. 75 of 2008) - Provides for criminal capacity assessment of children between the ages of 10 to under 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.

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.

Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007), Provides for the management of Victims of Crime

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.

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

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.

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.

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

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.

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.

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

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.

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.

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

3.1. National Development Plan: Vision 2030

The strategic intent of the National Development Plan (NDP) 2030 for the health sector is the achievement of a health system that is accessible, works for everyone and produces positive health outcomes. The NDP vision is that by 2030 it is possible for South Africa to have: (a) raised the life expectancy of South Africans to at least 70 years; (b) produced a generation of under-20 year olds that is largely free of HIV; (c) reduced the burden of disease; (d) achieved an infant mortality rate of less than 20 deaths per thousand live births, including an under-5 year old mortality rate of less than 30 per thousand;(e) achieved a significant shift in equity, efficiency and quality of health service provision; (f) achieved universal coverage; and (g) significantly reduced the social determinants of disease and adverse ecological factors.

Chapter 10 of the NDP has outlined 9 goals for the health system that it must reach by 2030. The **overarching goal** that measures impact is “Average male and female life expectancy at birth increases to at least 70 years”. The next 4 goals measure health outcomes, requiring the health system to reduce premature mortality and morbidity. Last 4 goals are tracking the health system that essentially measure

inputs and processes to derive outcomes.

3.2. Sustainable Development Goals

In 2015, all countries in the United Nations adopted the 2030 Agenda for Sustainable Development. Goal 3 ensures promotion of healthy lives and well-being for all at all ages.

The following goals pertain to health, goal 3:

3.2.1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

3.2.2. 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.

3.2.3.By 2030 , end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.2.4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

3.2.5.Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

3.2.6. By 2020, halve the number of global deaths and injuries from road traffic accidents.

3.2.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.2.8.Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential.

3.2.9. By **2030, substantially reduce the number of deaths and illnesses from hazardous chemicals** and air, water and soil pollution and contamination.

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

3b.**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.

3c.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.

3d.Strengthen the capacity of all countries, in particular developing countries, for **early warning, risk reduction and management of national and global health risks**.

3.3. Medium Term Development Plan 2024 - 2029

In May 2024, the country made a transition to the 7th Administration of government which led to the introduction of the Medium-Term Development Plan which sets priorities to be pursued by sector department. The **Medium-Term Strategic Framework (MTSF)** is renamed to the **Medium-Term Development Plan (MTDP)**. as the **implementation plan of the National Development Plan (NDP)** and align to **the goals and objectives of the NDP and Programme of Priorities of the Government of National Unity.** The MTDP has a **greater emphasis on development outcomes** and are framed as an **economic plan** to address existing **socio-economic challenges**. The MTDP sets out 3 Strategic Priorities namely, : Inclusive growth and job creation, Reduce Poverty and tackle the high cost of living as well as a capable, ethical and developmental state. The health sector contribution towards the strategic outcome of reduction of poverty and tackling high cost of living will be implemented through 4 sector priorities outlined below:

3.3.1.Pursue achievement of universal health coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care

3.3.2. Improve the quality of health care at all levels of the health establishments, inclusive of private and public facilities.

3.3.3. Improve resource management by optimizing human resources and healthcare infrastructure and implementing a single electronic health record.

3.3.4. Strengthen the primary health care (PHC) system by ensuring that home and community- based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative.

3.4. National Health Insurance Act

The attainment of Universal Health Coverage (UHC) is one of the 17 Sustainable Development Goals (SDGs) 2030 to be achieved globally by 2030. The World Health Organisation (WHO) asserts that UHC exists when: "all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.[1] The implementation of the National Health Insurance (NHI) is the pathway that the Country has chosen to attain Universal Health Coverage 2[2]. The NHI Act was signed into law in May 2024 to;

- establish the National Health Insurance Fund and set out its powers, functions and governance structure;
- to provide a Framework for the strategic purchasing of health care services by the Fund on behalf of users;
- to create mechanisms for the equitable, effective and efficient utilization of the resources of the Fund to meet the health needs of the population; and
- to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users[1]

3.5. Presidential Health Compact 2024-2029

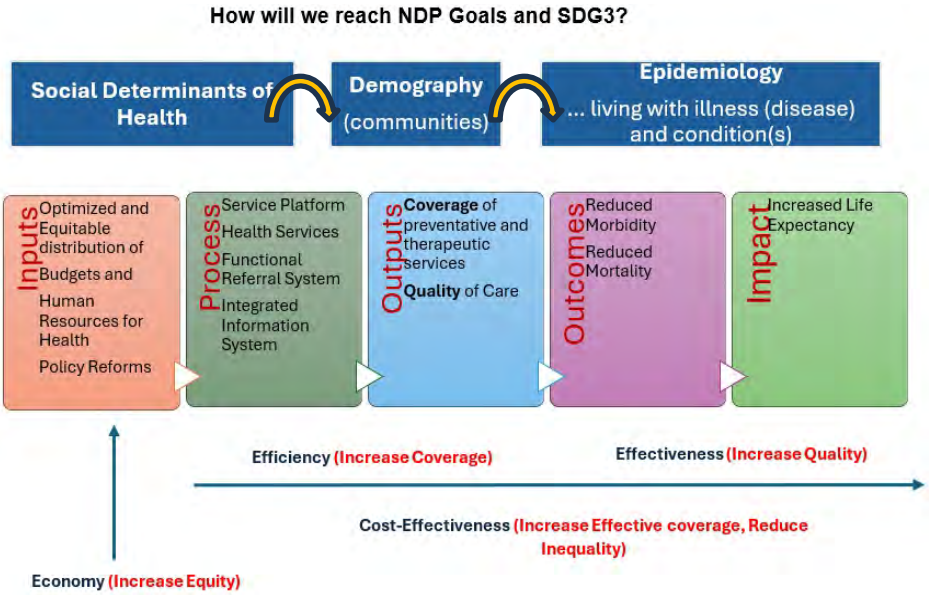
The Presidential Health Compact (PHC) is an agreement and commitment by key stakeholders signed in July 2019, developed to identify primary focus areas towards establishing a unified, integrated and responsive health system. Partners committed themselves to a 5-year program of partnering with government in improving healthcare services in our Country. In 2024 the second Presidential Health Compact (2024-2029) was adopted. Health compact is essential for ensuring collaboration and coordination the state and key stakeholders in achieving better health outcomes for the population; the State, as the main provider of healthcare services, needs the support of other stakeholders, including the labour, private sector, civil society organisations, and communities.

Under the theme, Accelerating Health System Strengthening and National Health Insurance (NHI), the Health Compact Pillars are outlined below:

Pillar 1: Augment Human Resources for Health Operational Plan.
Pillar 2: Better supply chain equipment and machinery management to ensure improved access to essential medicines, vaccines, and medical products.
Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities.
Pillar 4: Engage the private sector in improving health services' access, coverage and quality.
Pillar 5: Improve health services' quality, safety, and quantity, focusing on primary health care.
Pillar 6: Improve the efficiency of public sector financial management systems and processes.
Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels.
Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care.
Pillar 9: Develop an information system to guide the health system's policies, strategies, and investments.
Pillar 10: Pandemic Preparedness and Response

[1] NHI Act 20, 2023

Figure 1: Theory of Change: Towards the 2030 goals and targets



The Health Sector follows the Theory of Change (Result-based Framework) approach in determining the delivery of health services for the sector based on the NDP and SDG goals. Factors, determining the inputs are related to the population (demography and epidemiology); social factors of the community (e.g. deprivation index; equity; disease burden) to prevent and prioritize illnesses and conditions that contribute to mortality and morbidity of the population. These interventions aim to reduce morbidity (Outcomes) and reduce mortality (Impact) by increasing the life expectancy of the population. Interventions are based on priority areas to reduce inequality, through an integrated patient centered approach, supported by adequate inter-departmental and intersectoral collaborations.

Table 3: Medium Term Priorities

NDP 2030	MTDP 2024-2029	PRESIDENTIAL HEALTH COMPACT 2024-2029
Vision 2030 ➢ A health system that works for everyone and produces positive health outcomes. ➢ By 2030, it possible to: ❑ Raise the life expectancy of South Africans to at least 70 years; ❑ Ensure that the generation of under-20s is largely free of HIV; ❑ Significantly reduce the burden of disease; ❑ Achieved an infant mortality rate of less than 20 deaths per thousand live births including an under-5 mortality rate of less than 30 per thousand ❑ A National Health Insurance system needs to be implemented in phases. ***StatsSA, Mid-Year Population Estimates, 2024, 30 July 2024***	Pursue achievement of **Universal Health Coverage** through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care	**Pillar 1:** Augment Human Resources for Health Operational Plan **Pillar 2:** Better supply chain equipment and machinery management to ensure improved access to essential medicines, vaccines, and medical products. **Pillar 4:** Engage the private sector in improving health services' access, coverage and quality. **Pillar 6:** Improve the efficiency of public sector financial management systems and processes.
	Strengthen the **Primary Health Care (PHC) system** by ensuring that home and community-based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative care services required for South Africa's burden of disease	**Pillar 5:** Improve health services' quality, safety, and quantity, focusing on primary health care. **Pillar 8**: Engage and empower the community to ensure adequate and appropriate community-based care
	Improve the **Quality of Health Care** at all levels of the health establishments, inclusive of private and public facilities.	**Pillar 5:** Improve health services' quality, safety, and quantity, focusing on primary health care. **Pillar 10:** Pandemic Preparedness and Response **(cross-cutting)**
	Improve **Resource Management** by optimizing human resources and healthcare infrastructure and implementing a single electronic health record	**Pillar 1:** Augment Human Resources for Health Operational Plan (also in priority 1) **Pillar 3:** Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities. **Pillar 7:** Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels **(cross-cutting)** **Pillar 9:** Develop an information system to guide the health system's policies, strategies and investments.

Part B:
Our Strategic Focus

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 to;

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

7. Situational Analysis

7.1. External Environment Analysis

7.1.1. Demography

South African populations is estimated at 63,02 million with the female population accounting for 51% (approximately 32 million people) and the male population estimated at 31 million (49%).[2] Population estimates by provinces shows that Gauteng province has the largest share of the population at 25.3% (approximately 15.9 million people) followed by KwaZulu-Natal with 19.5% (approximately 12.3 million people). Northern Cape remains the province with the smallest share of the population with 1.37 million (2.2%) people.

The population distribution according to race

Black Africans make the majority of the population estimated at 81.4% followed by Whites (7.3%), Indians (2.7%) and Coloureds at 8.2%. The figure below shows the breakdown of the population per province.

Figure 2: Proportion (%) of total population by Province

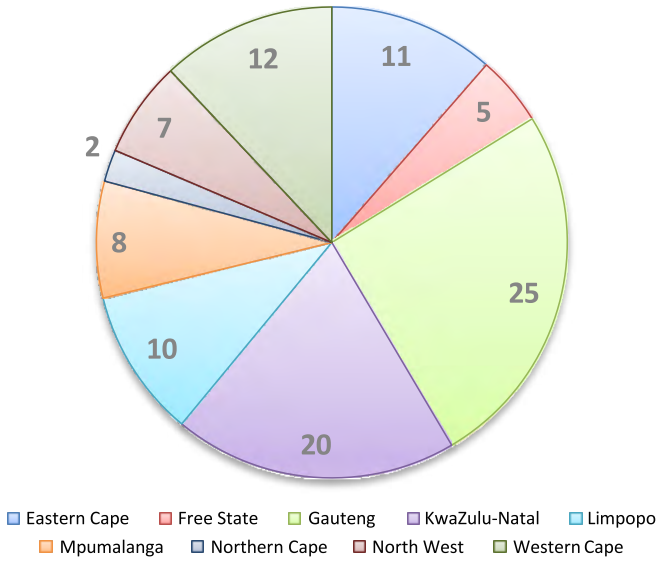
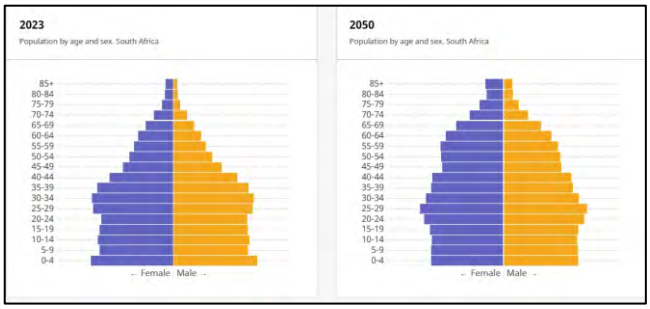


Figure 3: Demographic change of the population, 2023 - 2050 *(Source: WHO, Population South Africa, 2023)*



The figure depicts the change in population as presented by the pyramids, as predicted by WHO. It is noted that the 0-4 years population will reduce from 2.9 to 2.8 million; the population between 25-29 years will increase from 2.8 to 3.3. million, accounting for the children that will reach maturity at this age, and the 65+ will increase from 1.2 to 2.2 million. Of note, this group shows the greatest increase over this period, which supports the progressive planning necessary for providing increased geriatric services for our older population.

