National Report for the Mid-Term Review of the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa

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National Department of Health

National Report for the Mid-Term Review of the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa

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PREFACE

It is with great pleasure that we present the findings from the MNCWH and Nutrition mid-term strategy review (MTR) conducted between April and July 2014. The review employed a multi-component approach (desk review, field visits and provincial workshops) which is presented in the final MTR report along with other accompanying documents.

This national report is accompanied by electronic copies of the tools and a number of other reports and documents. Together the electronic copy and hard copy of the final report make up the findings and recommendation package. Documents provided electronically are not less important than the overarching report, however due to the vast number of pages produced, it would not be feasible to print all the documents.

The hard copy report provides an overview of the MTR and consolidates the findings across both the desk and field components of the MTR. It provides an overarching framework for operationalizing the findings of the review. This report is complemented by documents provided electronically which provide detailed technical area reports, provincial reports and detailed workshop reports.

The following documents are provided in pdf:

1. Technical desk review reports compiled during the desk review phase of the MTR in the area of maternal and newborn health, child health, adolescent health, women's health and nutrition
2. Provincial summaries detailing key bottlenecks, promising practices and recommendations
3. Provincial reports compiled from the provincial field visits
4. All district action plans compiled during the 2-day workshop that took place following the field visits in each province
5. Tools used to conduct the field review

All documents within the findings and recommendations package should be reviewed as part of the package. This will ensure that the MTR findings and recommendations can be operationalized across all programmatic areas and levels of care.

ABBREVIATIONS

AIMS	Advanced Incident Management System
ALHIV	Adolescents Living with HIV
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ART	Antiretroviral Treatment
ASRH	Adolescent Sexual and Reproductive Health
AYFS	Adolescent Youth Friendly Services
BANC	Basic Antenatal Care
CAC	Comprehensive Abortion Care
C-IMCI	Community Based Integrated Management of Childhood Illnesses
CARMMA	Campaign on Accelerated Reduction of Maternal Newborn and Child Mortality in Africa
CBO	Community Based Organization
CCGs	Community Care Givers
CDC	Centers for Disease Control
CFP	Contraception and Fertility Planning
CHC	Community Health Centre
CHIP	Child Health Care Problem Identification Programme
CHWs	Community Health Workers
CoMMiC	Committee on Morbidity and Mortality in Children
CSI	Child Status Index
CSO	Civil Society Partners
Cu IUD	Copper Intrauterine Device
CYPR	Couple Year Protection Rate
d-IMCI	Distance Learning (IMCI) Integrated Management of Childhood Illnesses
DBE	Department of Basic Education
DCSTs	District Clinical Specialist Teams
DDG	Deputy Director General
DFID	Department for International Development
DHB	District Health Barometer
DHIS	District Health Information System
DoH	Department of Health
DSD	Department of Social Development
EBF	Exclusive Breast feeding
ECD	Early Childhood Development
ELRU	Early Learning Resource Unit
EMS	Emergency Medical Services
EOST	Emergency Obstetric Simulation Training
EPI	Expanded Programme on Immunization
ESMOE	Essential Steps in the Management of Obstetric Emergencies
FP	Family Planning
FPI	Family Planning Integration into HIV Care and Treatment Services project
GBV	Gender-based Violence
HBB	Helping Babies Breathe
HCT	HIV Counselling and Testing
HCW	Health Care Worker
HDACC	Health Data Advisory and Co-ordination Committee
HPCSA	Health Professions Council of South Africa
HPV	Human Papillomavirus
HR	Human Resources
HSIL	High-Grade Squamous Intraepithelial Lesion
ICATT	IMCI Computerized adaptation and Training Tool
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ISHP	Integrated School Health Programme
KMC	Kangaroo Mother Care
LEEP	Loop Electrosurgical Excision Procedure

LGBTI	Lesbian Gay Bisexual Transgender and Intersex
LIDS	Linking Communities with District Health System
M&E	Monitoring and Evaluation
M&Ms	Mortality and Morbidity
MBFI	Mother-Baby Friendly Initiative
MDG	Millennium Development Goals
MMC	Medical Male Circumcision
MMR	Maternal Mortality Ratio
MNCWH and N	Maternal, Newborn, Child, and Women's Health and Nutrition
MOU	Maternal Obstetric Unit
MOU	Memorandum of Understanding
MSSN	Management of Sick and Small Newborns
MTR	Mid-Term Review
MUAC	Mid-Upper Arm Circumference
NaPeMMCo	National Perinatal Mortality and Morbidity Committee
NBC	Newborn Care
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NCDs	Non-Communicable Diseases
NDoH	National Department of Health
NGO	Non-Governmental Organization
NHI	National Health Insurance
NMR	Neonatal Mortality Rate
NPO	Not for profit Organization
NYDA	National Youth Development Agency
OSS	Operation Sukuma Sakhe
PHC	Primary Health Care
PHCIS	Primary Health Care Information System
PMTCT	Prevention of Mother to Child Transmission of HIV
PPIP	Perinatal Problem Identification Programme
PPP	Public-Private Partnership
PREMIS	Pre-Hospital Medical Information System
PRICELESS	Priority Cost-Effective Lessons for Systems Strengthening – South Africa
QA	Quality Assurance
QI	Quality Improvement
RMCH	Reducing Maternal and Child Mortality in South Africa through Strengthening Primary Health Care Programme
RMNCH	Reproductive, Maternal Newborn and Child Health
RMS	Rapid Mortality Surveillance
RTCs	Regional Training Centres
RTHC	Road to Health Card
SAM	Severe Acute Malnutrition
SANHANES-1	South African National Health and Nutrition Examination Survey
SAPS	South African Police Services
SASSA	South African Social Security Agency
SBCC	Social and Behaviour Change Communication
SAE	Serious Adverse Event
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TOP	Termination of Pregnancy
U5MR	Under-5 mortality rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAS	Vitamin A Supplementation
VR	Vital Registration
WBOTs	Ward Based Outreach Teams
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

South Africa is committed to working towards achieving Millennium Development Goals (MDG) 4, 5 and 6 to reduce maternal, newborn, child and women's mortality. The National MNCWH and N 2012-2016 strategic plan has key objectives linked with the Campaign on Accelerated Reduction of Maternal Newborn and Child Mortality in Africa (CARMMA) towards achieving the set targets. Both these strategies were launched by the Minister of Health in May 2012.

The NDoH commissioned a mid-term review (MTR) of the maternal, newborn, women, adolescent and child health and nutrition programmes in the health sector in 2014. This was an independent review supported by various stakeholders working towards improving maternal and child health outcomes in the country.

Objectives

The review aimed to understand the current status as well as assess progress on the implementation of the strategy for the maternal, newborn, under-5 child health, adolescent health, women's health and nutrition programs across the country.

Key objectives of the review included:

- To review progress towards achieving the targets to date, as outlined in the MNCWH and N Strategy 2012-2016 focusing on high impact but poorly implemented interventions outlined in the countdown to MDGs 4 and 5 report for South Africa, February 2014
- To identify key implementation challenges on the ground focusing on quality, access, service utilization and coverage linked to specific time bound actions
- To conduct in-depth analysis of critical systemic bottlenecks reducing effective coverage of high impact implementation
- To identify best practices and lessons learnt from the field specific to the key interventions for improving MNCWH and N outcomes for potential replication and scale up across the country

Methodology

The MTR review was conducted between February and June 2014.The preparatory phase, consisting of meetings, planning and establishing steering committees and technical teams took place between February and April 2014.

The implementation phases, as described below, took place between April and June 2014.

- **Desk review phase**
  - Conducted to identify existing knowledge from published and grey literature and interviews with key informants in the five technical areas; maternal and newborn health, child health, adolescent health, women's health and nutrition
- **Field review phase**
  - Field visits were conducted at national level and in all 9 provinces in 21 districts (two per province, except for Gauteng and Kwa-Zulu Natal where three and four districts were visited respectively)
  - In each province, one better performing district and one underperforming district was selected based on performance in 2013 for key countdown indicators related to MNCWH and N
  - One hospital, one community health centre (CHC) and two primary care clinics were visited in each district
  - At each facility, interviews were conducted with management, health care workers, clients, clinic committees and hospital boards
- **All districts workshop per province**
  - In each province an all-districts workshop bringing together key representatives and stakeholders from all districts in the province was conducted
  - District teams reviewed bottlenecks identified through the review and completed planning and identification of action points to fast track momentum towards the MDGs and to improve maternal and child health and nutrition outcomes at all levels

Collation of data from the review followed by data analysis and report writing took place during July and August 2014.

Findings

Overall there has been a downward trend in maternal mortality in South Africa over the last few years. Facility-based data and population-based global estimates indicate that the Strategic Plan's Maternal Mortality Rate (MMR) 2014 target of 270 has been well exceeded, although the decline is not sufficient to meet the target for MDG 5. After remarkable reductions between 2006 and 2011 in under-5 and infant mortality, both rates stagnated in 2012. The achievement of MDG 4 by end-2015 is therefore unlikely, although the strategic plan target for neonatal mortality has been met.

Key achievements in the area of adolescent health include the drafting of the National Adolescent and Youth policy 2012-2013 and the development and implementation of the Integrated School Health Programme (ISHP), instituting accreditation standards in facilities for the provision of Adolescent Youth Friendly Services (AYFS), as well as the roll out of the human papillomavirus (HPV) vaccine for young girls.

Key programmatic achievements in the areas of women's health include the development and implementation of the Contraception and Fertility Planning Policy and Service delivery Guidelines allowing for an expanded method mix and the implementation of the national family planning campaign.

With respect to nutrition, programme achievements include the development and finalization of the Roadmap for Nutrition in South Africa (2013-2017) and the publication of theInternational Code of Marketing of Breast milk Substitutes in December 2012.

As the national MNCWH and N review covered a wide range of technical programme areas and involved both a desk review and field review phase, an analytical framework was developed to consolidate the findings of the review. The framework, based on the program effectiveness model highlights gaps/bottlenecks and progress in the following areas:

- **Functional effectiveness:** (activities/cascades/pathways including supplies, health care workers)
- **Organizational effectiveness:** (resource mobilization, partnerships, integration with other programmes, capacity development, and management systems
- **Political effectiveness:** (civil society and community engagement and leadership)

The evaluation found limited progress with respect to the components in functional effectiveness, with lengthy and cumbersome procurement and human resources (HR) processes resulting in stock outs of medicines and supplies and shortages of critical HR staff. Some progress has been made with regards to the components in organizational effectiveness, although more needs to be done to strengthen procurement procedures and decentralize processes. Political effectiveness has shown progress, however more needs to be done around the communication of key messages to staff and communities.

Key recommendations

Identified top line recommendations:

1. **Know your issues, track your response, we are accountable:** target setting and data management, communication, accountability and involvement
2. **Getting the basics right:** infrastructure, drugs, equipment, balance supply and demand, supervision and mentoring systems, consistency and quality of care
3. **Connecting the dots:** cascades, pathways, transport and referrals.

The report further prioritized the following groups:

- Women, with a focus on adolescent girls; and
- The first 1000 days of life (mother and child)

While the review was successful in providing a picture of implementation of the MNCWH and N strategy, it was conducted under extremely tight deadlines and as a result was limited to assessing implementation successes and challenges of the MNCWH&N strategy and did not focus on evaluating the impact of the MNCWH and N strategy in terms of programmatic outcomes, and did not assess service user (beneficiaries) experience and utilization.

SECTION 1

Overview

Background

South Africa is committed to working towards achieving MDGs 4, 5 and 6 to reduce maternal, newborn, child and women's mortality. The national MNCWH and N 2012-2016 strategic plan has key objectives linked with the Campaign on Accelerated Reduction of Maternal Newborn and Child mortality in Africa (CARMMA) towards achieving the set targets.