Social Determinants of Health for South Africa

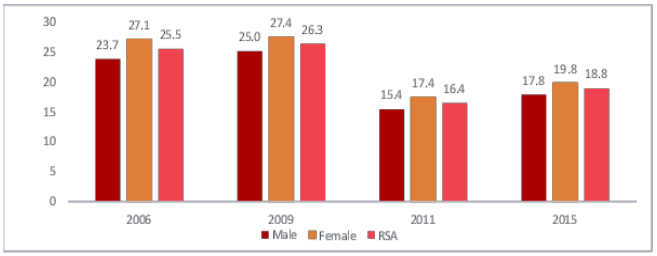
"The social determinants of health (SDH) are the non-medical factors that influence health outcomes"[3] Health equity according to WHO, is striving for the highest possible standard of health for all people, giving specially attention to those most vulnerable populations in society. Social determinants of a country can be adversely affected by wars, poverty and epidemic outbreak of diseases, including decision-making processes, policies, social norms and structures that exist in a society.

[2] StatsSA Mid-year population estimated, July 2024

[3] WHO, Social Determinants of health, Website: https://www.who.int/health-topics/social-determinants-of -health#tab=tab_1,accessed 28 Oct 2024.

SDG Goal: 1.1.1. Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)

Figure 4: Proportion of the population living below the international poverty line by sex



Source: Income and Expenditure Survey 2006 & 2011, Stats SA, and Living Condition Survey 2009 & 2015, Stats SA

"The percentage of people in South Africa living below the international poverty line peaked at 26.3% in 2009 but dropped to 18.8% by 2015. This roughly translates to 10.6 million South Africans having less than R34 per day to survive in 2015 based on data from Stats SA (2006, 2009, 2011 & 2015)". Proportionately, more females are living below the poverty line at 19.8%, than men at 17.8%. The current international extreme poverty line is at US 2.15 (around R40 per person per day, as per Mar 2023 conversion rates, the Word Bank, 2022), StatsSA, SDG country report, 2023.

SDG Goal 1.4.1 Proportion of population living in households with access to basic services.

In South Africa, it is estimated that more than 50 million tons of general waste are generated every year, with only 1/3 being recycled, with the remainder ending up in landfill sites and dumpsites. Pollution from waste, are linked to diarrhea, respiratory illness, and educational underachievement[4]

Table 2: Proportion of population living in households with access to basic services[4]

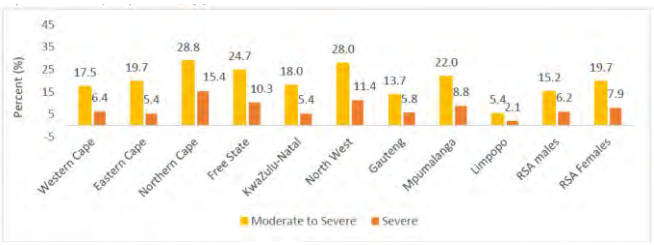
Basic sanitation services	82.3 (2017)	82.6 (2019)	83.4 (2022)
Basic drinking water services	86.4 (2017)	86.2 (2019)	86.2 (2022)
Access to electricity	89.6 (2017)	90.7 (2019)	93.6 (2022)
Access to waste removal	62.4 (2017)	56.5 (2019)	57.3 (2022)

The country report for South Africa, indicate that no significant progress was made in the access to waste removal services, from the baseline of 62.4 % (2017) of the population living in households with access to waste removal services, with the current data, revealing 57.3% (2022) of households with access to waste removal services.

SDG 2.1.2 Prevalence of moderate or severe food insecurity in the population (based on the Community Childhood Hunger Identification Project (CCHIP) index)

Food Insecurity is primarily responsible for co-morbidities such as low birth weight and maternal malnutrition in women and children. SDG 2 seeks to eradicate hunger word wide by 2030. According to StatsSA country report, factors like load-shedding, inflation, unemployment and climate change are all contributing factors to food insecurity in South Africa.

Figure 5: Food inadequacy and hunger in South Africa, 2021[5]



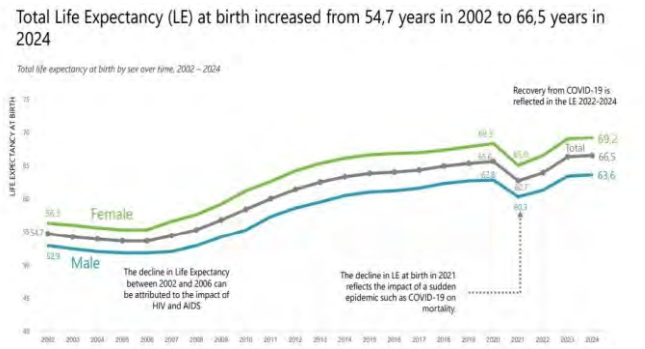
As indicated, Northern Cape and North West are the provinces with the highest percentage of moderate to severe food insecurity in the populations. The Northern Cape is the province in the country with the highest percentage of severe food insecurity. South Africa has high stunting rates (22.8%)[6], a sign of chronic child malnutrition. Female headed households are also more likely to succumb to a lack of food and hunger.[7] The data from the SDG report also indicate that in South Africa, more women than men experience moderate and severe food insecurity, which have a ripple effect on the children of these households.

Life Expectancy and Healthy life expectancy

The definition of life expectancy according to WHO is "the average number of years that a newborn could expect to live". According to the latest StatsSA report[8], the current life expectancy is 63.6 years for males and 69.2 years for females with total life expectancy of 66.5 years.

[4] Wasteaid, Website: https://wasteaid.org/programmes/current-programmes/south-africa/, accessed 28 Oct 2024.
[5] Data sourced from General Household Survey, StatsSA, 2021
[6] The State of Food Security and Nutrition in the World, WHO, 2023
[7] Prevention Stunting in South African Children Under 5: Evaluating the Combined Impacts of Maternal Characteristics and Low Sociaeconomic Conditions, Wand, et. al., 2024
[8] 2024 Mid-year population estimates, StatsSA, 2024

Figure 6: Life Expectancy at birth from 2002 – 2024.



The decline in life expectancy at birth in 2021 reflects the impact of COVID-19, however, the country is on a recovery trajectory.

The WHO Health data overview for the republic of South Africa[9] shows a healthy life expectancy at birth has improved by 4.28 years from 48.5 years in 2000 to 52.8 years in 2021. "Healthy life expectancy (HALE) at birth" is the average number of years that a person could expect to live in "full health" from birth. This measurement considers years lived in less than “full health” due to disease and/or injury.

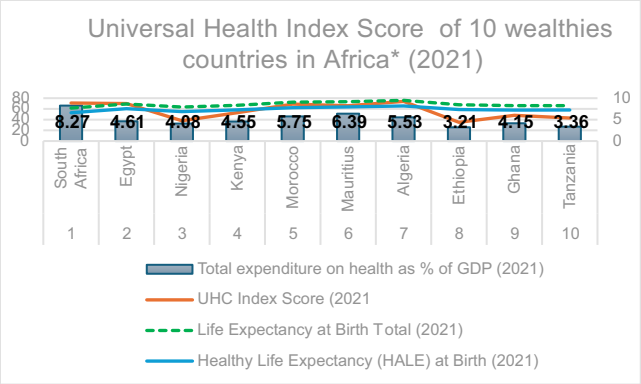
Universal Health Index Score (UHC)

SDG Target 3.8 is defined as “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”.

The WHO Universal Health Index Score is based on the coverage of essential health services as expressed as the average score of 14 tracer indicators of health service coverage. Figure 7. indicates the wealthiest countries, ranked from 1 to 10 for 2021. Although South Africa has the highest UHC index score (71) in 2021, it is also spending the most on health as a percentage of GDP (8.27).

One variable that influences spending on health is related to the disease profile of the country, which is a factor in GDP spending of the country. Predominantly in South Africa, communicable diseases (TB and HIV) ranked amongst the ten leading causes of deaths, including non-communicable diseases like Diabetes and Hypertensive diseases. However, there is scope for improvement for efficiency spending. A recent systematic review recommends three main criteria for improving efficiency in health systems with clear links to expenditure and health service outcomes[10] In order to improve health outcomes related to spending, the authors suggest that long-term financial sustainability requires ongoing focus and monitoring as opposed to responsive planning[11].

Figure 8: Universal Health Index Score compared to % of GDP expenditure and life expectancy measurements

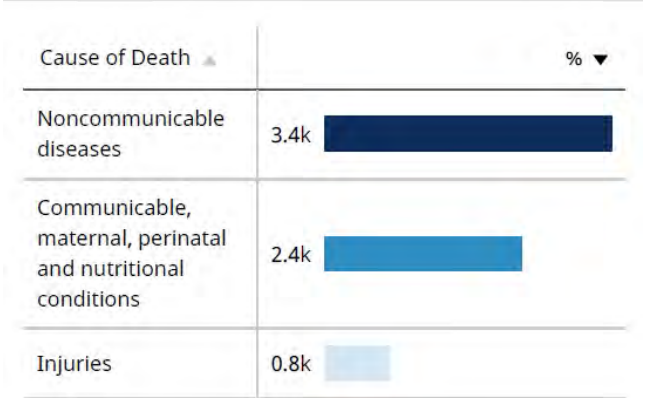


* *Based on the number of high-net-worth individuals (Dec 2023)*[12]

7.1.2. Epidemiology and Quadruple Burden of Disease

The WHO country report[13], using the latest data for 2019, indicate that non-communicable diseases accounted for most deaths in the country, followed by communicable diseases.

Figure 10: South Africa: Share of deaths, grouped per broad cause of death, 2019.



The latest StatsSA, mortality data reports that four of the ten leading natural causes of death were common for the four population groups (African, Coloured, Indian/Asian, Whites), namely, Diabetes mellitus, COVID-19; hypertensive disease and cerebrovascular diseases[14].

The disease profile amongst the population group in terms of ranking order differs also. For example,

[9] World Health Ortanization https://data.who.int/countries/710, accessed 16 Oct 2024
[10] Supporting efficiency improvement in public health systems: a rapid evidence synthesis, James et. Al, 2022,BMC Health Services Branch.
[11] Data sourced from Mitropoulos P, Mitropoulos I, Karanikas H, Polyzos N. The impact of economic crisis on the Greek hospitals' productivity. Int J Health Plann Manage. 2018;33(1):171-84.
[12] Heanley and Partners, https://www.henleyglobal.com/publications/africa-wealth-report-2024/africas-wealthiest-countries, accessed 16 Oct 2024
[13] WHO Global, Country report, 2019, website accessed 21 Oct 2024.
[14] All -Cause Mortality, Appendix Q1; StatsSA, 2020

diabetes mellitus was the leading cause of death among the black African population, accounting for 7.1% of all deaths in this group; and for the coloured population, the leading cause of deaths was COVID-19 at 10.1% as well as for the Indian/Asians population at 14.5% of natural cases of deaths. The white population was dominated by non-communicable diseases, namely, ischemic heart diseases causing 11.2% of all natural deaths.

The percentage of deaths between genders differs also. Between 2016 to 2018, males accounted for 52.8% of deaths and females for 47.2%. However, male deaths decreased to 51.1% in 2020, and female deaths increased to 48.9% for the same year. The highest number of deaths by age group in 2020 was in the aged group 65-69, accounting for 9.3% of all deaths.

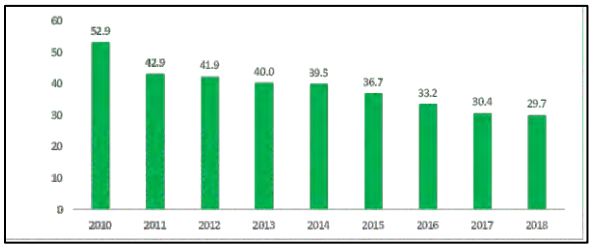
Communicable Diseases

Child Mortality

The under 5 mortality rate (U5MR) refers to the number of children under five years old who die in a year, per 1,000 live births in the same year.

The SDG target for under 5 mortality is by 2030, at least as low as 25 deaths per 1,000 live births. The Under-5 mortality rate has been steadily declining since 2010 from 52.9 deaths per 1 000 live births, to 29.7 deaths per 1 000 live births by 2018.

Figure 9: Under-5 Mortality per 1 000 live births



The infant and under-five mortality rates are proxy indicators for a country's health and development. Data on these age groups are typically recorded from vital registration systems. However, for many middle- and lower-income countries, these data sources may be unreliable. An alternative approach to monitoring age-specific mortality nationally since 2009 is the rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs[15].

In StatsSA all-cause mortality report[16], it is noted that the three leading causes of death for children aged from 1–4 year were intestinal infectious diseases (7,6%), influenza and pneumonia (5,6%) and malnutrition (4,4%). Metabolic disorders (2,4%) was the fourth leading cause of death while tuberculosis (2,0%) was the fifth leading cause of death.

Deaths (Case Fatality Rate) due to Severe Acute Malnutrition (SAM); Pneumonia and Diarrhea are monitored in all health facilities as part of the child indicators. These indicators are an indication of sentinel conditions for the assessment of health services for children[17]. The overall rates for South Africa, case fatality rates for diarrhea 1.3%, (2023/24) shows improvement from 2.5%, (2020/21). Pneumonia case fatality rates are at 1.8%, improved from 2.1% in 2020/21. SAM is the only proxy indicator that remained constant at a case fatality rate of 7 %. "Scaling up the implementation of management of severe acute malnutrition in healthcare facilities using the WHO guidelines can reduce case-fatalities related to this condition by 55%[18]". Breastfeeding, complementary feeding and vitamin A supplementation are also known preventative interventions.

In 2020 the COVID-19 lockdown had positively influenced outcomes in the Under 5 and Infants mortality rates due to the restrictions on socializing and travel, protecting young children from infectious diseases that contribute to mortality as shown by the Rapid mortality Surveillance Report 2019-2020[19].

Recent estimates from the Rapid Mortality Surveillance report noted a rise in both groups mortality rates from 2020. These predictions will be confirmed by future publication of the causes of death data published by StatsSA[20].

Neonatal Mortality

Neonatal deaths are defined as infants that died within the first 28 days of life [neonates]. According to the World Health Organization[21], in 2020 the Sub-Saharan Africa (SSA) region recorded the highest neonatal mortality rates in the world, with 27 deaths per 1000 live births. Despite reaching the SDG target of < 12 deaths per 1000 live births for neonatal deaths by 2030, South Africa has not managed to go beyond this number in the past 10 year.

Premature birth, birth complications (birth asphyxia/ trauma), neonatal infections and congenital anomalies remain the leading causes of neonatal deaths[22] Birth asphyxia, defined as the failure to

[15] Reference: Bradshaw D, Dorrington R, Nannan N, Laubscher R. Rapid Mortality Surveillance Report 2013. Cape Town: South African Medial Research Council. 2014.
[16] All Cause Mortality, StatsSA, 2020
[17] Child Health, Section A, DHB, HST, N McKerrow, 2016
[18] Integrated Management of Children with Acute Malnutrition in South Africa, 2015, NDoH
[19] Website: Child Mortality http://childrencount.uct.ac.za/indicator.php?domain=5&indicator=23, Statistic on children in South Africa, University of Cape Town, 2024
[20] Data compiled by Child Mortality, Authors; N Nannan (Burden of Disease Research Unit, MRC)
[21] and Katharine Hall, Aug 2024, Website WHO, Newborn mortality. Newsroom, 28 January 2022. https:// www.who.int/news-room/fact-sheets/detail/levels -and-trends-in-child-mortality report- 2021 (accessed 26 July 2022)
[22] WHO, https://www.who.int/news-room/fact-sheets/detail/newborn-mortality#:~:text=Premature%20birth%2C%20birth% 20complications%20(birth,leading%20causes %20of%20neonatal%20deaths, accessed 23 Oct 2024.

establish breathing at birth, accounts for an estimated 900,000 deaths each year globally, and is one of the primary causes of early neonatal mortality. (Reference: All-Cause Mortality, StatSA, 2020).

The neonatal period is also the most vulnerable period due to the infant's underdeveloped immune system. Infections specific to the perinatal period (period from conception to 1 year after birth) is ranked fourth highest cause of death at 12.8% of deaths with respiratory and cardiovascular disorders in the perinatal period accounted for 26.7% of deaths[23]

Many of the deaths from infants up to under 5 years of age are preventable. Modifiable factors include: Better response in the community and clinics when danger signs are detected; e.g. Improving the referral to higher level of health care (e.g. from clinic to hospital); training caregivers to recognize the danger signs or severity of illness.

The following recommendations are made by the National Committee for Confidential Enquiries into Maternal Deaths (NCCEMD) members[24]: The provision of a comprehensive package of preventive and promotive services to mother-infant pairs during the first 1000 days. Ensuring all Community Health Workers programmes have a clear focus on mothers and children; Attend to basics hospitals availability of high care beds and daily ward rounds, triaging of patients and implementation of early warning signs. Furthermore, performing clinical audits and monitoring of Quality Improvement Plan implementation and improve data on child deaths, especially community deaths and unnatural deaths.

Maternal Mortality

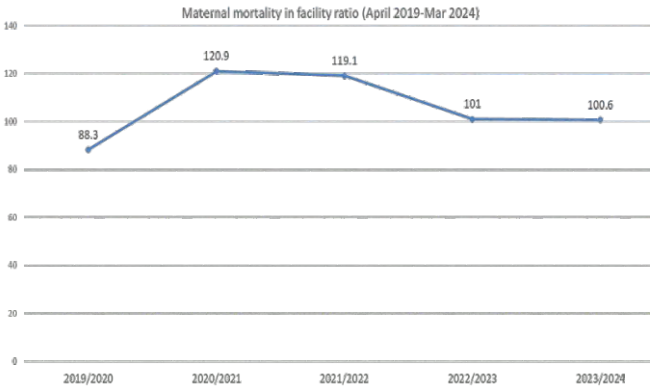
The SDG target for Maternal Mortality by 2030 is an incidence rate of less than 70 deaths per 100 000 live births. Maternal Mortality in facility ratio (iMMR) refers to a death occurring during pregnancy, childbirth and approximately 6 weeks after delivery or within 42 days of termination of pregnancy. The iMMR value serves as a proxy for the Maternal Mortality ration of an country as per the SDG goals.

Maternal Mortality in South Africa is improving since 2009, when the maternal mortality rate was recorded as 311 per 100 000 live births[25]. The reduction coincides with the increase in access to Antiretroviral therapy (ART)[26]. According to the Antenatal HIV Sentinel Survey, 2022 that monitors trends in HIV prevalence among 15-49 year pregnant women for those attending public antenatal care (ANC), the overall HIV prevalence at national level is 27.5%, a decline of 2.5% from 2019 estimate. The highest overall HIV prevalence is in KwaZulu-Natal 37.1%, followed by Eastern Cape (32.9%) and the lowest prevalence in Western Cape at 16.3%.

During 2020 to 2022 there were just over 3 million live births reported in the public facilities (DHIS[27]), which equates to 126 maternal deaths per 100 000 live births, compared to 113.8 in the previous triennium. There is an improvement in facility maternal mortality (iMMR) as seen in figure 10 below, from 120.9 deaths per 100 000 live births during COVID, to 100.6 (2023/2024).

There are notably considered variances in maternal deaths in provinces as average over this period, Free State resulted with the most deaths and Western Cape with the least deaths per 100 000 live births[28].

Figure 10: In facility Mortality Rate (iMMR), April 2019 – Mar 2024[29]



Non-pregnancy related infections (including COVID related death) are responsible for most of the deaths (29.1%). Obstetric haemorrhage (16.4%) and hypertensive disorders of pregnancy (14.7%) are the causes for most deaths during 2020 - 2022.

The latest report from the National Committee on the Confidential Enquiries into Maternal Deaths[30] recommends sustained political commitment amongst other interventions including strengthening clinical management and ongoing training. However, previous reports also highlighted the importance of these recommendations. “The inclusion of 'community issues' in the recommendations requires the health sector to look beyond health facilities and into ecosystem issues that affect maternal health and wellbeing”[31]

[23] All Cause Mortality, StatsSA, 2020
[24] Dr S.N.Cebekhulu: Specialist ObGyn, Head of Clinical Unit DGMAH-SMHRU & NCCEMD Chairperson; Presentation, NDoH, 2024
[25] 30-Year Review Report, Health Sector, NDoH, 2023
[26] National Committee on the Confidential Enquiries into Maternal Deaths. Saving Mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa: Short report. Pretoria: NCCEMD, 2018
[27] District Health Information System, NDoH
[28] Saving Mothers Executive Summary, 2020-2022, NDoH
[29] Presentation, NDoH, 2024, Data sourced DHIS, NDoH
[30] National Department of Health. Saving Mothers: Executive Summary 2020-2022: Includes data for COVID-19 pandemic. Pretoria: NDoH, 2023
[31] Will South Africa meet the Sustainable Development Goals target for maternal mortality by 2030? Y Pillay and J Moodely, S Afr Med J 2024

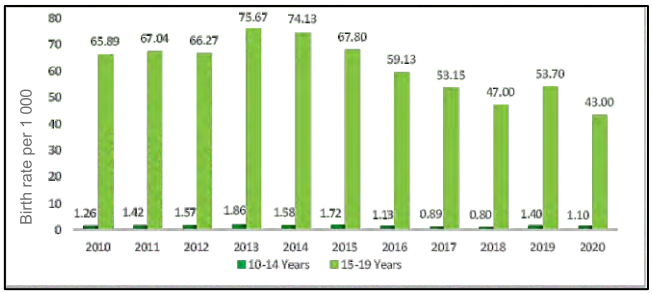
Adolescent Mothers

Adolescent mothers are those females that fall pregnant between the ages of aged 10-19[32] years.

Globally, maternal conditions are among the top causes of disability-adjusted life years (DALYs) and death among girls aged 15-19 Based on 2019 data, 55% of unintended pregnancies among adolescent girls aged 15–19 years end in abortions. Despite the medical risks, the phenomenon of adolescent mothers has social and economic consequences as well.

Globally the adolescent birth rate for girls 10–14 years in 2023 was estimated at 1.5 per 1000 women with higher rates in sub-Saharan Africa (4.4)[33]

Figure 11: Adolescent birth rate (births to women aged 10–14 years; aged 15–19 years) per 1 000 women in that age group[34]



The figure illustrates adolescent birth rate per 1 000 women in South Africa for 10–14-year-old and 15-19 years old girls. Although the birth rate for both cohorts reduced in 2017, there were an increase in 2019 to 1.4 and 53.7 births per 1000 women respectively.

Reasons for pregnancy in adolescent age group include amongst other, cases of statutory rape, or sexual relationships with elder men. The Criminal Law (Sexual Offences and Related Matters) Amendment Act (No13 of 2021), protects children, where the minimum age to consent to sex is only once they turn 16 year of age.

The Department of Women, Youth and Persons with Disabilities has developed a Programme of Action (POA) aimed at tackling the issue of teenage pregnancy by implementing a Comprehensive National Gender-Based Violence Prevention Strategy (CNPS).

Current intersectoral collaborations to mitigate teenage/adolescents' deliveries in facilities, are as follows:

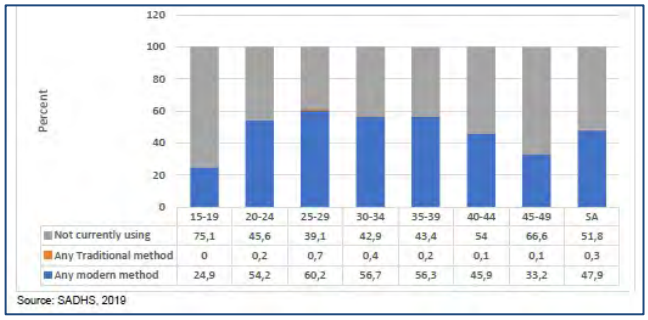
- The National Integrated School Health Programme (ISHP) Task Team, wherein DBE, DSD, DWYPD, UN agencies (WHO, UNICEF and UNFPA and now UNESCO-will be joining in 2025) as members.
- Quarterly Capacity building workshops that are conducted through the Departmental Knowledge Hub and session facilitated by DSD officials on mandatory reporting of child abuse and/or neglect to Department of Social Development Social Service Points.
- The provincial Adolescents and Youth Health programme managers embark on activation and Youth Zones in PHC facilities and have interventions geared on adolescents and youth with loveLife, Soul City and other implementing Partners.
- The South African Coalition on Menstrual Health and Hygiene Management (SACMHM) Education & Health Task Team and
- The Sanitary Dignity Programme led by DYWPD Forum

Furthermore, intersectoral collaboration is needed to reduce the rates of unwanted pregnancies.