There have been substantial strides in improving maternal and child health outcomes over the last few years. The country has dramatically scaled up the HIV/ART programme with increasing numbers of women reached through the Prevention of Mother to Child Transmission of HIV (PMTCT) programme and more numbers of HIV-positive children receiving treatment. These efforts have likely contributed to increased life expectancy, but more still needs to be done to reduce preventable deaths of women, mothers and children.

The NDoH commissioned a mid-term review of the maternal, newborn, women, adolescent and child health and nutrition programmes in the health sector in 2014. This was an independent review supported by various stakeholders working towards improving maternal and child health outcomes in the country.

Objectives

The review was aimed at understanding the current status as well as to assess progress on the implementation of the strategy for maternal, newborn, under-5 child health, adolescent health, women's health and nutrition programmes across the country. In this regard, the identification and understanding of promising practices, lessons learnt, as well as challenges was of particular interest in the review.The review used the eight pillars of the strategy as the framework to understand and track progress as well as identify best practices for scaling up.

Eight pillars - MNCWH and N strategic plan 2012-2016[1]

1. Addressing inequity and the social determinants of health
2. Development of a comprehensive and coordinated framework for provision of MNCWH and N services
3. Strengthening community-based MNCWH and N interventions
4. Scaling up provision of key MNCWH and N interventions at PHC level
5. Scaling up provision of key MNCWH and N interventions at district hospital level
6. Strengthening the capacity of the health systems to support the provision of MNCWH and N services
7. Strengthening human resource capacity for delivery of MNCWH and N services
8. Strengthening systems for monitoring and evaluation of MNCWH and N interventions and outcomes

Key Objectives of the Mid-Term Review

- To review progress towards achieving the targets to date, as outlined in the MNCWH and N strategy 2012-2016 focusing on high impact but poorly implemented interventions outlined in the countdown to MDGs 4 and 5 report for South Africa, February 2014
- To identify key implementation challenges on the ground focusing on quality and coverage linked to specific time-bound actions
- To conduct in-depth analysis of critical systemic bottlenecks reducing effective coverage of high impact implementation
- To identify best practices and lessons learnt from the field specific to the key interventions for improving MNCWH and N outcomes for potential replication and scaling up across the country

[1] National MNCWH and N strategy 2012-2016, NDoH, South Africa

Implementation Processes

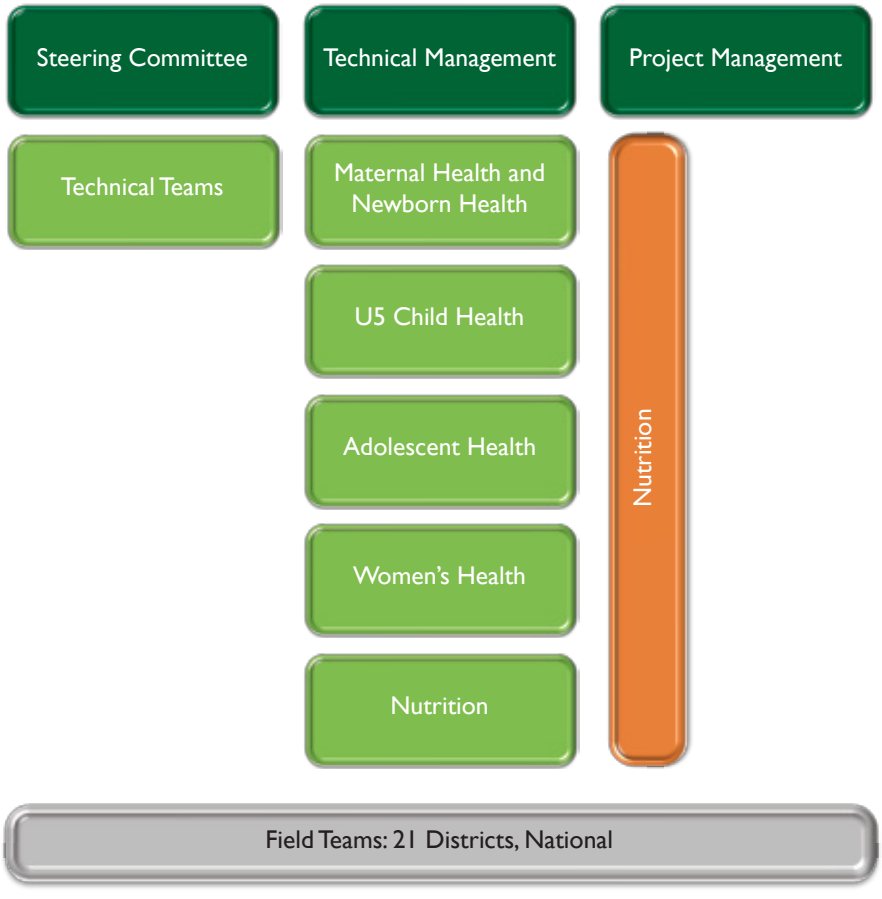
Management and organization

The review was conducted under the leadership and overall coordination of the NDoH DDG Strategic Programmes – HIV, AIDS, TB, MCWH, drawing on technical experts and financial resources from multiple development partners. United Nations Children's Fund (UNICEF) was the lead technical agency for the review. The Reducing Maternal and Child Mortality in South Africa through Strengthening Primary Health Care (RMCH) program supported by Department for International Development (DFID) was the lead partner for project management and logistics, supported by UNICEF and NDoH.

The five thematic groups were composed of experts from development partners, academic institutions and implementing partners. The local agencies and academic institutions involved as the lead agencies for the thematic groups include, Maternal and Newborn health (University of Cape Town), Maternal and Child health (Save the Children and University of Cape Town), under-5 child health (WITS University), Women's health (WITS Reproductive Health & HIV Institute), Nutrition (North West University), Adolescent health (Health Development Africa). The international agencies supporting the thematic areas include UNICEF (Maternal and newborn health, under five child health, nutrition) and UNFPA (Adolescent health).

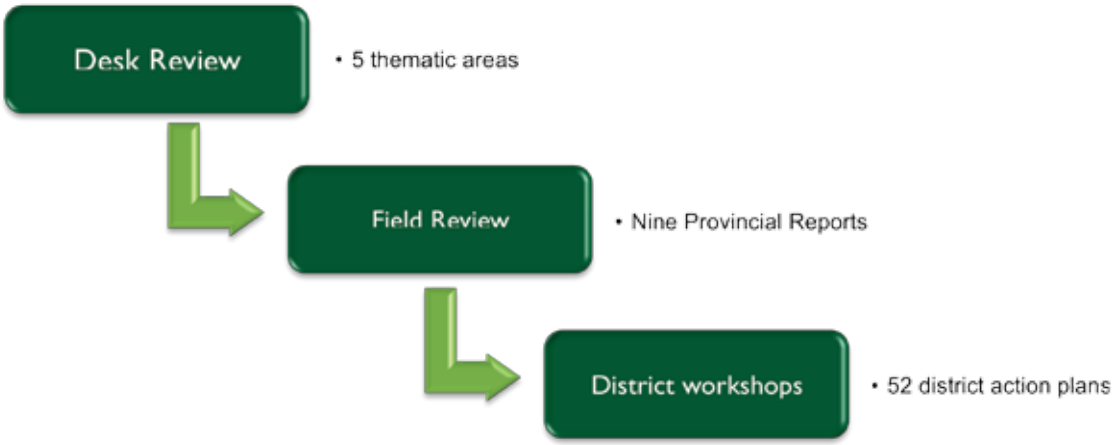
A meeting was held with civil society partners regarding the review process and representatives from organizations participated in the field review phase of the review.

Organizational and management structure of the review



Methodology

The review was completed in the stages shown below:



Desk review: April to May 2014

A detailed desk review was conducted to identify existing knowledge from published and grey literature and interviews with key informants. This supported the identification of priority issues to explore further during the field visit phase of the review. The key thematic areas explored during the desk review include, maternal and newborn health, under-5 child health, adolescent health, women's health and nutrition.

Field review: 17th to 22nd June 2014

Field visits were conducted at national level and in all nine provinces in 21 districts (two per province, except for Gauteng and Kwa-Zulu Natal where three and four districts were visited respectively). In each province, one well performing district and one underperforming district was selected based on performance in 2013 for key countdown indicators related to MNCWH and N. In each district, one hospital, one CHC and two primary care clinics were visited as part of the fieldwork. At each facility, interviews were conducted with management, health care providers, clients, as well as clinic committees and hospital boards where functional.

District workshops: 23rd and 24th June 2014

At the end of the field reviews, the review teams held provincial workshops which provided provinces and their districts with immediate feedback based on the findings from the field review. The workshop brought together key representatives and stakeholders from all districts in the province. This facilitated the presentation of the preliminary findings from the field visits and understanding of the countdown interventions. District teams then completed the planning and identification of action points to fast track momentum towards the MDGs and to improve maternal and child health outcomes at all levels.

Report writing

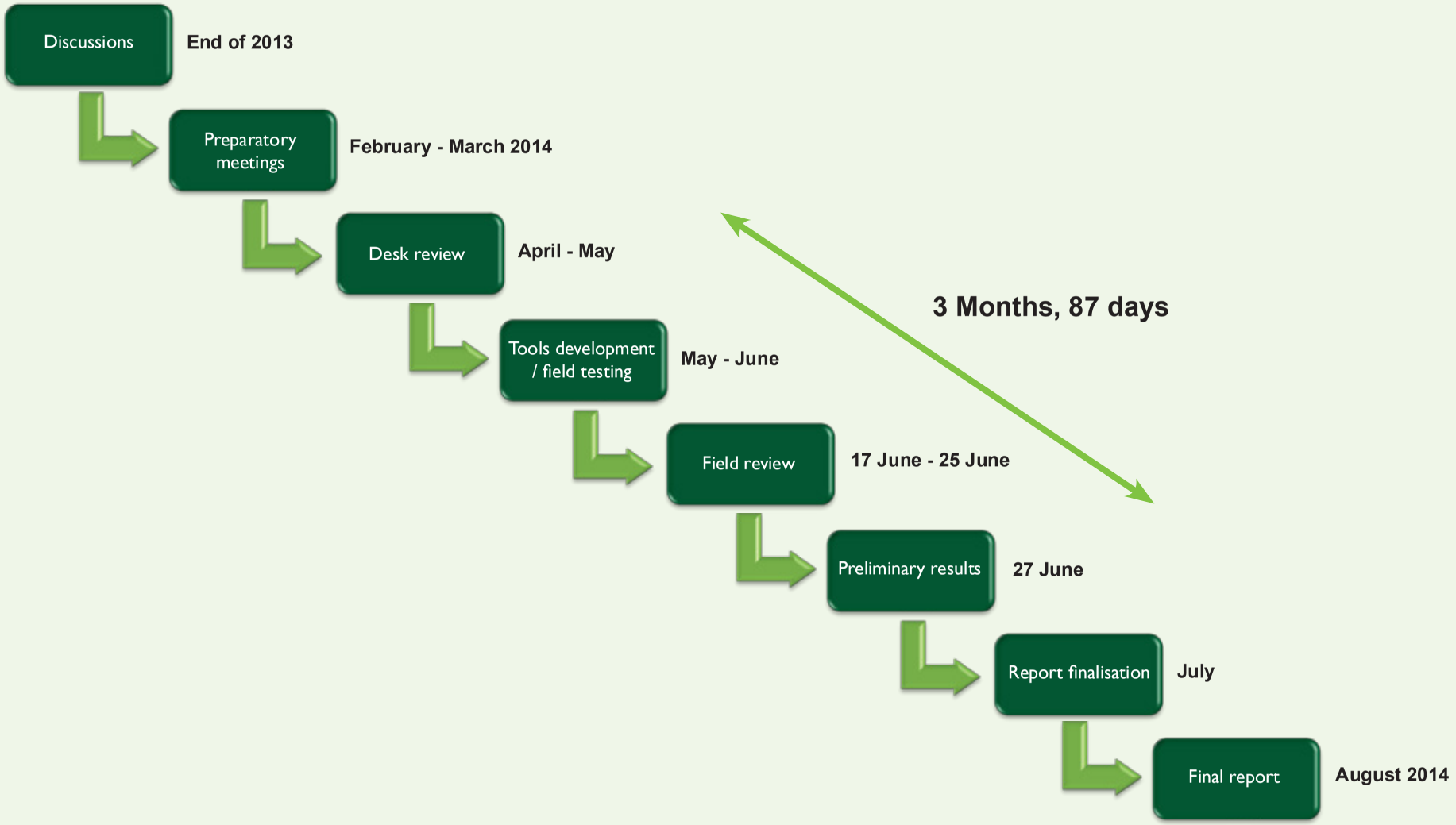
The findings from the field visits were collated over two days, the 25th and 26th June, with the participation of all provincial team leads, co-leads and leads of the thematic groups.

Further data analysis was conducted in July and key findings from the desk review and field visit phase were consolidated. A one day meeting was organized on the 24th of July to review the results and recommendations.

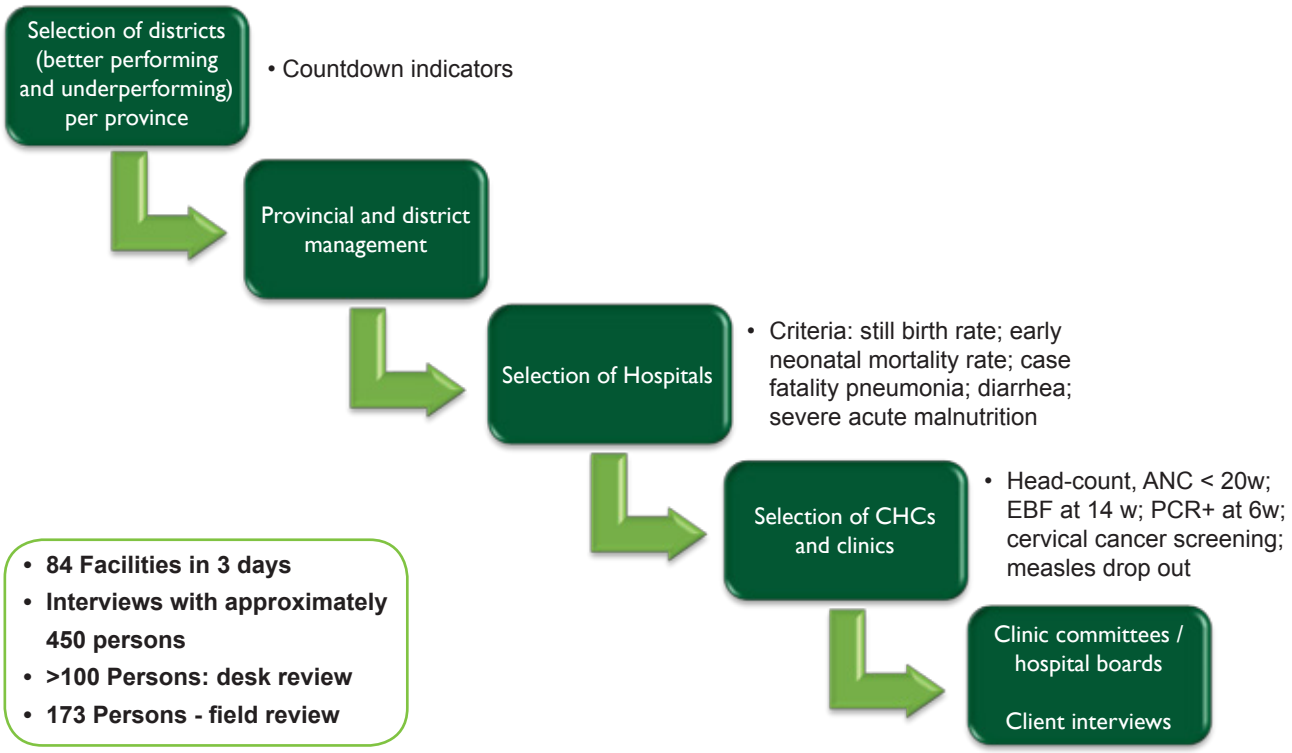
The final report was put together using the key findings and recommendations from the five thematic areas as well as the cross cutting system issues from the desk review and field-visit phases.

[2] District Health Information System (DHIS) 2013

Timeline of the review



Sampling for the review



Limitations of the review

The review was conducted within a tight timeframe given the urgent need to fast track momentum and action towards reaching the MDGs. This resulted in limited time to conduct both the desk review and field visits, including in depth probing for an understanding of the bottlenecks and promising practices linked to programme implementation.

The District Health Information System (DHIS) was used as the source of data to facilitate sampling of districts and facilities for field visits and the concerns with quality of data was noted.

There were an insufficient numbers and lack of technical expertise spread between teams, making it difficult to review multiple programmes simultaneously during the field review phase. In addition, reviewers had to focus on multiple technical areas at the facilities. Review teams expressed that they spent long days in the field, with little or no time to debrief at the end of the day and make assessments. As five technical areas formed the basis of the review, tools were lengthy and reviewer interpretation of questions varied in the field.

Despite the above limitations, the review provided an excellent opportunity to understand the current status and unpack bottlenecks at programme implementation level for MNCWH and N programmes. Furthermore, the rich diversity of stakeholders ranging from government counterparts at national, provincial, district levels, facility level staff, academicians, representatives from professional bodies, civil society representatives, implementing support partners, donor partners and UN bodies, brought in immense resources in terms of technical expertise and implementation science to the review.

SECTION 2

Programme achievements

Key achievements and progress

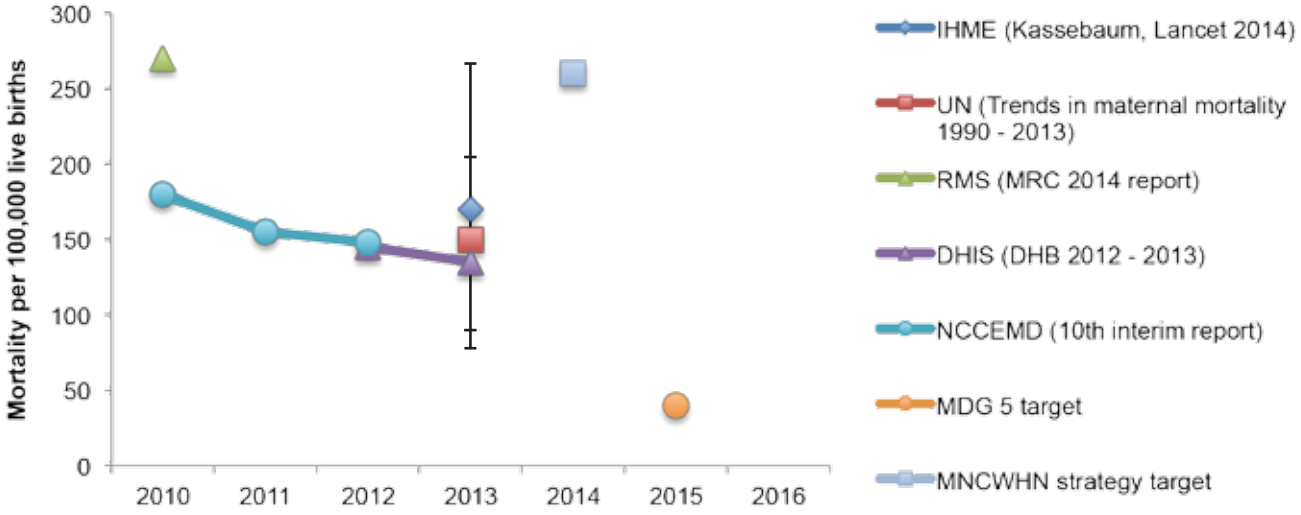
This section provides an overview of the key achievements and progress against overall implementation of the strategy focusing on the five thematic areas as well as the progress against the eight pillars and the key indicators from the results matrix outlined in the national MNCWH and N 2012-2016 strategy document.

Overall achievements and progress across the five thematic areas

Maternal and newborn health

There has been a significant decline in maternal mortality over the last few years, however there are several challenges as the country moves forward to meet the MDGs by end of 2015.

Figure 1: Trends in maternal mortality

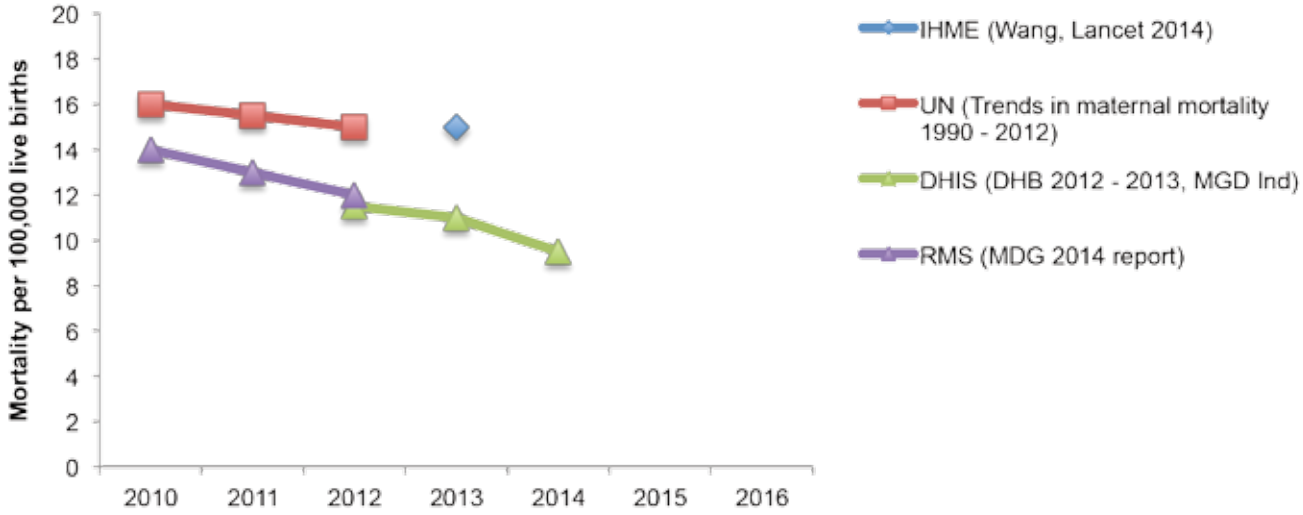


What we know:
- 1426 maternal deaths in 2012 (NCCEMD)
- Recent estimates released have MMR declining, in line with local data
- But numbers are small and confidence intervals are wide

Overall there is a downward trend in maternal mortality, but the uncertainty around the true current level of mortality is high (Figure 1). The point estimates vary across sources but the facility-based data as well as the population-based global estimates indicate that the MNCWH and N maternal mortality 2014 target of 270 has been well exceeded. The decline is not sufficient to meet the MDG 5 target however, and a recent analysis by the Priority Cost-Effective Lessons for Systems Strengthening – South Africa (PRICELESS SA) group have shown that this achievement is not likely to be possible by 2015 even with concerted effort[3].

[3] Chola L, Pillay Y, Barron P, Tugendhaft A, Kerber K, Hofman K. Cost and impact of scaling up interventions to save lives of mothers and children: Taking South Africa closer to MDGs 4 and 5. Lancet Global Health 2014 (submitted).

Figure 2: Trends in neonatal mortality



What we know:

- DHIS, VR coverage neonatal deaths continues to increase
- Trend is toward slight decline but non-significant. There is no change in where babies are dying, the top three causes of neonatal and perinatal deaths, nor the high death rates in the weight category 1000g - 1999g for the period 2012 /13 (PPIP)

The MNCWH and N target for neonatal mortality rate has also been met at this stage and similar to maternal mortality, it is possible that the target set in the strategy was not ambitious enough (Figure 2). Neonatal mortality has remained stagnant despite extremely rapid declines in infant and under-five mortality after the neonatal period[4]. The neonatal mortality rate indicator suffers from a data gap, given that both Perinatal Problem Identification Programme (PPIP) and DHIS report on early neonatal deaths, which most of the time refers to deaths that occur in health facilities prior to discharge. Babies who are discharged from health facilities and die in the community, or those who who are born and die at home may not be counted at all. These children are often those born to younger, more vulnerable women in need of extra care and support.