The proportion of pregnancy rate and terminations of pregnancy (abortions) are a concern to society.

The figure below indicates the distributions of all women by any contraceptive methods currently used by age groups 15-48 years, 2016[35]

Figure 12: Use of contraceptive method by women in different age groups. (ages 15-49 years, 2016)



As noted, majority of sexually active women uses modern contraceptive methods such as injections in all the age groups and from 2018 to 2020 there has been changes in the type of contraceptives preferred. The injections are now preferred (47.9% change) over Sub-dermal contraceptive implants (-28.9% change) from 2018.

[32] Website, accessed 15 Oct 2024, https://data.unicef.org/topic/child-health/adolescent-health/
[33] WHO, Adolescent pregnancy, Website: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy, accessed 15 Oct 2024.
[34] Source: CRVS 2010-2020, Stats SA
[35] South African Demographic Health Survey, 2016 as published in The Status of Women's Health in South Africa: Evidence from selected indicators (2018)

HIV and AIDS

The country is dedicated to eradicating the AIDS epidemic by 2030, aligning with the Sustainable Development Goals (SDGs). To reach this objective, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has outlined the 95-95-95 targets. This means that 95% of individuals living with HIV should know their status, 95% of those diagnosed with HIV should be receiving antiretroviral therapy (ART), and 95% of individuals on ART should achieve viral suppression (VLS). To meet these targets by March 2030, we need to enroll 7,125,435 individuals in ART.

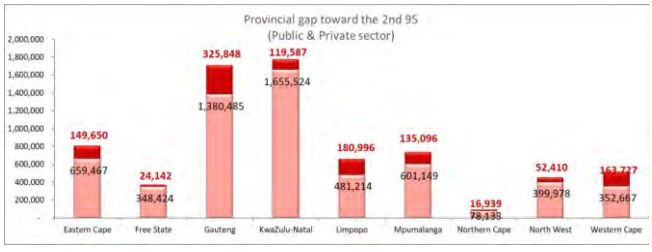
In South Africa, there are approximately 7.8 million people living with HIV. The latest progress data on the 95-95-95 National HIV treatment cascade indicates that as of July 2024, South Africa is currently achieving a status of 96-79-94 across the entire population served by both public and private sectors.

The statistics for specific sub-populations are as follows: Adult females at 96-81-94, adult males at 95-75-94, and children under 15 at 87-81-70. This shows that 76% of individuals with HIV who are aware of their status are receiving ART.

Among the provinces, Free State and KwaZulu-Natal are performing particularly well, both achieving 85% and above. To meet the 95-95-95 targets, South Africa must increase the number of individuals on ART by the following: Total clients on ART by 1,168,395; Adult females on ART by 630,788; Adult males on ART by 506,780; Children under 15 on ART by 30,827.

Amongst the provinces, Free State and KwaZulu-Natal achieved 85% and above.

Figure 13: Provincial gap towards the 2nd 95 (Public and Private sector)



The biggest gap in terms of numbers on treatment is Gauteng and Limpopo province[36].

Amongst others, the challenges for the disease burden are:

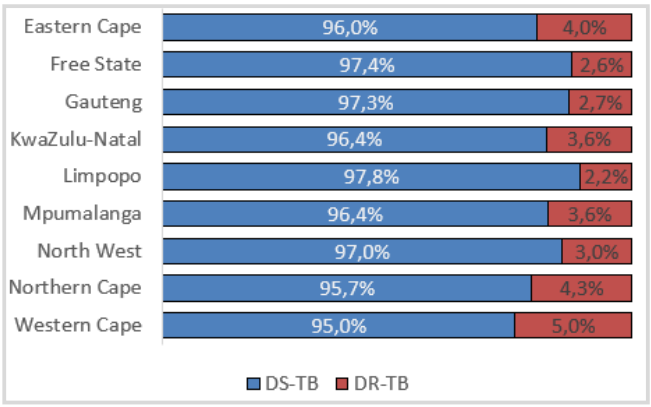
Low case finding (Mainly men and children under 15 years); poor linkage to care (Mostly men predominantly not willing to be linked to facilities); Gaps in treatment initiation and retention in care (1.1. Million Gap) with men and children bearing more proportion on treatment gap; High loss to follow-up and treatment interruptions at 6-12 months. Some of the interventions in promoting HIV testing services had been related to establishing "youth zones" for HIV self-screening services, (HIVSS) and Index testing. This allows the youth to conduct the test themselves in safe spaces where the test results can be provided by a counsellor. Through this initiative the youth is also linked to either prevention (condoms, PrEP, VMMC, abstinence) or treatment (ART and adherence counselling) services.

Apart from HIV testing and counselling, youth zones provide a preventative focus on health care, addressing issues related to NCDs, example, mental health care and obesity apart from addressing other social factors, e.g. relationship matters and preventative care. The Youth Zones are focusing on capacity building of youth through Partner intervention, focusing on youth to take an active leadership role.

Tuberculosis

An estimated 222 041 TB cases were reported in South Africa in 2023[37]. The incidence of TB has reduced significantly, more than 41% from 2015, (from 454 000 to 270 000) in 2023, however, this remains very high at 427 people per 100 000 population incidence rate. There has been a marked reduction in the number of TB deaths at 43% from 2015 to 2022. However, the number of TB deaths remained high at 56 000 in 2022. The target is to attain a 90% reduction in the number of deaths by 2030 from the 2015 baseline. The treatment success rate in 2022 was 75% for drug-sensitive TB (DS-TB) and 62% for MDR-TB (Drug Resistant TB) in 2021. The HIV-TB co-infection rate is 53% with 90% of HIV positive TB patients on antiretroviral treatment.

Figure 14: DS and DR-TB Notifications by province, 2023



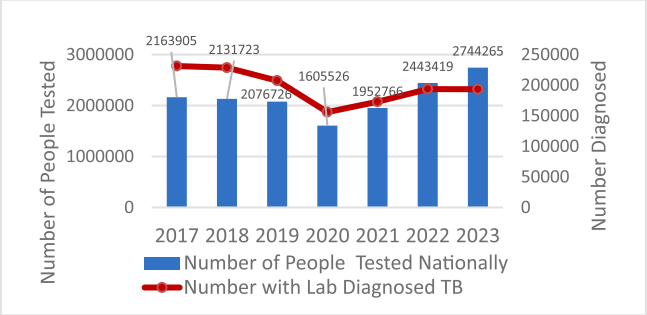
36 HIV Activities, Progress, Challenges and Opportunities, NDoH Presentation, Sept 2024.
37 WHO TB Global report, 2024

In 2022, the success rate for DS-TB varied in provinces between 61% in the Western Cape to 84% in Gauteng. None of the provinces reached the 90% set target.

The fifth National Strategic Plan (NSP) for HIV, TB and STIs NSP 2023-2028 provides the strategic framework for a multi-sectoral approach. The NSP emphasizes the need to collaborate and maximize equitable access to HIV, TB and STI services.

TB testing increased following the introduction of the Policy on Targeted Universal TB Testing in 2022. This policy recommends testing people living with HIV (PHLHIV), household contacts and people previously treated for with TB[38]. This resulted in a 32% increase in TB testing from 2019, reversed the pre-pandemic declining trend. Approximately 4.6% of people tested in 2023, 6.8% tested positive for TB.

Figure 15: Number of people tested Nationally and those Diagnosed for TB, 2017-2023[39]



TB prevention, increasing ART coverage, strengthening community outreach services to reach all communities with TB services, tracing people lost to follow up, strengthening data use at all levels and addressing social determinants of health are key in the efforts to reduce the TB disease burden.

Malaria

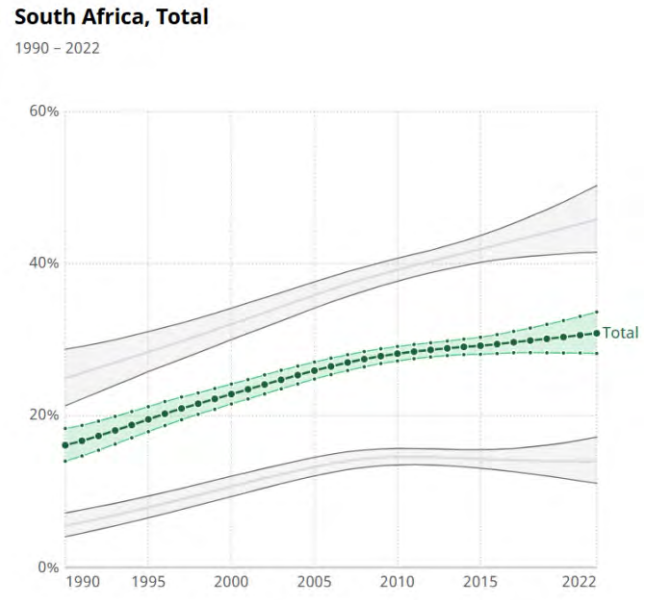
SDG goal 3.3.3. indicate that the epidemic of malaria incidence per 1 000 population must be ended by 2030.

The country report indicates progress from 0.98~1 (2015), an increase to 1.39 (2018) and the latest data shows a reduction to 0.6 (2021) malaria incidence per 1 000 population. The implementation of the foci clearing programmes plays a key role in the Malaria Elimination Strategic Plan (2019-2023)[40]. The foci programme is based on various steps namely, to investigate, trace and follow up on cases in order to treat, prevent and eliminate malaria.

Non-Communicable Diseases

SDG goal 3.4. stipulate that by 2030, premature mortality from non-communicable diseases should be reduced by prevention and treatment and the promotion of mental health and well-being[41].

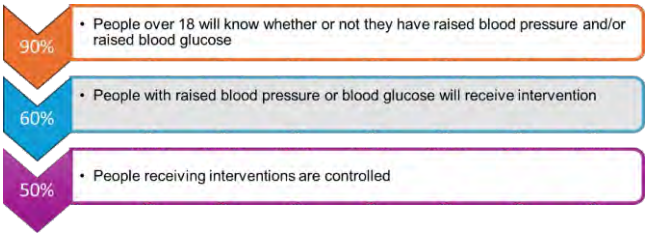
Figure 16: Age-standardized prevalence of obesity among adults (18 + years)



Data from the WHO data[42] country report on non-communicable diseases, indicates the percentage of adults in the country aged 18 and older with a body mass index of 30kg.m2 (BMI more or equal to 30), indicating obesity levels are rising. For the period from 1990-2022, according to WHO, the total percentage increase in obesity percentage was 16.1% in 1990 to 30.8% in 2022, with females at 45.8 % at 2022 and males at 13.9%.

The National Strategic Plan for Non-communicable diseases 2022 - 2027, adopted the same cascade approach as HIV and TB using the cascade as indicated below: The proposed 90-60-50 cascade for diabetes and hypertension is aimed at early detection and treatment of NCDs+ to improve outcomes.

Figure 17: NCD+ cascade for hypertension and Diabetes[42]



[38] Evaluating systematic targeted universal testing for tuberculosis in primary care clinics of South Africa: A cluster-randomized trial, Martinson, et al, 2022).
[39] Source: Bill and Melinda Gates Foundation, 2024
[40] The Malaria Elimination Strategic Plan (2019 - 2023), NDoH
[41] Sustainable Development Goals, 2030 Agenda, United Nations
[42] Sustainable Development Goals, Country Report, South Africa, StatsSA, 2023

Programmatic interventions are amongst others:

- Continue strengthening screening services through campaigns.
- Ensuring that a (Chronic) medical electronic register is made available for proper data collection at all levels.
- Promote multi-sectoral coordinating mechanism between government departments, other sectors & civil society to address the challenges.
- Use platforms like **Operation Phuthuma** that will contribute to the improved health outcomes especially in NCDs
- Expansion of the District Specialist teams to include the management of NCDs as a way of enhancing supervision and mentoring of colleagues.

Cancer

According to the Global Cancer Observatory, 2022[43] in South Africa, 120 226 total new cases of all cancer types in both genders were diagnosed, with 69 874 deaths. The top 3 leading cancers ranked by number of cases are in both sexes Breast, prostate and Cervix uteri (Cervical Cancer). The risk of dying from cancer before the age of 75 years (cumulative risk %) is higher for males at 13.2% than females at 10.4%.

Figure18: Cancer Today, South Africa, 2022, Global Cancer Observatory

	Males	Females	Both sexes
Population	34 025 573	35 166 105	69 191 678
Incidence*			
Number of new cancer cases	55 929	64 297	120 226
Age-standardized incidence rate	224.1	186.2	197.4
Risk of developing cancer before the age of 75 years (cum. risk %)	22.4	18.3	19.9
Top 3 leading cancers (ranked by cases)**	Prostate Lung Colorectum	Breast Cervix uteri Colorectum	Breast Prostate Cervix uteri
Mortality*			
Number of cancer deaths	32 842	37 032	69 874
Age-standardized mortality rate	141.2	108.4	119.0
Risk of dying from cancer before the age of 75 years (cum. risk %)	13.2	10.4	11.6
Top 3 leading cancers (ranked by deaths)**	Prostate Lung Colorectum	Cervix uteri Breast Lung	Lung Cervix uteri Prostate
Prevalence*			
5-year prevalent cases	130 881	173 475	304 356

HPV vaccination is a screening program expected to result in a significant reducing in the number of new cervix cancer diagnoses, however, opinion leaders believes that there is a need for formal proactive screening programs for most common cancers, e.g. Breast and Prostate Cancer, to avoid poorer outcomes of cancers including increasing treatment of later stage presentation of cancers.

According to experts in the field, insufficient planning and funding for infrastructure maintenance, new equipment; slow HR processes of filling of crucial posts including training staff are some of the key needs to be addressed in order to improve the management of cancers.

Mental Health

The SDG goal 3.4 refers to the prevention, treatment and promotion of mental health and well-being.

Figure 19: Suicide mortality rate, 2011 – 2018, StatsSA, 2023

In South Africa, suicide mortality rate declined from a high 1.14 per 100 000 people to 0.58 in 2018. The burden associated with mental disorders is high locally and internationally. The Global Burden of Disease Study[44] found the 12-months prevalence (the proportion of a population who have mental disorders at any point during a given period) in South Africa to be 15,9%. Depressive disorders, anxiety disorders and alcohol and other drugs-use disorders are the most common mental disorders in South Africa. Emotional and behavioral disorders and post-traumatic stress disorders are also prevalent among adolescents. WHO estimates indicates that suicide mortality rate per 100 000 population for both genders in South Africa is at 23.5, with females at 9.8 and males at 37.6

The South African mental health legislation and policy propagates for integration of mental health into the general health services environment through strengthened mental health services delivery at community, primary health care and general hospitals to reduce the treatment gap, facilitate holistic care, reduce stigma and promote human rights. However, recent studies and reviews have found that there is continued overreliance on institutional care. Child and adolescent mental health services are lacking while an increasing number of people are accessing the mental health system through the criminal justice after they have

[42] Data sourced from NCD NSP 2022-2027, NCD presentation, NDoH
[43] 2022 Global Cancer Observatory: Cancer Today. Lyon, France: International Agency for Research on Cancer. Available from: https://gco.iarc.who.int/today, accessed [14Oct 2024].
[44] Global Burden of Disease Study 2017 (GBD 2017). 2018. Results [Internet]. Institute for Health Metrics and Evaluation (IHME). http://ghdx.healthdata.org/gbd-results-tool-accessed November 2018

relapsed and committed crimes resulting in forensic mental enquiries and State patients' backlogs. There is also a high readmission rate which further add strain on the mental health services.

The National Mental Health Policy Framework and Strategic Plan 2023-2030 packages interventions that must be implemented to reduce the burden associated with mental health conditions, increase access to mental health services and also contributes to the SDG goal 3.4 referring to prevention, treatment and promotion of mental health and well-being.

Disability and Rehabilitation Services

The countries' disability and rehabilitation services are based on global frameworks and international instruments such as the UN Convention on the Rights of Persons with Disabilities (UNCRPD). The White Paper on the Rights of Persons with Disabilities was put into effect to improve the realisation of the rights of persons with disabilities. Progress made with the improvement of the realisation of the rights of persons with disabilities are provided to the Department of Women, Youth and

Persons with Disabilities

The National Disability Rights Machinery (NDRM) is a structure that emanated from the White Paper on the Rights of Persons with Disabilities. The NDRM has biannual meetings that provides a platform to track the implementation of the White Paper on the Rights of Persons with Disabilities and to discuss interventions to accelerate the implementation of the white paper. The National Department of Health is in the process of establishing an interim working group as a coordinating structure to fast track the progress made with improving the realisation of the rights of persons with disabilities.

The World Health Organisations' World Disability Report (2010) identified service delivery gaps which includes limited access to assistive technology and in they have placed emphasis on improving access to assistive technology in their action plan. The department was part of a task team that was set up by the Department of Basic Education to explore the status of the provisioning of assistive devices (wheelchairs; spectacles; hearing aids) to learners with disabilities. Most provinces indicated a backlog on the provisioning of assistive devices with the reasons being lack of funding for these services. While transversal contracts are in place for these critical devices to make the procurement process easier, the timeously renewal of these contracts were a challenge. Human Resources are also a major challenge with lack of specialised positions such as eye specialists and audiologists.

The following Strategic Frameworks that will improve access to rehabilitation services, need to be in place: National Framework and Strategy for Disability and Rehabilitation services; Strategy on the Screening of Childhood Hearing; and a National Framework and Strategy for Eye Health Care.

7.1.3. Service Delivery Platform

District health system

The District Health System (DHS) is a central pillar of the health system where most contact with service users takes place. The DHS platform provides an interface for individuals, households as well as communities. As the country is well on its way to achieving Universal Health Coverage, community-based services are a critical enabler of this realization where access for all people who needed health services with no financial hardship is essential. Community-based services enable comprehensive response to community needs through Primary health care, community outreach programmes, school health and environmental health. The district health system will be capacitated in the planning aspect to strengthen alignment with National and Provincial plans for effective implementation of sector priorities.

Hospital System

The ongoing hospital reforms are critical to address the lack of uniformity in planning, resource allocation and priority-setting in provinces which leads to under development of hospital services in some areas resulting in inefficient operational management and poor health outcome[45]. To address these challenges, various interventions are being implored to improve hospital management, governance and leadership, promote efficiencies in delivery of care and improve quality of care rendered.

Human Resources for Health

The health workforce remains the backbone of service delivery. Human Resources for Health (HRH) Strategy sets out the overall vision, goals and actions required to address persistent issues of inequity and inefficiencies

[45] The South African Health Reforms 2009-2014

in the health workforce. The goals of the strategy are as follows:

- Effective health workforce planning to ensure HRH aligned with current and future needs
- Institutionalise data-driven and research-informed health workforce policy, planning, management and investment
- Produce a competent and caring multi-disciplinary health workforce through an equity-oriented, socially accountable education and training system
- Ensure optimal governance, and build capable and accountable strategic leadership and management in the health system

There is notable improvement in the availability of Human Resources for Health, e.g. Medical doctors per 100,000 increased from 21.9 per 100, 000 in 2000 to 32.6 per 100, 000 in 2022. Pharmacists increased from 3.1 to 11.1 per 100,000 and professional nurses' categories also expanded.[46] The HRH interventions in the medium term will focus on promoting equity in distribution of health professionals.

Health Infrastructure

Appropriate health infrastructure is crucial to create an inducive environment for quality healthcare and workspace for workers. Despite the improvements made in infrastructure, maintenance repairs to health facilities remain a challenge in most provinces. Pillar 3 of the Presidential Health Compact commits towards execution of the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities. One of the interventions for the realisation of this commitment is to explore innovative financing options for infrastructure development and maintenance. The health facility revitalisation grant is the largest source of funds for public health infrastructure, which is aimed at accelerating construction, maintenance, upgrading and rehabilitation of new and existing infrastructure including technology. Monitoring and oversight activities are carried out to enhance capacity for delivery of infrastructure.

Health Technology and Innovation

In response to the demand of healthcare within the socio-economic challenges, the delivery of healthcare requires reforms to enable improving the quality of care through optimisation and digitilisation of health systems aimed at improving diagnostics and treatment, improved disease management and enhance patient's experience.

The Science, Technology and Innovation Decadal Plan, addresses the priority areas for health innovation, which include: Strong support for research, development of therapeutics, diagnostics and devices and digital health. The South African Medical Research Council, an entity of the department, is a key role player in the health innovation space through research projects informing improvements in diagnostics and treatment. Additionally, the department has started a process of development of an electronic medical record which will introduce a single record for patient to enable improved access to patients records which is essential for continuity of care and reduce inefficiencies as a result of duplication of services rendered to patients.

The Health Patient Registration system (HPRS) is a software that enables registration of patients, by health facilities where patients can be traced by a unique identifier. In this financial year HPRS will be expanded to more facilities.

Nursing Services

The nursing programme develops, guides and monitors the implementation of a national policy framework for the development of required nursing skills and capacity to deliver effective nursing services to healthcare users.

The focus is on ensuring consistent supply of adequate numbers of nursing professionals with required skills mix to contribute to the goal of long and healthy life for all. Requisite clinical training platforms for all nurses following the new nursing curriculum were re-introduced in facilities accredited as public health facilities. Thus, promoting access to facility based clinical training opportunities for nursing students studying in public colleges and universities in the private sector. These Clinical Education and Training Units (CETU) have been appropriately equipped as platforms for rolling out of Continuing Professional Development (CPD) programmes for nurses, midwives and nurse specialists. In addition, a framework to ensure ongoing competence for in-service nurse practitioners strengthening their capabilities in all areas of expertise including clinical care, leadership and management, ethics and professionalism was developed. Finally, the shortage of nurses was quantified, by category, and

[46] DPME. Synthesis Report on the implementation and impact of government programmes in South Africa

demographically. This exercise will inform forecasting, posting, retention and education and training strategies.

Access to medicine and other commodities

Access to medicine has improved through various strategies including the introduction of the Centralised Chronic Dispensing and Distribution Programmes (CCMDD), which enable collection of medicine parcels for stable chronic patients at a Pick-up Point of their choice thereby reducing congestion at health facilities. Additionally, the Differentiated Model of Care (DMOC) programme provides a similar platform where HIV clients are able to collect medicines at Facility Pick-Up-Points, Adherence clients and External Pick-Up points, which expand the medicine dispensing platform promoting adherence to treatment. With respect to medicine stock management, the implementation of a Stock Visibility System (SVS) which has been largely a success, has led to a reduction in stock-outs and reduced pressure at facilities. A key challenge during implementation largely relates to constraints around personnel capacity, where there has been a substantial lack of Pharmacy Assistants in facilities to drive SVS.

The sector will be implementing strategies to improve the availability of medical equipment which is affected by a myriad of challenges owing to the laborious process related to procurement. The interventions will be aimed at stabilising the supply of equipment to health facilities and improving quality of equipment.

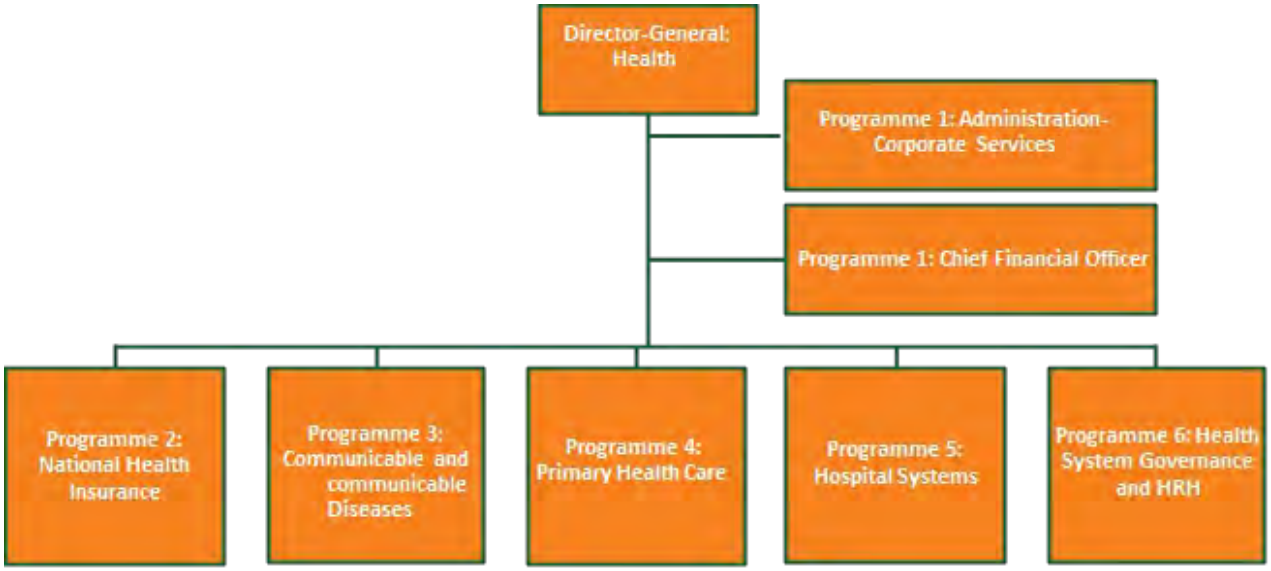
Quality of care and health system improvement

Delivering high-quality healthcare services is a critical aspect for the implementation of the National Health Insurance. Through the quality improvement initiatives such as the ideal facility realisation programme, the department aims to ensure that all health facilities participate in a quality improvement programme which will facilitate compliance with the norms and standards regulations by the Office of Health Standards Compliance (OHSC). Additionally, an effective complaints management programme by health facilities enables the sector to address quality challenges to improve health outcomes. Patient experience of care surveys is another platform that is utilised by the sector to get feedback related to the quality of care from the client's perspective. Quality is a cross-cutting enabler for the provision of care, as well as the health sector investment in the improvement of health infrastructure, equipment, human resources and information system, is essential in improving access to quality healthcare, the experience of care by clients and overall better health outcomes.