Under-5 child health

Figure 3: Trends in child mortality

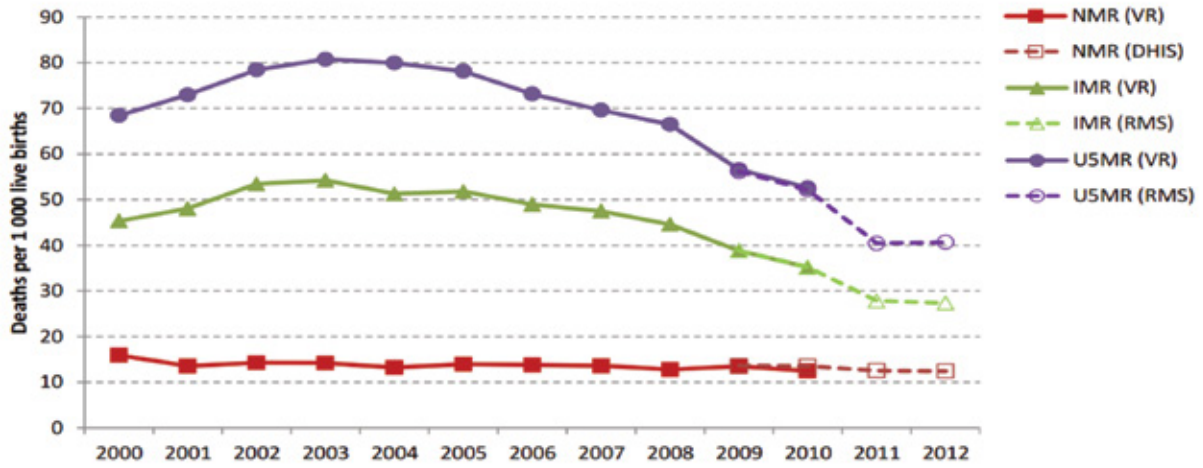


Figure 3: Under-5 Mortality Rate (U5MR) and Infant Mortality Rate (IMR) from Vital Registration (VR)/Rapid Mortality Surveillance (RMS) and Neonatal Mortality Rate (NMR) from VR/DHIS.

[4] Kerber KJ, Lawn JE, Johnson LF, et al. South African child deaths 1990-2011: have HIV services reversed the trend enough to meet Millennium Development Goal 4? AIDS 2013; 27(16): 2637-48.

After remarkable reductions between 2006 and 2011 in under-5 and infant mortality, both rates stagnated in 2012. The achievement of MDG 4 by end of 2015 is therefore unlikely. Case fatality rates for diarrhoea, pneumonia and severe malnutrition are decreasing but have not reached set targets. There has been some improvement in exclusive breastfeeding maintenance rates at 14 weeks as per DHIS. There continue to be gaps in supplementary feeding for children who are failing to thrive. Routine immunization coverage remains sub-optimal in most districts. Delivery of other preventive strategies such as growth monitoring, vitamin A supplementation and deworming is also poor. Integrated Management of Childhood Illnesses (IMCI) has not been widely adopted as standard practice at all primary level facilities despite considerable investment in training. Increased coverage of antiretroviral treatment (ART) for pregnant women has resulted in substantial reduction in HIV transmission at six weeks of age. Longer-term (18 months) outcomes are uncertain however. ART coverage in children remains low, ranging from 63 to 68% (with the target set at >90%).

Adolescent health

A significant preventive health care intervention for young female adolescents has been the national HPV vaccination programme. The introduction of the HPV vaccine represents a significant public health milestone for South Africa, and is expected to significantly contribute to the control of cervical cancer and reduce associated mortality within the next few decades.

There is an overall lack of age-disaggregated data and reporting on adolescents and youth. This has posed a challenge in measuring progress, identifying bottlenecks and building support around efforts to achieve improved health outcomes for South Africa's young people. Key achievements in the area of adolescent health include the drafting of the National Adolescent And Youth Policy 2012-2013 (still to be finalized and endorsed), and the development and implementation of the ISHP, including a joint working group comprising of DoH, Department of Basic Education (DBE) and Department of Social Development (DSD) that meet on a regular basis to coordinate ISHP activities and reporting. Furthermore, the DoH has put in place accreditation standards for the provision of AYFS at two levels – implementing facilities meeting the 5 minimum AYFS standards and those implementing all 10 AYFS standards.

Women's health

The review focused on the following areas, as reflected in the Strategic Plan

(i) Contraception
(ii) Termination of pregnancy
(iii) Cervical screening
(iv) Gender based violence (GBV) and post rape care
(v) Nutrition in relation to women's health

Key programmatic achievements in the areas of women's health include the development and implementation of the Contraception and Fertility Planning Policy and Service delivery Guidelines – expanded method mix and the implementation of the national family planning campaign. In addition, a large number of health care providers have been trained on long acting reversible methods of contraception - the IUCD and newly introduced sub-dermal contraceptive implant since April 2014.

Nutrition

With respect to nutrition, programme achievements include the development and finalization of the Roadmap for Nutrition in South Africa (2013-2017) and the publication of the International Code of Marketing of Breast milk Substitutes in December 2012.

Overview of progress related to the key indicators from the MNCWH and N strategy

In order to score progress on the indicators, the following scoring legend was used.

- No progress made towards achieving targets
- Progress made, but target not reached
- Target Reached
- Insufficient Data to Score

Indicator	Current status 2013	Note /comment	Source	Strategy target 2014
High level indicators				
Maternal mortality ratio	128-174 deaths per 100,000 live births	Sources vary but the trend from facility-based data indicate that the target values from the MNCWH&N strategy was exceeded but the decline is not sufficient to meet the MDG 5 target		270 per 100,000 livebirths – target met however, target needs to be reviewed in view of the MDGs
Neonatal mortality rate	12-15 deaths per 1000 live births	Sources vary and though the MNCWH&N strategy target is met, it is likely that NMR has been and continues to be stagnant		12 per 1000 live births – target met but rates are stagnant, target needs to be reviewed in view of the MDGs
Infant mortality rate	27 deaths per 1000 live births	IMR calculated from vital registration (VR) for the period 2006-2010 and from the RMS for the period 2010-2012. The IMR and the U5MR declined rapidly after 2008, by 2011 were below the targets recommended by the HDACC for 2014. However, the rapid decline appears to have ended, with no further decline in 2012	Vital Registration	36
Under 5 year mortality rate	41 per 1000	Calculated from VR for 2006-2010 and from RMS for the period 2010-2012. The U5MR declined rapidly after 2008 and by 2011 were well below targets recommended by HDACC for 2014. However, the rapid decline appears to have ended, with no further decline in 2012	Vital Registration	50 per 1000

Indicator	Current status 2013	Note /comment	Source	Strategy target 2014
High level indicators				
Prevalence of underweight children < 60 months	5.2	Base line is unknown, so it's difficult to measure against target for indicator. The South African National Health and Nutrition Examination Survey (SANHANES-1) was established as a continuous population health survey. It is not possible to use the DHIS as a data source for this indicator as DHIS records underweight for children < 24 months	SANHANES 2013	
Prevalence of stunting among children < 60 months	21.5	Baseline unknown so difficult to measure against target for indicator. The South African National Health and Nutrition Examination Survey (SANHANES-1) was established as a continuous population health survey. There is no DHIS indicator on stunting (height is not recorded in the DHIS)	SANHANES 2013	
Other indicators				
% Pregnant women who attend ANC	94%	Public sector only; data are not population based	DHIS	Coverage is high. Quality and equitable access for those hardest to reach is the next hurdle.
% Women who attend ANC before 20 weeks	44%	Gestational age calculation difficult (no disaggregation to understand women who register <14 weeks and between 14-20 weeks)	DHIS	80% - progress being made but huge missed opportunity. Issues of demand and quality and availability of services
% of births supervised by skilled attendants	No recent data	No population based data; closest proxy is DHIS facility deliveries which uses an estimate of expected deliveries in the population	-	90% - Population-based household survey needed to validate DHIS birth estimates data.
Mother-to-child transmission of HIV	2.5% 2.6%	Rates seem to be around 2.5-2.6% over the last two years. Further reduction to < 2% will require targeted and evidence based interventions	DHB 2012/2013 MRC PMTCT Impact study 2012	< 2%(6 weeks) - important progress being made but need to also closely monitor postnatal transmission
Stillbirth rate	22 per 1000 births	Rates have not declined since 2010 and are worryingly high. Stillbirths at home may be missed by DHIS	DHIS	10 per1000 births – stillbirth rates are high and stagnant.

Indicator	Current status 2013	Note /comment	Source	Strategy target 2014
Other indicators				
Low birth weight rate (<2.5kg)	13%	Quality problems with weighing and reporting birth weight in facilities	DHIS	10% - no progress according to DHIS since 2010 and national average hides wide variations across districts
% of infants (0-6 months) who are exclusively breastfed	37% DHIS indicator at 14 weeks cannot be extrapolated to 6 months. Furthermore, the drop-out rate from DPT1 to DPT3 is more than 40% indicating the number of children in the 0-6 months age group that are missed	DHIS data are self-reported by mothers at 14 weeks and do not align with any other sources The global indicator is a 24-hr recall methodology to establish feeding practice. In SA the collection of the data is on a yes/no report to 'Are you breastfeeding?	DHIS	75%
% District with 90% children fully immunized under 1 year	22	The number of districts with 90% of children fully immunized under 1 year has decreased from 47 (2011/12) to 22 (2013/14)	DHIS	All 52 districts
Reduce the in-hospital case fatality rate for children (under-5) with diarrhoea	3.9	Under-5 mortality is declining and is likely to be the consequence of fewer diarrhoea deaths through effective prevention strategies	DHIS	3.8
Reduce the In-hospital case fatality rate for children under-5 years with pneumonia	3.7	Under-5 mortality is declining and is likely to be the consequence of fewer pneumonia deaths through effective prevention strategies	DHIS	3.4
In-hospital case fatality for children under-5 years from Severe Acute Malnutrition (SAM)	11.1	Decline in severe malnutrition mortality is seen, but it is still twice the suggested target of the WHO, and may again reflect a combination of HIV-related mortality and poor standards of routine care. This does not explain why SAM case-fatality is 3 times higher than diarrhoea or pneumonia, which could also have underlying HIV co-morbidity. This points to poor diagnosis, poor management and that SAM cases are complicated and should be treated as emergency	DHIS	11.4

Indicator	Current status 2013	Note /comment	Source	Strategy target 2014
Couple Year Protection Rate (CYPR)	37%	Although the country is on track to meet the 2013/14 Annual Performance Plan target of 36% CYPR, the steady increase observed over the past few years appears to be losing momentum, with several provinces including Western Cape performing less well in quarter 3 of this financial year, and a worrying decline in CYPR seen in Free State since 2012.	DHIS	36
% of hospitals where dedicated, trained staff provide comprehensive post-rape care	No specific data found			95%
Sexual Assault Prophylaxis Rate (%)	57.5%	There has been a decline in the prophylaxis rate over the last two years however this could be due to better reporting	DHIS (District Health Information System). National feedback with regard to dashboard indicators for the HIV, AIDS & STI programme (Reporting period: 1 April 2011 to 30 September 2013) DOH; HIV, AIDS and STI programme 26 February 2014	95%
Prevalence of HIV infection in women (15-24 years)	29.5%	Slight drop of 0.7% from 2010. According to the UNAIDS SPECTRUM model, the estimated national HIV prevalence among the general adult population aged 15-49 years old has remained stable at around 17.3% since 2005.In 2011, an estimated 5,600 000 [5 300 000-5 900 000] people living with HIV resided in South Africa. The estimated number of new infections was 1.43% in 2011 compared to 1.63% new infections in 2008	The 2011 National Antenatal Sentinel HIV and Syphilis Survey in South Africa	

Other indicators

Although the MNCWH and N strategy has highlighted the above mentioned indicators for programme monitoring, the following list of indicators have been highlighted for possible inclusion into the list of indicators by the review team for wider understanding and monitoring of the entire MNCWH and N programme along the continuum of care.