7.2. Internal Environment Analysis

7.2.1. Organisational Structure

The budget programme structure shown below, depicts the organisational structure of the National Department of Health. The Department's organisational structure, which was endorsed by DPSA in 2012, is currently under review.



7.2.2. Personnel Information

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 2025		Number and cost[2] of personnel posts filled/planned for on funded establishment													Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate								
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
Health			**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**		
Salary level	**987**	**52**	**858**	**614.9**	**0.7**	**914**	**694.1**	**0.8**	**920**	**744.3**	**0.8**	**910**	**779.4**	**0.9**	**898**	**815.3**	**0.9**	**-0.6%**	**100.0%**
1 – 6	287	32	281	93.8	0.3	281	98.1	0.3	275	102.8	0.4	269	106.0	0.4	260	108.7	0.4	-2.5%	29.8%
7 – 10	371	5	334	222.9	0.7	345	240.5	0.7	351	260.5	0.7	348	273.7	0.8	347	287.6	0.8	0.2%	38.2%
11 – 12	197	7	141	152.2	1.1	176	190.8	1.1	183	207.3	1.1	184	220.2	1.2	184	231.6	1.3	1.4%	20.0%
13 – 16	130	8	100	140.8	1.4	110	159.2	1.4	109	167.8	1.5	106	173.3	1.6	105	180.9	1.7	-1.6%	11.8%
Other	2	–	2	5.3	2.7	2	5.6	2.8	2	5.9	3.0	2	6.2	3.1	2	6.6	3.3	0.0%	0.2%
Programme	**987**	**52**	**858**	**614.9**	**0.7**	**914**	**694.1**	**0.8**	**920**	**744.3**	**0.8**	**910**	**779.4**	**0.9**	**898**	**815.3**	**0.9**	**-0.6%**	**100.0%**
Programme 1	425	23	389	266.1	0.7	362	255.8	0.7	354	267.5	0.8	350	279.8	0.8	344	292.5	0.8	-1.7%	38.7%
Programme 2	110	15	76	57.9	0.8	114	93.5	0.8	120	104.1	0.9	120	109.7	0.9	120	115.3	1.0	1.8%	13.0%
Programme 3	177	1	151	121.1	0.8	162	141.8	0.9	160	149.8	0.9	160	156.7	1.0	158	163.8	1.0	-0.8%	17.6%
Programme 4	74	13	63	43.2	0.7	88	62.0	0.7	92	68.4	0.7	90	71.6	0.8	88	74.8	0.8	0.1%	9.8%
Programme 5	33	–	29	25.1	0.9	33	30.0	0.9	34	32.3	0.9	34	33.7	1.0	33	35.3	1.1	-0.1%	3.7%
Programme 6	168	–	150	101.6	0.7	155	111.0	0.7	159	122.2	0.8	157	127.9	0.8	154	133.6	0.9	-0.3%	17.1%

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

2. Rand million.

7.2.3. Diagnosis - PESTEL

Political factors	The medium-term planning environment happens at the time when the Administration is constituted by various political parties in the form of the Government of National Unity. The National Health Insurance Act was assented in May 2024 paving the way for implementation of reforms towards universal health coverage to address the inequities to accessing health care in the country. Both the National Health Act and National Health Insurance Act are the two enabling legislatives for the sector and key regulations to give effect to the much-needed reforms for the implementation of the NHI. The NHI enjoys political commitment from the Presidency and the Ministry.
Economic factors	The sector is confronted with budget cuts which are further compounded by high medical inflation (medicines and equipment), due to foreign exchange, and payment of medico-legal claims which negatively affects the provision of essential services. The sector is currently exploring various mitigation strategies which include review of resource allocation (equitable share), improving revenue collection and strengthen financial reporting, monitoring and accountability.
Social factors	Social determinants namely, low levels of income, access to housing, suboptimal food environment, high levels of alcohol and substance abuse, low levels of social cohesion, access to clean water and sanitation are contributory to premature mortality as they predispose communities to ill health and negatively affect recovery from diseases. Patient Centered Care approach advocates for better through better coordination in communities and stakeholder engagements to encourage concerted efforts in addressing the social determinants as well as advocate for behavioral change for health, prevent diseases and delay progression if already diagnosed. Additionally, high youth unemployment presents an added risk to ill-health due to exposure to poverty, substance abuse and mental health conditions.
Technological factors	Current challenges include inadequate ICT infrastructure across the sector. Advancement in technology requires departments to leverage ICT capabilities for improved operations. The sector utilizes various digital platforms to improve access to services. The NDoH will embark on Enterprise Architecture development to ensure that the ICT infrastructure is Fit-for-purpose and aligns ICT strategy to business goals, integration of systems, leverage on emerging technologies, as well as strengthening cyber security within the department.
Environmental factors	District municipalities have the responsibility to ensure that environmental norms and standards are upheld. Recently communities have been faced with incidents of Food-borne illness, the sector in collaboration with stakeholders conducted investigation into the outbreak of food related poisoning. Insufficient human resource capacity at municipalities to conduct inspections, were noted to be contributory to a high incidence of foodborne illnesses. To strengthen environmental safety in communities, the department will embark on improving the approach to the oversight assessments conducted for compliance with environmental health norms and standards. Emerging pathogens have emphasized more focus on Preparedness and Resilience for Emerging Threats, which has led to the launch of PRET by WHO for countries to strengthen their existing systems and capacities, avoid silos and promote coherence and efficiency in time of pandemic.
Legal factors	The management of Medico-legal claims in provinces requires drastic improvement in a holistic approach as the cost of medical litigation remains on the rise and affects the provision of essential services. Measures to strengthen the handling and management of Medico-Legal Claims include the establishment of enabling legislation with the provision of future medical treatment, the implementation of the Case Management System and capacity building for provision to make use of the mediation process.

7.2.4. Employment Equity

The Department has made progress towards in response to the employment equity targets for Women, Youth and People with Disabilities. Challenges include financial constraints, delays in recruitment processes, unique challenges related to people with disabilities i.e., non-disclosure of disability on application forms and suitability of candidates. The department is responding to the evaluation of Gener Sensitive Policies.

Since the democratic era, the health sector has undergone several reforms to establish a more equitable, accessible and affordable healthcare system, that can meet the health needs of all South African residents. The Department of Health has already adopted several policies, strategies and programs that include gender equality for health equity as a principle, strategic objective or outcome. Some of the policies include National Integrated Sexual and Reproductive Health and Rights Policy 2019 and National Adolescent and Youth Health Policy 2017.

The table below reflects current programmes led by the programs:

PROGRAM	YOUTH DEVELOPMENT AREA
Internship Programme	Youth are provided with experiential training in the workplace.
Skills Development	Interns are enrolled into a skills programme to enhance their skills in the workplace.
HIV and AIDS	HIV Youth Program
Child, Youth and School Health	Adolescent and Youth Health
Child, Youth and School Health	Integrated School Health
Human Resource Development	Young Professionals including Cuban Doctors recruitment
Employment Equity	Data on Youth Employment

Part C: Measuring Our Performance

Part C: Measuring Our Performance
8.Institutional Performance Information

8.1. Measuring the Impact

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

8.1. Measuring Outcomes

Medium Term Development Plan Priority: Pursue achievement of universal health coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care.			
Outcomes	**Outcome Indicators**	**Baseline**	**Five-year targets (2029/2030)**
1.Financial management strengthened in the health sector	**1**.Audit outcome for the National Department of Health	Unqualified audit opinion Received for 2023/2024 FY	Unqualified audit opinion
2.Improved access to equitable healthcare services	**2**.Ministerial Advisory Committee on Health Care Benefits established *(MTDP)*	National Health Insurance Act assented to in May 2024	Benefits Advisory committee established under the NHI fund
	3.Ministerial Advisory Committee on Health Technology Assessment established (*MTDP)*	Health Technology Assessment Technical Working Group (TWG) established	Health Technology Assessment functional
3.National Health Insurance awareness improved	**4**. Number of NHI Media Adverts placed per year	NHI Media (SABC adverts, Billboards, Digital screens (airports and malls), Bus wraps, Flyers) Communication coverage	50 NHI Media Adverts
4.Governance of Public Entities strengthened	**5**.Audit outcomes for public entities	2 public entities with clean audit opinion for 2023/2024 FY	At least 2 public entities receive clean audit opinion, and 4 public entities obtain an unqualified audit opinion

Explanation of Planned Performance over the Five-Year Planning Period

The implementation of National Health Insurance is a key priority of the sector which will drive the reduction in inequities and financial hardship associated with seeking care. The National Health Insurance Act makes provision for the establishment of two Ministerial Advisory Committees (MACs) with the focus on determining the health care benefits to be covered under the NHI as well as mechanisms to ensure that medical interventions are subjected to an assessment process in order for NHI to cover interventions that are cost-effective (value for money) and derived the greatest health benefits(produce the best result) for the population thus ensuring that South African live a long and healthy life.

The health system strengthening reforms will focus on strengthening leadership, governance and health financing, with sector financial management being an imperative in light of NHI reforms which will introduce decentralized models through cost centers at districts. The respective mandates of the public entities are central to improve quality of healthcare, thus the governance of these important bodies is crucial in closing the existing gaps to access and quality of care, as well as to contribute to overall to the implementation of NHI. There is an opportunity to widely improve awareness on NHI, with the focus on improving the knowledge on the intended benefits to counter the misinformation in the public domain.

Medium Term Development Plan Priority: **Strengthen the primary health care (PHC) system by ensuring that home and community-based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative care services required for South Africa's burden of disease**			
Outcomes	**Outcome Indicators**	**Baseline**	**Five-year targets (2029/2030)**
5.Improved responsiveness to community needs	**6**.Number of community outreach services visits to households per year	14 million	15 million
	7.Number of Community engagements on health programmes per year	2	2
	8.Number of Visits to health facilities per year	8	10
6.Reduced Burden of Disease	**9**.Number of screenings for elevated blood pressure per year	32 million	45 million
	10.Number of screenings for elevated blood glucose per year	31 million	43 million
7.HIV and AIDS related deaths reduced	**11**.Proportion of people living with HIV who know their status *(MTDP)*	96%	96%
	12.Percentage of People Living with HIV on ART *(MTDP)*	79%	95%
	13.Percentage on ART with viral suppression *(MTDP)*	94%	95%
8.TB mortality reduced	**14**.Number of people started on TB treatment per year	160 000	150 000
	15.Drug Resistant-TB (DR-TB) treatment success rate	61%	78%
	16.Drug Susceptible-TB (DS-TB) treatment success rate *(MTDP)*	75%	85%
9.Malaria related deaths reduced	**17**.Number of Malaria endemic sub-districts implementing foci clearing programme	10	30
10.Mortality due Cervical Cancer reduced	**18**.Number of Districts performing HPV Screenings for Cervical Cancer	18 districts	52 districts
11.Improved maternal and child health	**19**.Maternal Mortality ratio *(MTDP)*	109.6 deaths per 100 000 live births	70 deaths per 100 000 live births
	20.Under 5 mortality rate *(MTDP)*	28.6 deaths per 1000 live births	25 deaths per live births
12.Improved access to School Health Programme	**21**.Number of Grade R leaners screened *(MTDP)*	115 097	800 000
13.Improved access to Youth Health Programme	**22**.Number of Primary Health Care facilities with Youth Zones	2101	2600
14.Mental health care integrated in Primary Health Care	**23**.Proportion of community health centres with at least one mental health care provider appointed (*MTDP)*	New Indicator	75%
	24. Mental Health Care Amendment Act	Mental Health Care Act (Act No 17 of 2002)	An amendment Mental Health Care Act
15. Early warning and integrated disease surveillance and response strengthened	**25**.Number of districts implementing Event - Based Surveillance (EBS)	3	30

Explanation of Planned Performance over the Five-Year Planning Period

Key to the sector's achievement on envisaged outcomes is the reduction of the burden of disease which requires focusing on the population's demography and epidemiology, which provides a profile of the population disease profile. The outcomes that are identified are aimed at preventing and prioritising illnesses and conditions that contribute to mortality and morbidity of the population. HIV/AIDS, TB, Malaria, Non-communicable diseases such as hypertension, diabetes and malaria amongst others contribute significantly to the morbidity and mortality in the country. The interventions are thus aimed at reducing the prevalence of diseases by ensuring that most people get tested or screened for diseases and conditions for early detection and prevention. Those who are found to have diseases are linked to treatment to prevent morbidity and reduce mortality, ensuring that the population have a long healthy life and thus increasing the life expectancy. By aiming for these outcomes, i.e., reducing deaths related to HIV, AIDS, TB, Malaria, non-communicable diseases, improving child and maternal health to prevent ad reduce preventable causes of deaths, which results in positive gains life expectancy.

Additionally, interventions such as Youth and School health programmes are aimed at promoting health in targeted settings in order to expand health services beyond health facilities and ensure that those who need health intervention receive it timeously. The sector will also increase the capacity to cater for mental health care users in line with the demand for mental health services at Primary Health Care, which is in line with the National Mental Health Policy Framework and Strategic Plan. The integration of mental health within the primary health care is key in preventing severity of mental conditions (morbidity) in communities that will require more expensive specialized care at higher levels of care. Furthermore, responding to the demand of care contributes to the reduction to premature mortality which is as a result of patients not accessing care at the time of need.

Medium Term Development Plan Priority: **Improve the quality of health are at all levels of the health establishments, inclusive of private and public facilities**			
Outcomes	**Outcome Indicators**	**Baseline**	**Five-year targets (2029/2030)**
16.Improved access to safe and quality healthcare	**26**.Number of facilities that qualify as ideal clinic per year	2700	2900
	27.Number of hospitals assessed for compliance with food service policy per year	70	391
17. Enabling legislation for effective service delivery	**28.** Inquests Amendment Bill developed	Inquests Act 58 of 1959	Inquest Amendment Bill finalised

Explanation of Planned Performance over the Five-Year Planning Period

Improving quality of care in all health establishments is one of the prerequisites for the implementation of the NHI. Under the NHI, health establishments must comply with the prescribed norms and standards. Establishments participate in the ideal facility programme to facilitate compliance in preparation for participation in the NHI. The ideal programme is a key quality improvement initiative which enables continuous improvement and identification of gaps in provision of care which may require to be addressed by different sector stakeholders. An additional mechanism which enables the provision of quality health care is compliance with food service policy in hospitals, ensuring that patients are provided with nutritious, healthy meals that contribute towards recovery and improved wellbeing.

[1] StatsSA, 2024

Medium Term Development Plan Priority: Improve resource management by optimizing human resources and healthcare infrastructure and implementing a single electronic health record			
Outcomes	**Outcome Indicators**	**Baseline**	**Five-year targets (2029/2030)**
18.Employment in line with equity targets	**29**.Percentage of women employed in senior management (SMS)employed at NDoH in line with equity targets	45%	50%
	30.Percentage of Youth employed at NDoH in line with equity targets	7.2%	30%
19.Equitable distribution of health professionals to health facilities	**31**.Number of district hospitals implementing the Framework for distribution of multidisciplinary teams of health professionals *(MTDP)*	Inconsistent distribution of Multi-disciplinary Teams of Health Professionals among district hospitals	179
20.Integrated electronic health record	**32.** Shared Health Record Digital Platform	Electronic Medical Record -Minimum Viable Product 1(HIV and TB Modules) developed	Shared Electronic Health Record Developed
21.Health infrastructure optimised for the delivery of care	**33**.Number of Public Health facilities maintained, repaired or refurbished per year *(MTDP)*	299	500

Explanation of Planned Performance over the Five-Year Planning Period

The sector will work towards driving equitable distribution of human resources in health establishments based on service delivery needs. This will be achieved through ensuring a framework which guides the skill mix of health professionals for district hospitals. District hospitals are the cornerstone of delivery of hospital services in local communities and thus the provision of the right mix of skills will ensure that the sector respond adequately to community needs, reducing prolonged hospital stay and the need to refer patients between facilities. The framework will facilitate the improved distribution of professionals in district hospitals, ensuring that the benefit package in district hospitals align with the requirements of the National Health Insurance.

The implementation of an integrated electronic health record will be accelerated to enable better management of patient records, improving patient referrals and continuity of care. This will result with improved access to patient information as the patient moves through the system, preserving the medical history for patients to be accessed by health care providers through the course of life. Health infrastructure maintenance remains key to ensuring that the facilities enable appropriate delivery of care. Health facility revitalisation, construction and maintenance is a continuous effort to ensurethat the facilities are fit-for-purpose and align with requirement to uphold provision of quality health care.

9. Key Risks

	Outcomes	Key Risks	Risk Mitigations
1	Financial Management strengthened in the health sector	Budget cuts which result in insufficient budget for essential services	Effective collaboration with National Treasury on Budget Review Sessions with Provincial Departments
2	Improved access to equitable healthcare services	Delays in the implementation of the National Health Insurance	Facilitate and accelerate National Health Insurance by implementing provisions that are within the competency of the National Department of Health
3	National Health Insurance awareness improved	Diminishing public trust due to information asymmetry on National Health Insurance purpose and benefits	Effectively implement the National Health Insurance communication plan in all sectors of society, with appropriate messaging tailored for targeted sectors
4	Governance of Public Entities strengthened	Delays in processes for finalization for appointment of boards for entities and councils	Expedite administrative process to ensure that all boards are appointment prior to expiry of term of office
5	Improved responsiveness to community needs	Reduced household services due to diminishing resources	Promote a coordinated and functional community outreach through CHWs
6	Reduced burden of disease	Poor coordination/integration of community-based services	Continuous capacity building for Community Health Workers to identify patients requiring referrals to be linked to o care
7	HIV and AIDS related deaths reduced	Poor linkage to care	Target specific (Men, Youth and Children), through community and formal structures to increase number of HIV clients on ARTs
8	TB Mortality reduced	Fewer patients tested for TB	Accelerate testing for vulnerable groups through targeted testing
9	Malaria related deaths reduced	Inadequate capacity in local areas to expand the foci malaria clearing programme	Continuous capacity building for effective implementation of foci clearing programme
10	Mortality due to Cervical Cancer reduced	Low uptake of HPV screening	Expand the HPV vaccination programme in order to vaccinate 90% of girls 9 – 15 years old
11	Improved maternal and child health	Slow progress in achieving the targets for reduced mortality	Promote 'whole sector approach' to tackling preventable causes of maternal and child health
12	Improved access to School health programme	Inadequate resources to expand screening for Grade R leaners	Strengthening stakeholder collaboration to leverage resources for expansion of screening
13	Improved access to Youth health programme	Primary Health Care of infrastructure not conducive to enable activation of Youth Zones	Collaborate with all relevant stakeholders to determine facilities that are ready to accommodate Youth Zones for expansion
14	Mental Health Care integrated in Primary Health Care	Slow progress in contracting mental health care providers at primary health care	Strategic purchasing of services from healthcare providers
15	Early warning and integrated disease surveillance and response strengthened	Inadequate capacity at district to implement Event-Based Surveillance	Targeted capacity building by transferring resources where most required in line with implementation of EBS
15	Improved access to safe and quality healthcare	Health establishment not adequately prepared for certification by the Office of Health Standards Compliance	Establish monitoring mechanisms and partnerships with private sector for capacity building
17	Enabling legislation for effective service delivery	Delays in processes outside the control of the department	Expedite internal administrative process to facilitate the finalization of the amendment bills
18	Employment in line with equity targets	Targets for employment for targeted groups are not achieved due to inability to fill replacement posts as all vacancies must undergo a reprioritization process	Reprioritized posts to target Women, Youth and people living with disabilities where appropriate
19	Equitable distribution of health professionals to health facilities	Poor implementation of Human Resources for Health policies	Strengthening accountability mechanism to ensure that national policies to improve human resources for health are implemented by provinces
20	Integrated electronic health record	Lack of financial resources required to accelerate the development of electronic health record	ICT infrastructure strategic purchasing
21	Health infrastructure optimised for delivery of care	Lack of capacity at local level to keep up with the demand for maintenance of health facilities	Regular project monitoring and reporting to facilitate timeous delivery of projects deliverable

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.	a. Regulating entities in compliance with National Policy, the Medical Schemes Act and other legislation b. Stakeholder engagement at local, regional and international level c. Good governance and ethical leadership d. To encourage risk pooling and innovation for the effective functioning of the private healthcare financing sector e. Conducting policy-driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry
Mines and Works Compensation Fund	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 dependents.	a. Ensure the effective and efficient management of the Compensation Commissioner for Occupational Diseases (CCOD)
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. The entity's specialised divisions include the National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry and the Anti Venom Unit.	a. An efficient and Effective Organisation b. Modernised Laboratory Service c. High-quality services d. Performance Driven Organisation e. Adequate and Suitably Qualified Workforce f. Sustain a financially stable organisation g. Good Governance
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.	a. Highly effective and financially sustainable OHSC b. Increased communication initiatives in profiling OHSC programmes c. Improved inspection coverage of Health Establishments d. Improved quality of healthcare services and patient safety through the implementation of Ombuds recommendations e. Improved access to health care services through registering and profiling of health facilities f. Enhanced public trust in the safety and quality of healthcare services
South African Health Products Regulatory Authority	The South African Health Products Regulatory Authority (SAHPRA) 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.	a. Effective compliance, financial and performance management b. Financial sustainability achieved c. Responsive to stakeholder needs d. A positive and enabling working culture created e. Attract and retain talent f. Digital transformation g. Efficient and effective regulatory practices maintained
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)	a. To ensure good governance, effective administration and compliance with government regulations b. To promote the organisation's administrative efficiency to maximise the funds available for research, capacity development and innovation c. To produce and promote scientific excellence and the reputation of South African health research d. To provide leadership in the generation of new knowledge in health e. To provide funding for the conduct of health research f. To support the development of innovations and technologies aimed at improving health g. To develop innovations and technologies aimed at improving health h. To enhance the long-term sustainability of health research in South Africa by providing funding and supervision support for career development and/or institutional research capacity development i. To facilitate the translation of health research

Part D:
Technical Indicator Description (TIDS)

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	Outcome Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumption	Disaggregation of Beneficiaries	Spatial Transformation	Desired Performance	Indicator Responsibility
1	Audit outcome for the National Department of Health	Audit opinion received for the period under review	Auditor General's Report confirming audit outcome	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Clean audit opinion	Chief Financial Officer
2	Ministerial Advisory Committee on Health Care Benefits established	The Ministerial Advisory Committee on Health Care Benefits for National Health Insurance, established in line as prescribed by the NHI Act	Terms of Reference for MAC; Call for nominations for MAC members, letters of appointment	Not Applicable	Process will not be delayed by legal challenges	Not Applicable	Not Applicable	MAC on Health Care Benefit established	DDG: National Health Insurance
3	Ministerial Advisory Committee on Health Technology Assessment established (MTDP)	The Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance, established in line as prescribed by the NHI Act	Terms of Reference for MAC; Call for nominations for MAC members, letters of appointment	Not Applicable	Process will not be delayed by legal challenges	Not Applicable	Not Applicable	MAC on Health Technology Assessment established	DDG: National Health Insurance
4	Number of NHI Adverts placed per year	Various communication channels or media to promote or raise awareness about NHI. Media Adverts are produced in Print, Broadcasting, outdoor, vehicle branding and digital	Reports detailing the number of NHI medial Adverts placed	Number of NHI Media placed per year	Not Applicable	Not Applicable	Not Applicable	Higher number of NHI Media Adverts placed	DDG: National Health Insurance
5	Audit outcomes for public entities	Audit opinion for public entities for the period under review	Auditor General's Report for public entities confirming audit outcome	Not Applicable	Not Applicable	Not Applicable	Not Applicable	At least 2 public entities receive clean audit opinion, and 4 public entities obtain an unqualified audit opinion	DDG: Health System Governance and Human Resources for Health
6	Number of community outreach services visits to households per year	Household visited by Community Health Workers (CHWs) first and follow up visits	DHIS	Number of households visited by CHWs	Accurate records provided by PHC Facilities	Not Applicable	All Districts	A higher number of household visits by CHWs	DDG: Primary Health Care
7.	Number of community engagements on health programmes per year	Health community engagements on Health Programmes conducted by the NDOH/ Minister/ Deputy Minister to engage communities in relation to health service delivery	Photos, media statements and newsletter articles	Total number of health community engagements conducted	No Denominator	Photos, media statements and newsletter articles	Accuracy of reporting	Not Applicable	DDG: Primary Health Care
8	Number of visits to health facilities per year	Visits to health facilities by the NDOH/ Minister/ Deputy Minister/ DG/DDGs to observe service delivery	Photos, media statements and newsletter articles	Number of visits done by NDOH Minister/ Deputy Minister/ DG/DDGs to observe service delivery	No Denominator	Photos, media statements and newsletter articles	Availability of Officials to conduct visits	Not Applicable	Head of Corporate Services
9	Number of screenings for elevated blood pressure per year	Number of screenings conducted for early detection and prevention of high blood pressure	DHIS	Number of screenings conducted for Hypertension	Availability of resources	Not Applicable	All Districts	Higher number of screenings conducted	DDG: Primary Health Care