Indicator	Current status (year)	Note /comment	Source	Strategy target
Adolescents				
HIV prevalence among population aged 15-24 years (%)	Male: 2.9% Female: 11.5% Total: 7.3%	Slight decline in prevalence from 2008. In the teenage population, the estimated HIV prevalence among females was 8 times that of their male counterparts, suggesting that female teenagers aged 15–19 years are more likely than their male counterparts to have sex, not with their peers, but with older sex partners	SA National HIV Prevalence, Incidence and Behaviour Survey, 2012	4.2
Condom use at last high risk sex	59.9	Unlikely to meet 2015 target	ANC prevalence survey	95%
Proportion of people living with HIV on ART Children - I0-14 years Young people - 15 -24	Children: 63-68% Young people: 14.3%	The DoH has made significant strides in ensuring that the paediatric ART programme is comprehensive, but the data indicates that there are challenges in ensuring the ART programme effectively covers older adolescents. This is a complex issue that includes challenges of adolescent health seeking behaviours, willingness to undergo HIV testing, ART initiation and adherence, and loss to follow up	2012 South African National HIV Prevalence, Incidence and Behaviour Survey Report	95%
Adolescent birth rate	13.7%	No baseline data. Difficult to measure	CARMMA StatsSA / Census Data	
Adolescent pregnancy rate (12-19 years)	19.2%	No baseline data. Difficult to measure. The implementation of the AYFS programme within the re-engineering of PHC and the ISHP requires further evaluation to ensure adequate scale up and good communication between these programmes in order to address more effectively the challenges related to teenage pregnancy	Cross sectional population based household survey	
Termination of pregnancy amongst adolescents	80% of 882 clients from Pathfinder International Comprehensive Abortion Care (CAC) project who had abortions were women 24 years and younger. A quarter of these were adolescents younger than 18	Teenage pregnancy and access to (Sexual and Reproductive Health) SRH services is an issue of great concern and is one of the outlined policy and development priorities. Under current legislation women (including teenage girls) are guaranteed the right to abortion on demandup to 12 weeks but inreality a range of factors mitigate against most women actualizingthis right	Pathfinder International CAC project (Communications with Path Finder International)	All eligible women

Indicator	Current status (year)	Note /comment	Source	Strategy target
Adolescents				
Cervical screening coverage	55.4%	National DoH target for cervical screening coverage 54% as shown in the NDoH Annual Performance Plan 2012/13	DHIS/DHB	
Percentage of TOP facilities (designated sites) functioning	54%		NDoH South Africa Internal Report (2013)	Increase the % of sub-districts which provide TOP services targets 60% (2013) and 80% 2016
% of children aged 12 to 59 months receiving at least one dose of vitamin A in the last year	54%	WHO indicator is 2 doses per year for children 6-59 months every 6 months. The DHIS indicator is not in line with this global standard. And given the low coverage it is not possible to reap the benefits of Vitamin A Supplementation (VAS). Given the low coverage of measles at 18 months it is not possible to reach 80% with the current routine child health facility-based platform	DHIS	80%

Please see annex for a review on the status of implementation of activities per pillar within the strategic plan

Achievements identified during the field visits

During the course of the field visit the following programmatic achievements were noted

- Commitment of all levels of health care staff to participation in the field review despite the high patient loads and often challenging infrastructural, equipment and commodities realities and ensuring that patient care was not compromised or delayed during the field visit phase
- Dashboards are being generated and used to identify gaps and challenges in service delivery and patient care at the national, provincial and district level
- Evidence of data verification and quality assurance mechanisms were in place. These include the presence of validation committees, internal system control mechanisms, and quarterly feedback forums at provincial levels
- Facilities were introducing expanded choice of contraceptive methods, including sub-dermal implants.
- Where implemented, Ward Based Outreach Teams (WBOT) help extend health care services into the community in districts
- Maternal mortality, perinatal mortality and child mortality meetings are being implemented regularly, although gaps in follow-up actions being implemented exist
- Availability of crisis centers which closely liaise with South African Police Services (SAPS) and facilities with regards to GBV/post rape care
- Where Thutuzela centers are available, they are providing a full range of care including referrals
- There was evidence of universal HIV Counselling and Testing (HCT) in children on admission and 18 months at Primary Healthcare (PHC) level in some facilities
- Training for new contraceptives (sub-dermal implants) is standardized and uptake is good
- Where present, District Clinical Specialist Teams (DCST) are making a difference with clinical mentoring and supportive supervision

SECTION 3

Analytical framework

Overview

The national MNCWH and N review covered a wide range of technical program areas, from maternal, newborn, under-5 child, women's, adolescent health and nutrition programs. Given the breadth and scope, as well as keeping in mind the different components of the review (desk review and field visit phase), it was important to develop an analytical framework to understand key findings and results of the review. This framework brought together the key findings (bottlenecks and enablers) identified during the desk review phase in the five thematic areas with the bottlenecks and program achievements observed during the field visit phase.

Analytical framework

The analytical framework is based on the programme effectiveness model and highlights gaps and bottlenecks as well as progress in three areas:

1. **Functional** – includes additional number and type of activities that are to be performed along the cascade/pathway including supplies and trained workers
2. **Organizational** – includes resource mobilization, building external partnerships, effective integration with other programs, capacity development and establishment of resilient management systems
3. **Political** – includes highest level and involvement of communities. At the national level this would entail strengthening and alignment between civil society, active leadership at all levels; at the community level this would entail strengthening of integration between formal and local community and sensitization of local leaders and community

A scorecard to track progress against each of the above areas for the strategy implementation was developed. Due to the nature of the midterm review, the components under each of the above areas were identified based on the commonalities seen across the five technical thematic areas.

Programme effectiveness defined as both intensity of the program (quality of implementation) and scale (coverage) linked to results.

Legend: Scoring for assessment of progress using the programme effectiveness framework

- No progress/Not doing well
- Making progress
- Exceeding/Doing well

Component 1: Functional effectiveness

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/challenges identified during field review
Staffing - Human Resources (HR)	Staff allocations and rotations based on facility head counts and patient loads		Centralization of HR policies and processes is one of the root causes of bottlenecks in effective HR It has resulted in inability to fill vacant positions, with positions remaining vacant for long periods of time. Furthermore, in-service and pre-service training remains a challenge. Negative attitudes of health care workers towards adolescents; women seeking termination of pregnancy; women coming for early antenatal care (4 weeks – 12 weeks) affects service delivery and health seeking behaviours
	Skilled health care worker vacancies		
	Skills of existing health care workers – clinical skills/patient/ client management		
	Attitudes and staff motivation		

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/challenges identified during field review
	Referral pathways community-to- facility		Lack of referral pathways and feedback mechanisms between facilities and community structures
	Emergency Medical Services		Insufficient ambulances
Procurement and Supply (including maintenance of equipment)	Overall procurement and supply		Centralized procurement systems delay procurement processes
	Purchasing and maintenance of equipment		Lack of equipment audits to identify procurement gaps and needs
	Procurement processes for supplies, medicines and consumables		Centralized processes for supplies, medicines and consumables
	Centralized depots for medicines and supplies		Processes are cumbersome and lengthy, resulting in stock outs of medicines and supplies
OVERALL SCORE FOR FUNCTIONAL EFFECTIVENESS			Based on the findings above, the overall scoring has been determined to be red

Component 2: Organizational effectiveness

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/Challenges identified in field review
Target setting	Setting targets at facility level		Minimal target setting at facility level Lack of understanding of district, provincial and national targets and how facility targets link to the bigger district and national picture
	Setting targets at district level		District targets are being set, however in the majority of districts, targets are set at the provincial level and communicated to districts without district involvement in the target setting. Furthermore, targets are also not disseminated to the facility level
	Setting targets at provincial level		Provincial targets are being set
	Setting targets at national level		National targets are being set in accordance with strategic documents
	Understanding of targets and achievement of targets at all levels		Varied understanding of targets and achievement of targets. Targets are well understood at national and provincial level; less well understood at district level and poorly understood at facility level
	Tracking results at all levels		Results are tracked at a national and provincial level. At the district and facility level, however, results are not tracked for each programmatic area. District and facilities are not working towards improvement targets, and in many instances are unaware of what these targets are

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/Challenges identified in field review
Data management	Use of data at all levels to inform program action (dashboards etc.)		Where dashboards have been developed, there is a better understanding of targets and working towards targets
	Age and gender disaggregated data availability		Lack of age disaggregated data and gender disaggregated data across the MNCWH and N continuum of care making it difficult to deliver adolescent focused services, as well as child-specific services effectively
	Standardised registers and data collection systems		Multiple registers and data collection systems at the facility level. Registers and data collection tools and indicators often do not speak to each other making it difficult to accurately respond to national level indicators
Programme championing	Critical role of managers at all levels to champion programmes to achieve results		Lack of programme champions at all levels. In instances where champions exist, greater achievement towards results is evident
Supervision systems	Functioning supervision systems		Supervision is being implemented and there is documentation of supervisory visits. However, supervision visits are not well coordinated, with multiple visits occurring and lack of follow-up actions following supervisory visits
Mentoring systems	Functioning mentoring systems		Mentoring systems are in place however there is a lack of follow up systems following mentoring. In some instances, mentoring is occurring very sporadically
Building partnerships	Intersectoral collaboration on implementation of programmes, common understanding and setting of targets and joint monitoring		Integration with the Department of Education is well documented with respect to the implementation of the ISHP. However integration with other departments such as Social Development, Justice etc. needs to be strengthened to ensure common understanding of targets and joint monitoring of programmes where overlap occurs
	External partnerships with developmental partners		Strong collaboration with development partners at national and provincial and district level. Engagement of development partners in strategic planning, implementation and programme monitoring and evaluation for results. Regular forums to discuss programmatic targets, gaps and strategize towards achieving results
	External partnerships with NGOs, CBOs		Varied relationships with CBO and NGO partners at the provincial, district and facility level. There is a need to strengthen reporting structures, accountability, communication and joint planning. In some cases, partner support is not aligned to specific gaps and bottlenecks within facilities

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/Challenges identified in field review
Capacity building (pre-service and in-service)	Pre-service training		Pre-service training includes updated to include updated policies and guidelines. Continued collaboration between DoH and academic institutions where training occurs is needed
	In-service training systems		In-service training is being implemented. Better documentation of training and participants is needed
	Management systems capacity building		Lack of training around management systems. Operations managers and supervisors often do not receive technical training and are unable to support health care workers within the facility
Overall score for organizational effectiveness			Based on the findings above, the overall scoring for this component is orange.