	Outcome Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumption	Disaggregation of Beneficiaries	Spatial Transformation	Desired Performance	Indicator Responsibility
10	Number of screenings for elevated blood glucose per year	Number of screenings conducted for early detection and prevention of Diabetes	DHIS	Number of screenings conducted for Diabetes	Availability of resources	Not Applicable	All Districts	Higher number of screenings conducted	DDG: Primary Health Care
11	Proportion of people living with HIV who know their status *(MTDP)*	Proportion of clients who have HIV and tested positive for HIV	DHIS and Stats SA	Numerator: Clients who tested positive for HIV Denominator: All HIV Positive clients (estimation)	Accurate records provided by PHC Facilities; Correct estimation of all clients living with HIV	HIV and AIDS clients	All Districts	A higher number of clients knowing their HIV status	DDG: Communicable and Non-Communicable Diseases
12	Percentage of people Living with HIV on ART *(MTDP)*	Percentage of clients tested positive for HIV on ART	DHIS	Numerator: Number of HIV clients on ART Denominator: Total clients who tested positive	Accurate records provided by PHC Facilities	HIV and AIDS clients	All Districts	A higher number of clients who are positive for HIV and know their status are on ART	DDG: Communicable and Non-Communicable Diseases
13	Percentage on ART with viral suppression *(MTDP)*	Percentage of clients on ART that are virally suppressed according to WHO guidelines	DHIS	Numerator: Number of clients who are virally suppressed Denominator: Total clients on ART	Accurate records provided by PHC Facilities	HIV and AIDS clients	All Districts	A higher number of ART clients that are virally suppressed	DDG: Communicable and Non-Communicable Diseases
14	Number of people started on TB treatment per year	Count of all people who had a diagnosis of DS-TB and DR-TB who were started on treatment	DHIS2	Number of people started on TB treatment	Not Applicable	TB clients	All Districts	Higher number of eligible people started on TB treatment	DDG: Communicable and Non-Communicable Diseases
15	Drug Resistant-/Rifampicin Resistant TB (RR/MDR-TB) treatment success rate	Drug resistant /Rifampicin Resistant (RR /MDR-TB clients who successfully completed drug-resistant tuberculosis treatment as a proportion of all RR /MDR-TB clients who started treatment during the same reporting period.	EDR Web	Numerator: Count of all RR/MDR-TB clients who successfully completed treatment Denominator: Count of all RR/ MDR-TB clients who started treatment during the same reporting period	Not Applicable	Not Applicable	All Districts	Higher success rate	DDG: Communicable and Non-Communicable Diseases
16	Drug Susceptible-TB (DS-TB) treatment success rate *(MTDP)*	TB clients who started drug susceptible tuberculosis (DS-TB) treatment and who successfully completed treatment as a proportion of all DS-TB clients who started treatment during the same reporting period (treatment cohort)	DHIS 2	Numerator: Count of All DS-TB clients who successfully completed treatment Denominator: Count of All DS-TB clients who started treatment during the same reporting period (Treatment cohort)	Not Applicable	Not Applicable	All Districts	Higher success rate	DDG: Communicable and Non-Communicable Diseases
17	Number of Malaria endemic sub-districts implementing foci clearing programme	Foci clearing programme is implemented in malaria-endemic subdistricts. There are 35 malaria-endemic subdistricts in the country, where the foci programme is implemented incrementally, targeting four endemic subdistricts per year.	MIS (Malaria Information System)- Web based DHIS2	Number of sub-districts implementing the foci clearing programme.	Provincial implementation of the foci clearing program within targeted sub-districts will be in accordance with the NSP 2024-28	Not Applicable	Endemic sub-district	All endemic sub-districts implementing the foci clearing programme	DDG: Primary Health Care

	Outcome Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumption	Disaggregation of Beneficiaries	Spatial Transformation	Desired Performance	Indicator Responsibility
18	Number of Districts performing HPV Screenings for Cervical Cancer	HPV screening included as the cervical cancer screening method in addition or substitute to cytology screening	NHLS report confirming requests for HPV screening	Number of Districts performing HPV screening for cervical cancer	NHLS has the capacity to perform HPV screening	Women	All Districts	A high number of districts performing HPV screening	DDG: Communicable and Non-Communicable Diseases
19	Maternal Mortality ratio *(MTDP)*	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)	DHIS; Reports produced by the National committee of Confidential Enquiry into Maternal deaths (NCCEMD) and Stats SA population figures	This is a proxy indicator derived from calculations from maternal mortality; and Stats SA on all confirmed maternal deaths.	Accuracy dependent on quality of data submitted by health facilities and period of NCCEMD findings	Women	All Districts	Lower ratio of maternal mortality	DDG: Communicable and Non-Communicable Diseases
20	Under 5 mortality rate (MTDP)	All deaths under 5 year of age	DHIS; DHA and Stats SA	This is a proxy indicator derived from calculations from death under 5 years against live birth rate; and the Department of Home Affairs, using Stats SA population figures	Accuracy and period of reporting	Children	All Districts	Lower rate of under 5 mortality	DDG: Communicable and Non-Communicable Diseases
21	Number of Grade R leaners screened *(MTDP)*	Grade R learners in the school screened by a nurse in line with the Integrated School Health Programme (ISHP) service package. This excludes follow-up visits and referrals, and each learner should be counted only once per school year	DHIS	Number of Grade R learners screened	Funding is available to expand school health services	Children	All Districts	Higher number of Grade R school leaners screened	DDG: Communicable and Non-Communicable Diseases
22	Number of Primary Health Care facilities with Youth Zones	Youth Zone is a dedicated space at a PHC facility where young clients' needs are addressed by staff trained to deal with the youth as required.	Reports from PHC facilities confirming the activation of youth zones	Number of PHC facilities with youth zones	The youth zone would remain active after the inspection and/or support visit	Youth	All Districts	A higher number of PHC facilities with Youth Zones	DDG: Communicable and Non-Communicable Diseases
23	Proportion of community health centres with at least one mental health care provider appointed *(MTDP)*	Proportion of Community Health Centres (CHCs) with at least one mental health care providers (Psychiatrist, medical doctor with a post basic diploma in psychiatry, Psychologist, Social Worker, Occupational Therapist, Registered Counsellor and Psychiatric Nurse) appointed	Ideal Clinic Software	Numerator: Number of CHCs with at least one mental health care provider appointed Denominator: Number of fixed CHC facilities	Not Applicable	Not Applicable	All Districts	A higher number of CHCs with at least one mental health care provider appointed	DDG: Primary Health Care

	Outcome Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumption	Disaggregation of Beneficiaries	Spatial Transformation	Desired Performance	Indicator Responsibility
24	Amended Mental Health Care Act	An amended Mental Health Care Act, 2002 (Act No 17 of 2002)	An amended Mental Health Care Act	Not applicable	Resources will be available, Stakeholders will submit comments, approval processes will be timeous	Not applicable	Not applicable	An amended Mental Health Care Act to further strengthen provision of quality, accessible mental health services	Chief Director: Non-Communicable Diseases
25	Number of districts implementing Event -Based Surveillance (EBS)	Event-based surveillance (EBS) is disease outbreak signals reported on the Event Management System	Event-based surveillance	Number of districts implementing EBS	Resources are available	Not Applicable	All Districts	Higher number of detection rate of outbreaks	Chief Director: Health Information, Research, Monitoring, Evaluation and Epidemiology
26	Number of facilities that qualify as ideal clinics per year	Fixed Primary Health Care facilities that obtained ideal clinic status per year.	Ideal clinic monitoring system	Number of fixed PHC facilities that obtained an ideal clinic status	Accurate records provided by PHC facilities	Not Applicable	All Districts	Higher number of fixed PHC facilities that obtained ideal clinic status	DDG: Primary Health Care
27	Number of hospitals assessed for compliance with food service policy per year	Hospitals assessed for compliance with food service management policy	Assessment reports for hospitals	Number of hospitals assessed	Hospitals implementing food service policy	Not Applicable	All Districts	Higher number of hospitals assessed	DDG: Primary Health Care
28	Inquest Amended Bill developed	Inquest Amendment Bill	Amendment Bill finalised and ready to be passed into law	Document evidence of administrative activities carried out by the NDoH on the process to revise the legislation	Process will not be delayed by administrative activities outside the control of the NDoH	Not Applicable	Not Applicable	Inquest Bill finalised	DDG: Hospital Systems
29	Percentage of women employed in senior management (SMS) employed at NDoH in line with equity targets	Appointment of women at SMS levels to ensure achievement of targets set for WYPD by NDOH	Staff Establishment report from persal	Numerator: Number of Women employed at SMS level in NDoH Denominator: All SMS Employees in NDOH	All employees are recorded on Persal	Women	Not- Applicable	50% of Women employed at SMS level in NDOH	Head of Corporate Services
30	Percentage of Youth employed according to the equity targets	Appointment of Youth to ensure achievement of targets set for WYPD by NDOH	Staff Establishment report from persal	Numerator: Number of Youth employed in NDoH Denominator: All Employees in NDOH	All employees are recorded on Persal	Youth	Not Applicable	30% Youth employed at NDOH	Head of Corporate Services
31	Number of district hospitals implementing the Framework for distribution of multidisciplinary teams of health professionals	District hospitals aligning staff establishments with the Framework	District hospitals organograms/staff establishments confirming alignment to the Framework	Number of district hospitals implementing the framework	Accurate reporting by district hospitals	Not Applicable	All Districts	Higher number of District Hospitals implementing the Framework	DDG: Hospital Systems
32	Shared Electronic Health Record Digital Platform	Shared Electronic Health Record software developed and available for implementation	Documented evidence of Shared Electronic Health Record: release note	Not Applicable	Development of the Shared Electronic Health Record could be delayed due to unavailability of required resources	Not Applicable	Not Applicable	Shared Electronic Health Record software developed and available for implementation	Chief Director: Health Systems - Digital Health
33	Number of Public Health facilities maintained, repaired or refurbished per year	Optimizing infrastructure requirements in maintaining Health facilities efficiency, reliability, and safety in the delivery of the service. *Public Health Facilities include Clinics, Hospitals, Nursing Colleges and EMS base stations.	Practical Project completion certificates	Number of all public health facilities maintained, repaired and/or refurbished	Accurate record keeping for number facilities maintained, repaired and/or refurbished, according to Maintenance Plans	Not Applicable	All Districts	Higher number of health facilities maintained, repaired and/or refurbished	DDG: Hospital Systems

ANNEXURES TO THE STRATEGIC PLAN

Annexure A: District Development Model

One of the key principles of the District Development Model One Plan is the incorporation of initiatives and interventions to deal with Gender Based Violence and Femicide as guided by the National Strategic Plan (NSP) on Gender Based Violence and Femicide (GBVF). The health sector has a critical role to play in providing support to victims of Gender Based Violence. These interventions include the designation of public health facilities to manage sexual offence cases and reporting on new cases of sexual assault presenting at health facilities. The health facilities are usually the first point of contact for teenagers who are pregnant, and pregnancy in the age group of 10-14 year is particularly concerning. Interventions are geared to ensure that the health personnel are capacitated to manage and report cases appropriately in collaboration with all key stakeholders in other sectors.

National Department of Health
Private Bag X828
Pretoria
0001
Republic of South Africa

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