Component 3: Political effectiveness

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/Challenges identified during field review
Political commitment and active leadership at all levels	Minster of Health and Presidency		Political commitment at the level of the minister and presidency is well documented in policy documents such as NSDA, MTSF and NDP 2030
	National/Provincial Department of Health		Under the leadership and direction of the Minister of Health, political commitment and support for MNCWH and N and achieving the MDGs via the MDG Countdown to 2015 indicators and CARMMA is well documented
	Development partners		Strong commitment from development partners to support government objectives and work strategically towards achieving common goals
	Implementing partners		Strong commitment from implementing partners to support government objectives and work towards achieving common goals
	Civil society		Although there is participation and engagement from civil society, this can be improved specifically for maternal and child health outcomes
Strengthening alignment between civil society, developmental partners and civil society	Ensuring that all levels are working towards addressing the same priorities and towards the same results framework		Regular strategy meetings, planning meetings, development partner meetings, partner meetings at national and province to ensure common goals and alignment with departmental priorities, targets and results
Support towards development of budgeted tailored plans for results linked to strategy	Budgeted plans linked to results available (linked to activities at facility, district, provincial and national levels)		District Health Plans (DHPs) are developed annually. These plans are linked to results, and provincial APPs but are unbudgeted

Key components (bottlenecks and critical enablers)	Description	Scoring	Remarks/Challenges identified during field review
Communication strategy	Communication plan and materials available for the MNCWH and N strategy document		Lack of a national communication strategy and key messages around the MNCWH and N strategy
	Communication plan and materials available for the key components of the strategy (e.g.results for under-5 child health, adolescent health etc.)		Lack of a standard national communication strategy and key messages around the continuum of care and key components of the strategy
Involvement of clinic committees and hospital boards	Functioning clinic committees and hospital boards with involvement in addressing bottlenecks at facility level and joint monitoring for results		Clinic committees and hospital boards are in place and in most cases meeting with management, however terms of reference and roles and responsibilities are needed to ensure effective management. In addition, formalization of communication pathways between hospital boards/clinic committees and communities needs to be strengthened
Coordination with civil society structures and community structures towards results	Coordination systems developed and functioning linking communities and health facilities towards results		Coordination systems between civil society linking health facilities and communities have been developed These need to be both strengthened and monitored
Overall score for political effectiveness			Based on the findings above, the overall scoring for this component is orange

SECTION 4

Recommendations

Recommendations

The following documents form the background and link with the implementation of the MNCWH and N programme

- Strategic Plan for MNCWH and N in South Africa 2012-2016
- South Africa's National Strategic Plan for a Campaign on Accelerated Reduction of Maternal Newborn and Child Mortality in Africa (CARMMA)
- MDG Countdown to 2015: Saving lives of mothers and children in South Africa
- Roadmap for nutrition in South Africa 2013 - 2017

In addition, three ministerial level committees have been set up and provide clear national and provincial recommendations at regular intervals on maternal, perinatal and child health

- National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD)
- National Perinatal Mortality and Morbidity Committee (NaPeMMCo)
- Committee on Morbidity and Mortality in Children (CoMMiC)

In 2013, a joint national review of the TB, HIV and PMTCT programme in South Africa was conducted. This review identified key bottlenecks in the implementation of these programmes and highlighted key recommendations. These include the integration of programmes at service delivery level, including further use of data for monitoring and action, as well as standardized registers. It is important to note that the key findings and recommendations from the TB, HIV and PMTCT review are in line with the key findings and recommendations of the MNCWH and N review, as well as those from the tri-ministerial committee. Recommendations from the MNCWH and N review should therefore not be seen in isolation, but rather as a component of a package of key recommendations for health system strengthening.

The below sections highlight the key recommendations from the mid-term review in specific sections

1. Recommendations for the strategic plan document
2. Priority groups
3. Topline recommendations linked to the program effectiveness framework
4. Recommendations by thematic area

Key recommendations for the strategic plan for MNCWH and N in South Africa 2012-2016

The strategic plan focuses on priority actions for implementation across MNCWH and N programmes. It is a well-developed plan with clear objectives and well-documented activities across eight strategic pillars.

The recommendations to strengthen the implementation of the strategic plan include

- Review activities within the eight strategic pillars and prioritize activities to be implemented in the short, medium and long term
- Ensure all activities are linked to the results matrix with clear lines of accountability within the different levels of care
- Review and revise the results matrix to ensure linkages with key strategies and priority actions
- Review targets and link targets with accountability mechanisms at all levels
- Broaden the strategy to include an expanded dedicated section on adolescence, nutrition (specific focus on obesity, stunting, and women's nutrition) and breast cancer
- Improve communication of the strategy by ensuring that all levels of care are aware of all the MNCWH and N-related strategic documents; that they have an understanding of the strategy and the response required

- Link and align the strategy with other strategic documents and recommendations from the inter-ministerial committees on maternal, perinatal and child health

Priority groups

a. Women, with a focus on adolescent girls
b. The first 1000 days of life (mother and child)

This prioritization does not mean that other groups should not be targeted for effective interventions, but rather that additional attention should be given to addressing the specific needs of women, adolescent girls and mothers and children during the first 1000 days of life (from conception through the first two years of life). The prioritization of these groups resulted from the fact that progress towards achieving SRH targets for women and adolescent girls has been particularly slow, and access and coverage of youth-friendly services remains a challenge. With respect to the first 1000 days of life, prioritization results from the fact that the majority of under-5 child deaths occur in the neonatal period. Ensuring prioritization of the first 1000 days of life should result in lower maternal and child mortality rates.

Topline recommendations linked to the program effectiveness framework

The scorecard developed to track the program effectiveness framework highlights the progress and gaps in each component, which are linked with the topline recommendations.

	Key components	Scoring	Topline recommendations
1	**Functional effectiveness**		**Connecting the dots:** Cascades and pathways and transport and referrals **Know your issues, track your response**
2	**Organizational effectiveness**		**Getting the basics right:** infrastructure, drugs, equipment, balance supply and demand, supervision and mentoring systems, consistency and quality of care
3	**Political effectiveness**		**We are accountable:** accountability and involvement

The following sections expand on each of the topline recommendations. For each recommendation, the key components, review findings, recommendations and promising practices are outlined. Further details on the promising practices are in Section 5.

1. Know your issues, track your response, we are accountable

Key components

Target setting linked to dashboards and communication strategies (include issues like equity, targets for multisectoral work, etc.)

Overview of what the review found

Targets for all components of the MNCWH and N programme have been set and national, provinces and districts are working to reach the targets. However, across all levels there is variable understanding of target setting with the national level determining targets with little to no engagement or inputs from provinces, districts and below. Provincial targets are often based on targets of the previous financial year with arbitrary increments added on an annual basis and then communicated to districts. District and provincial targets are monitored through quarterly national review meetings, monthly review of DHIS indicators and dashboards and other monthly meetings such as maternal mortality meetings and perinatal mortality meetings. There are some targets and indicators that are difficult to monitor routinely as they can only reliably be

collected at the population level through large-scale household surveys, which are conducted intermittently, often every three to five years. Furthermore the DHS which is an important source of data for the country was conducted over ten years ago. The ability to assess performance against targets and identify challenges and bottlenecks also varies across different levels. While dashboards exist for some components of the MNCWH and N programme, a standardized MNCWH and N dashboard across all areas of the programme is needed. Furthermore, the use of dashboard methodology is often poorly understood and used across the service delivery levels and across provinces. However, where programmatic dashboards exist, they are being used to track progress and identify challenges and bottle necks, with more active quality improvement plans and the monitoring thereof. Little to no target setting at the facility level is taking place. Operation managers are often unaware of national and provincial targets and how these relate to their facility's performance and achievements.

The issues linked to adolescent and youth health and nutrition are not clearly prioritised in national health planning and strategy documents, which means that there is limited incentive to set clear goals and targets for this group. Furthermore, data management systems, including DHIS, are not capturing enough age-disaggregated data to allow for evidence-informed strategies to be developed for adolescent and youth health, as well as for other age groups (e.g. 5-10 year olds). The resulting lack of consistent age disaggregated data at service delivery levels has led to inadequate reporting on adolescent and youth health at various levels within the health system, including sub-district, district, provincial and national levels.

For programmes to function optimally, services need to extend beyond the health sector. For example, the Department of Water and Sanitation needs to ensure that households have access to clean running water; the Department of Social Development needs to ensure that individuals are receiving their social grants and that they are referred to social services as needed and the Department of Education needs to strengthen linkages between the integrated school health program and nearby facilities so that children and adolescents get all the services they need. Multisectoral collaboration facilitates the identification of problems that exist beyond the health sector. To ensure accountability, targets for multisectoral collaboration should be set and monitored.

Key recommendations

- Set targets at **facility level** along the continuum of care (have targets in numbers where possible)
- Develop targeted and focused responses (i.e. for hard to reach areas, adolescents, 5-10 years age group)
- Involve communities and stakeholders in target setting and response, i.e. early Antenatal Care (ANC) booking
- Harmonize dashboards – develop scorecards to track progress along the continuum.
- Ensure accountability mechanisms/systems are set and functioning at all levels

Promising practices

	Know your issues, track your response, we are accountable	Technical Area	Site of implementation as found in the review
1	**Advanced Incident Management System, AIMS**	Cross Cutting	FS
2	**The Child Health care Problem Identification Program (CHIP)**	Under-5	Multiple Provinces
3	**Child Status Index (Zoe Life)**	Under-5	KZN
4	**Target setting at facility level using numbers rather than percentages**	Cross Cutting	WC

	Know your issues, track your response, we are accountable	Technical Area	Site of implementation as found in the review
5	**Data harmonisation project.** By trying to link all different data systems, the WC province has created a method of linking monthly data dumps using a unique identifier. This system also works on an algorithm basis	Cross Cutting	WC
6	**RMCH** have developed a **matrix of risk and protective factors for adolescent pregnancy in South Africa** that can be used by service providers and provides a quick overview of some of what is known about these risk and protective factors in relation to adolescent pregnancy in the South African context	A&Y	National
7	The newly opened maternal section of Brits hospital has institutionalised the process on providing feedback on adverse events by having a **multi-disciplinary meeting every Monday morning** that involve ambulances, Emergency Medical Services (EMS), obstetric, paediatric, nursing staff	MNH	NW

2. Getting the basics right, working together

Key components

Infrastructure, drugs, equipment, HR, service delivery platforms, supervision and mentoring systems, staff capacity and competency, attitudes, following guidelines and protocols, prioritization, costing and involving communities.

Overview of what the review found

Centralisation of services and lack of responsive systems such as HR; purchasing of supplies and equipment, repair and maintenance is often identified as an important contributing factor to poor service delivery at the facility level.

At the national level, norms and standards for HR and equipment exist, although it is not clear if these have been finalized. HR norms and standards are not well understood at the province and district levels. As a result the provincial and district organograms are not aligned with norms and standards, making it difficult to achieve results. In addition, the lack of an updated staffing structure makes it difficult to recruit new staff and address deficiencies. Staffing norms do not exist at the provincial level, with poor deployment of staff as a consequence.The newly established Office of Health Standards Compliance is a statutory body created to monitor compliance with norms and standards for healthcare delivery. One of its primary responsibilities will be to inspect public hospitals for six basic health standards; cleanliness, infection control, attitude of staff, safety and security of staff and patients, waiting times and drug stock-outs.

At both the facility and district level, centralisation of human resources to the provincial level is a significant bottleneck to service delivery, as it affects both the number of staff in facilities as well as the skill mix available. The centralis ation of recruitment and appointment of staff has resulted in a large number of staff vacancies, and positions that have remained unfilled for significant periods of time, in some instances more than two years. Furthermore, lack of retention policies at the central level, prohibit districts from retaining staff and keeping vacancies to a minimum.

Procurement processes for supplies, consumables, equipment and upgrading of infrastructure are long and cumbersome. All processes follow the tender system and procurement of supplies, medicines and equipment is centralized, resulting in long delays in reaching the facilities. Order forms are sent to the depot and distribution is not equitably done according to order and as per available stock. Equipment is often purchased without maintenance plans and furthermore, technicians often lack skills to repair equipment, making it difficult to maintainit. As a result equipment remains broken for long period of time and in some instances cannot be repaired, resulting in facilities functioning without it and compromising quality of service delivery protocols.

Policy stipulates that supervision be conducted frequently. Tools have been developed to assist with supervision and supervisors are required to complete the tool and define follow-up actions.

Records of supervisory visits are well documented, however, monitoring of follow-up actions has not been documented or monitored. In addition, there is a lack of a coordinated and integrated approach to supervision and mentoring, resulting in clinics receiving multiple visits for different programme areas rather than one supervision visit that cuts across the spectrum of services.

There is a lack of clarity on guidelines and protocols for supervision of MNCWH and N services. A separate cadre of PHC supervisors exists but they have a limited focus on MNCWH and N supervision, and generally lack adequate training and skills in supervision. Furthermore, the current supervisory tools are lengthy and result in a time consuming process.

There is also lack of data on PHC facilities that receive a supervisory visit with a written standardized report at least once a month as well as general concerns with the quality of supervision.

Regional training centres (RTCs) have been established in each of the nine provinces to oversee and co-ordinate in-service training for health care professionals at the provincial level. RTCs are mandated to provide and co-ordinate training on all health-related programmes. Programme training models are variable across the provinces with some offering distance learning options. Availability of human, financial and information technology resources to carry out training remains a challenge nationally. Some provinces have collaborated with universities and other training partners to complement their efforts.

While hospital boards and clinic committee exist, their roles are often unclear, and they are not engaged in annual planning at the provincial, district and facility level. In addition, feedback mechanism between communities and hospitals/clinics are not clearly defined.

Budget allocations are determined at the national level and communicated to the province. The prioritization of actions takes place annually for inclusion in plans, although these plans are generally not costed.

Key recommendations

- Address infrastructure issues urgently (prioritise)
- Review organograms at all levels to ensure adequate staffing, address vacancies and link with expected results by identifying focal persons
- Develop a decentralized plan of action for the maintenance of equipment
- Decentralize HR practices (vacancies and competencies)
- Define/implement service delivery platforms (comprehensive care)
- Link implementation plans with policy and results
- Ensure structured, integrated supervision and mentoring linked with results
- Address staff attitudes and morale (motivation)

- Strengthen clinic committees and hospital boards to engage with communities to determine community needs; and participate in annual provincial, district and facility level health planning (community involvement)
- Ensure that at provincial and district levels, mechanisms are in place to facilitate strong collaboration with civil society and community based organisations (community engagement)
- Ensure guidelines are communicated down to the facility level and work on harmonizing guidelines to limit confusion
- Explore ways to retain trained staff, such as agreements not to transfer newly trained staff for a minimum period of time
- Alternate and innovative methods of in-service training, such as courses of shorter duration, computer-based training or distance learning need additional investment and testing

Promising practices

	Getting the basics right, working together	Technical Area	Site of implementation
1	**Operation Sukuma Sakhe (OSS)**	Cross Cutting	KZN
2	**Phila Mntwana centres**	Cross Cutting	KZN
3	In order to **minimize waiting times for chronic medication repeat scripts**, the NC Province developed a system whereby patients hand in scripts while the clerks trace files, the RN dispenses the meds and the patient collects the following day without standing in a queue	Cross Cutting	NC
4	Youth are coming to facilities for **adolescent services after 18:00** when most adult clients have left	A&Y	NC
5	**Fast queue for adolescents** and flexible/extended hours	A&Y	LP
6	Some facilities have a **fast lane** for issuing contraceptives	Women	FS
7	In Northern Cape, a CHC promotes **Sunday as cervical screening day**	Women	NC
8	A Home Affairs desk responsible for ensuring **vital registration at birth** has been established in a hospital	MNH	NW
9	**Provincial birth registration forms** are being implemented to avoid using the RTHC as an identity document to obtain birth certificates, social grants	Under-5	EC
10	Pathfinder International collaborates closely with provincial and district health officials as well as health facility leadership to support the implementation of comprehensive adolescent and youth friendly services as a means of addressing unmet needs for contraception, reduce HIV transmission and offer treatment and support to young people living with HIV	A&Y	National
11	The DBE working with a range of CSO partners have researched and targeted the challenge of teenage pregnancy and associated health and psycho-social issues (EC and KZN)	A&Y	Multiple Provinces
12	KZN and NW have been able to **integrate Nutrition in Child Health** and it functions as components of one programme	Nutrition	Multiple Provinces
13	**Public-Private Partnership (PPP) referral agreements to ensure timely access to TOP services:** Marie Stopes South Africa (MSSA) entered into public private partnerships (PPP) with the Eden district in the Western Cape and with selected hospitals in Ethekwini and Ugu districts of KZN to provide TOPs in both of these districts and also to provide post-abortion family planning services in Eden district. The available data suggest that the PPP model with MSSA has alleviated the over-burdened public sector and most public sector TOP procedures have been shifted to the MSSA clinics	Women	Multiple Provinces
14	**Paediatricians teamed up with obstetricians** to reduce deaths due to asphyxia from 10% to 2% in GP. The province also provides lodging space to the mother	MNH	GP
15	Free State was the first province to offer **stand-alone AYFS for HIV treatment**	A&Y	FS
16	**Adolescent (ALHIV) Transition Clinics** at KwaMashu CHC and PMMH	A&Y	KZN

	Getting the basics right, working together	Technical Area	Site of implementation
17	Admitted **mothers are brought into discussions with the clinic committee** regarding quality of care in NW	MNH	NW
18	**Patient Complaint Response System**	Cross Cutting	GP
19	In order to ensure accountability, **nurses are required to sign-off** on having read circulars and policies	Cross Cutting	WC
20	**BANA PELE** (intersectoral initiative including DOE, DoH, SAPS, DSD and partners) hold meetings on a quarterly basis and discuss how each stakeholder can contribute to reduce the burden of diseases in children under-5 years	Cross Cutting	GP
21	**Soul City** programmes focus on adolescent and youth SRH issues through TV, radio and print media	A&Y	National
22	**A *Speak Out* handbook** for learners has been developed on how to prevent sexual abuse in public schools	A&Y	National
23	**Competent, senior person/advanced midwife anchors programme implementation**	MNH	MP
24	**Ideal clinic model** is being rolled out	Cross Cutting	Multiple Provinces
25	**ICATT and C-IMCI by Zoe Life (Community Based IMCI)**	Under-5	KZN
26	The **Queue Marshall programme** has assisted in improved service delivery by reducing patient waiting times at Zola CHC in Soweto, GP	Cross Cutting	GP
27	**Traditional healers serve on hospital boards** and are trained on what care to provide (and not provide) to pregnant women and newborns	MNH	
28	Advances in training methodologies: **Distance Learning IMCI** (d-IMCI) and IMCI Computerized adaptation and Training Tool (ICATT)	Cross Cutting	
29	**Local collaboration with universities and other training organisations** can serve to improve quality, sustainability of training and to strengthen follow-up supervision and mentoring of trained health workers	Cross Cutting	EC
30	**Dedicated nurses in some facilities supporting and promoting exclusive breast feeding (**EBF) and providing support to women with premature newborns	MNH	EC
31	**Scheduled 2 week-long induction programme** which includes a 20 hour MBFI course conducted regularly for new staff to bridge aspects not covered in general pre-service training	MNH	WC
32	Staff motivation and retention through use of **recognition awards, certificates**, etc.	Cross Cutting	EC
33	**Family Planning Integration into HIV Care and Treatment Services** (FPI) project	Women	WC
34	Training of **CHW roving teams** on MNCHW and N programmes	MNH	FS
35	**Enrolled nurse trained in family planning and collecting pap smears** working under supervision of a registered nurse. Sometimes left to run the clinic and train other students and enrolled nurses	Women	GP
36	Mozambique and Malawi have formal **task shifting statements from professional associations**	Cross Cutting	International
37	**The Stock Visibility Solution** enables nurses at 680 clinics in KZN to manage the availability of chronic medication and avoid stock-outs	Cross Cutting	KZN
38	Milk Banks	MNH	WC
39	One health facility partnered with a company that is supplying human milk for neonates. This is an example **of a PPP**	MNH	EC
40	**MomConnect** initiative uses SMS and mobile technology to reach out to mothers and their babies	MNH	National

	Getting the basics right, working together	Technical Area	Site of implementation
41	**Ndabezitha Izimbizo Project** is a public awareness and legal education initiative aimed at **empowering rural communities on the issues of domestic violence**. Through the programme traditional leaders are trained and sensitized.Safety plans and public awareness-raising campaigns have been developed	Cross Cutting	KZN
42	**Philani Project** aimed to improve maternal skills and achieve positive outcomes for pregnant mother and infants from low-income households, through a strategy of home visits by trained paraprofessional 'mentor mothers'	MNH	WC
43	**Yakhumndeni Mentor Mother Project.** Mentor mothers go house to house and conduct follow up visits to screen, refer, support, monitor and advise mentees. Linkages are maintained with government via a local project leader who participates in a Local Task Team for Operation called Sukuma Sakhe	MNH	KZN
44	**Khululeka Community Education Development Centre** offers services such as a preschool enrichment programme (20 week-long workshop over two years), a family home visiting programme (eight or more visits twice a month) focusing on access to social grants, health and nutrition and caregiver support, and an infant and toddler support programme for caregivers of children aged 0 – 6 years (weekly group sessions for between 16-19 weeks)	Under-5	Eastern Cape and Western Cape
45	**Early Learning Resource Unit (ELRU) Family and Community Motivator Programme** consists of 20 home visits taking place twice a month, monthly workshops with other caregivers and informal playgroups. The program provides information on accessing social grants, creating safe stimulating and healthy environments for children and an opportunity for the motivator and caregiver to play with the child using locally made toys	Under-5	NW
46	**Partnership approach to link C-IMCI with child survival project in Limpopo.** AMREF trained a group of CHWs, Project Steering Committee members, child care forums on c-IMCI (content of the training included identification of the sick child, knowledge of 17 key family practices and the referral systems) and they received certificates of attendance as a way of motivation and recognizing their key role in addressing child health problems	Under-5	LP
47	**Sobambisana Project: (Ilifa Labantwana)** included a stakeholder and community awareness campaign as part of creating an enabling environment for young children in under resourced areas in the Eastern Cape	Under-5	EC
48	**Malamulele Onward** focuses on improving the quality of life for children with cerebral palsy living in remote rural areas in the EC, LP, and KZN (Malamulele Onward). Malamulele Onward works to improve access to rehabilitative health services for hard to reach communities through outreach programs	Under-5	EC, LP, KZN
49	**Infant feeding Buddies (PATH)** Home based EBF support programs have been shown to be beneficial for HIV positive mothers. Women in South Africa need extra support to overcome challenges related to adhering to whichever option they chose—formula feeding or EBF. Infant feeding buddies can potentially be developed to provide support for child health practices at a community level	MNH	EC
50	**GroundBREAKERs youth development programme** are young people, aged 18-25, who are placed in work experience in various loveLife initiatives for a year. They provide peer education and support; represent the needs of young people on the QI team; assist with quality assessments such as focus group discussions and are involved in a range of outreach activities	A&Y	National

	Getting the basics right, working together	Technical Area	Site of implementation
51	The national loveLife media campaign along with the groundBREAKERs outreach activities are significant adjuncts to the youth coming to the clinic. The current **Nakanjani campaign has created a demand for the loveLife brand** that is associated with the YFS clinics and community hubs	A&Y	National
52	The DoH is working closely with ***Imbhumbha ya Makhosikazi*** (wives of the chiefs) to improve community level education and referral of sick children to facilities. This seems to have increased service utilization in the few areas where it is being implemented	Cross Cutting	EC
53	**Mayihlasele Izazi** Girls education/support groups for HIV prevention and speaking out about sexual assault	Women	MP
54	WC has begun **process of consultation with community organisations/ health committees to incorporate community voice** in the 2016 provincial health plan	MNH	WC
55	**Dedicated CHW assigned to Mother-Baby Pair**	MNH	KZN
56	Philani **CHWs trained in cognitive-behavioural strategies to** lower preterm birth rates and risks	MNH	WC

3. Connecting the dots: Cascades and pathways and transport and referrals

Key components

Cascades and pathways, transport referrals

Overview of what the review found

There are several challenges with the referral services in the country. These include low coverage of emergency ambulances; the availability and accessibility of some referral services including transport from district-level facilities to referral centers, as well as the availability of transport for other district-level functions such as supervision, delivery of school health services and transport of laboratory specimens; and a poor feedback system between services. Transport to secondary and tertiary level hospitals is problematic, resulting in delays or non-arrivals; patients often return home with health conditions not being attended to until they have become worse, increasing the severity of the disease and treatment costs when the patient does arrive. Furthermore, there are inadequate linkages between clinics and the community. Once CHWs identify patients and refer them there is no feedback from the clinic about the status of the patient or schedule for community follow up.

In addition, the costs of emergency transportation remain a key determinant of healthcare access for many South Africans. Although primary health care should be available for free, and uninsured children under the age of six years are exempted from hospital fees, out-of-pocket payments have been made by 17% of uninsured children attending public hospitals and 8% of children attending a PHC clinic. Further, unaffordable transport obstructed immediate care for 18% of children under the age of six years, but for only 1% of insured persons based on data from 2011 (Harris et al. 2011)[5].

The NDoH has made some progress in addressing these deficiencies across provinces with the rollout of mobile clinics to hard-to-reach areas. At the inception of the ISHP in 2012, especially equipped mobile health vehicles were procured for National Health Insurance (NHI) pilot sites to render services to schools in those districts.

Recommendations

- Map and define the referral system between facilities and refer down to the community/household level and schools through the ISHP, WBOTs and health facilities for continuity of services

[5] Harris B, Goudge J, Ataguba JE, et al. Inequities in access to health care in South Africa. J Public Health Policy 2011;32(S1):S102-S123.

- Build skills for Emergency Medical Services (EMS) –including triage, joint planning/review
- Ensure availability of transport i.e. ambulances at all times. If ambulance is unavailable, contract with local transport agencies and/or contracts in a designated catchment area and prioritise urgent referral cases
- Consider the expansion of 24-hour specialized emergency transport services for emergency obstetric and neonatal care to include paediatric care, particularly for the inter-facility transfer of critically ill children
- Maintain updated lists of referral transport options
- Track progress using routine programme data (DHIS) along the continuum of care for women and children
- Ensure mother and baby are given care as a unit
- Improve fleet management and maintenance at a district management level for the transport of patients and specimens between institutions (i.e. facilities and laboratories).

Promising practices

	Cascades and pathways and transport and referrals	Technical Area	Site of implementation
1	Defaulter tracing register for immunizations	Under-5	NC
2	**Tracer cards** to follow up newborns	MNH	EC
3	Women enter **raffle for booking before <20 weeks ANC**	MNH	WC
4	Some referring clinics **contact hospital by telephone** to obtain specific appointment dates for women referred for specialized services to strengthen linkages	MNH	EC
5	MNCWH services **use Community Care Givers (CCGs) optimally to track defaulters** and establish communication with Operational Managers	Cross Cutting	KZN
6	**Written referral system for mother** from WBOTs to facility has been developed, including a formal down referral system from facility to WBOTs which uses pigeon holes for communication with CHWs	MNH	NC
7	Locally developed **formal patient referral system** linking PHCs to CHCs and to referral hospital in Kimberley, with written feedback on each patient from each level of referral	Cross Cutting	NC
8	**Newborn retrieval teams** are used to stabilize and transport newborns before referral	MNH	KZN
9	Long term **follow up by dietician** of kangaroo mother care (KMC) babies when discharged home	MNH	FS
10	**Loan schemes or arrangements** with local transport agents for low-cost emergency transport	Cross Cutting	NC
11	In Nigeria, a project worked with transport unions to provide reliable and affordable transport. A seed fund for the cost of fuel was provided, which was replenished with contributions from users to address patient cost barriers	Cross Cutting	International
12	A project in Sierra Leone provided radios to summon vehicles to take women to hospital in the case of obstetric emergency	MNH	International
13	**PHCIS (Primary Health Care Information System) and PREMIS system** Every person coming into any health facility gets a unique identifier number and a bar coded sticker, which goes onto the patient folder. It uses multiple information systems to track patients through electronic footprint enabling providers to see where they have been, what treatment they received. It provides detailed information on the patient, including pharmacy records	Cross Cutting	WC

Key Findings, recommendations and promising practices related to the thematic areas

Maternal and newborn health

The importance of quality care for women and babies has never been clearer. This year's global Every Newborn Action Plan and the forthcoming Maternal Health Action Plan have demonstrated that high coverage of care around the time of birth and care of small and sick newborns would save nearly 3 million lives (women, newborns and stillbirths) each year in 75 high burden countries around the world at an additional cost of only ZAR 11 per person. This would have a triple impact on investments – saving women and newborns and preventing stillbirths.

This review has identified 5 main recommendations that cut across maternal and newborn health and nutrition and align with existing recommendations including the push to accelerate progress ahead of the MDG deadline, and the impetus to improve health within the sustainable development goals.

These recommendations, with specific actions for various constituencies include

1. Integrate MNH services within the health system and with other sectors
2. Plan for and support assessment of maternal and newborn signal functions to provide a baseline for quality of care and inform rationalization of birthing units at clinics and CHCs
3. Focus on and prioritize quality of care, particularly at the time of birth and immediately after to maximize impact
4. Address delays in EMS transport and capacity which causes significant maternal and neonatal mortality and morbidity
5. Support further education and training at all levels

Topline recommendations and key actions by constituency

Recommendations for MNH are provided with key actions for decision makers at national level, district level, health professionals and associations and civil society, including families. The action is placed where most relevant for the decision-makers but many of the actions overlap actors. Where available, examples of 'promising practices' are mentioned.

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facility	Civil society
1. **Integrate MNH services within the health system and with other sectors**	• Engage relevant departments outside the health sector on the **Call to Action** for RMNCH • Improve **guidelines for early postnatal care** including newborn care, family planning and maternal wellbeing, nutrition, and mental health support • Budget for and recruit provincial DHIS/PPIP/ CHIP co-ordinator. (Can be done by outreach/ regional clinician) *MP Promising Practice: MNCWH coordinator's role has increased accountability and closed the data gap through collection and collation of data from facilities*	• Strengthen and integrate all **BANC services at first contact:** focus on screening for case-identification and management of TB, syphilis, hypertension and anaemia. ANC booking should be done immediately upon pregnancy confirmation. Fast-tracking initiation of treatment of both TB and HIV in pregnant women must be a priority *WC Promising Practice (George): Enter raffle for booking before <20 weeks ANC* • Ensure **Integrated Postnatal Care** for every Mother-Baby pair within 3 days after delivery following improved national guidelines. Ensure women are not discharged from facility without **family planning** method • Ensure **PMTCT and MCWH** plans, service delivery, and reports/monitors under the same programmatic umbrella, using **raw numbers as well as proportions** for monitoring and reporting services • Empower communities by strengthening **local structures** and **task shifting**	• Partner with civil society in networking and call to action • Develop formal statement in support of **task shifting** to other health worker cadres at community level *International Promising Practice: Mozambique and Malawi have formal task shifting statements from professional associations* *NW Promising Practice: Significant improvement in <20 week bookings through screening all women who have missed a period for pregnancy*	• Screen for **gender-based violence** at first ANC visit and follow referral plan • Identify and develop a support plan for high-risk mothers and newborns • Use raw data, not rates to address the issue • Write an action using the **7-step implementation plan** with the DCST providing guidance • Let the CEO be part of the planning and sign off on the plan • Do quarterly reviews of the plan and amend as required	• Bring together a network of civil society actors to align advocacy goals and mobilise action, including strengthening local structures (health committees) to identify **adverse social determinants**, e.g. teenage pregnancy and availability of contraceptive services, poor communications/ roads/transport/medicines supply • Engage **male and female youth advocates** in communities, especially for teenage pregnancies • NGOs, CBOs and others should **align data with facilities** they serve

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facility	Civil society
2. Plan for and support assessment of maternal and newborn signal functions to provide a baseline for quality of care and inform rationalization of birthing units at clinics and CHCs	• Develop guidance on **rationalization of birthing units** and staffing (weighing patient access to facilities, number of deliveries), particularly where clinics are delivering patients but are not open 24/7 • Implementation of reliable communication and feedback systems. Assess betamethasone availability and SOP for nurses to administer	• Plan for **quarterly support and assessment** of signal functions by DCST • **Monthly reporting via maternal/ perinatal mortality and morbidity (M&Ms)** re: signal functions, stock outs to district/province *LP Promising Practice: Specific documentation and reporting of poor management of APH, PPH as result of supply problems* • Promote and support betamethasone use at all clinics/ CHC birthing units. • Provide additional resources (human, financial) to support and supervise hospitals and primary level facilities	• Produce Essential Steps in the Management of Obstetric Emergencies (ESMOE) self-study guide • Conduct in-service and refresher training on partogram use, plotting and interpretation	• Perform step 2 of the **7 step implementation plan** • Send the results to the DCST	• Advocate for **standing agenda item regarding signal functions** and EMS for hospital boards/ clinic committees with updates back to communities *NW Promising Practice (Letsopa Clinic): Admitted mothers are brought into discussions with clinic committee regarding quality of care*
3. Focus on and prioritize quality of care, particularly at birth and immediately after to maximize impact	• Appoint an **obstetrician at national level** in the maternity directorate to fill the currently vacant post • **Recommend provincial maternal health posts** (obstetrician or midwife) to provide guidance on planning, budgets and recommendations for maternal health	• Ensure tracking and monitoring of **quality indicators** already defined by the ministerial committees to get beyond coverage of care and ensure accountability • Strengthen referral, feedback and tracking systems – report in Maternal / Perinatal M&Ms • Develop newborn care champions at each level, especially MOUs and District Hospitals with special focus on interventions which require education and advocacy for uptake, (e.g. KMC)	• Develop and nurture champions within professional associations • Adapt existing training materials/briefing documents on evidence for **effectiveness of mid-level and community health workers** at scale in similar settings globally; and in pilot sites within South Africa	• Ensure that staff managing babies are skilled and trained in HBB and MSSN • Aim for 80% coverage of both HBB and MSSN • Monitor and evaluate the quality of care indicators as per page 20 of the **7 step implementation plan**	• Ensure regular sessions are held with health facility boards to raise awareness of factors adversely affecting quality of care at birth • Increase awareness amongst health facility boards, health committees and the general public of the need for greater involvement of mid-level workers and CHWs

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facility	Civil society
	• Highlight actions and timeline to achieve maternal and newborn quality of care indicators in national review report • Support innovative quality of care **pilot projects** • Regularly **evaluate, document and circulate best practices** within and outside of the country • Encourage **cross-country** learning opportunities on quality of care • Strengthen policy and strategic framework around **community health workers** *International Promising Practice: Community health workers in Bolivia, Colombia and Ecuador provide home visits for pregnancy and postnatal care and may provide a more analogous health system compared to other African settings using CHWs*	• Ensure sufficient and adequately trained CHWs to undertake early postnatal home visits • Ensure a training programme for ambulance staff on emergency Newborn Care *KZN Promising Practice: Dedicated CHW assigned to mother-baby pair*	*WC Promising Practice: Philani CHWs trained in cognitive-behavioural strategies lowered preterm birth rates and risks* *KZN Promising Practice: Home visits from CHW during pregnancy and postnatally linked women to facilities to improve postnatal care seeking and healthy behaviours including exclusive breastfeeding and was highly cost effective* • Promote harmonization of research to address the outstanding high impact questions		• Advocate for a **consistent quality of care message** in the call to action campaigns that should run quarterly and in accordance with the national health calendar

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facility	Civil society
4. Address delays in EMS transport and capacity which causes significant maternal and neonatal mortality and morbidity	• EMS to be incorporated into DoH, not a stand-alone system	• Review **call centre allocation of emergency vehicles weekly** (assess number of calls/area, severity and response times) • **Dedicated obstetric ambulances** to be used for obstetric care only • **Monthly report to District/ Province:** o EMS Weekly Reviews to be done by both DoH and EMS o Complications and Deaths from M&Ms o Staffing availability / vehicles in use, with plan to address staff shortages / maintenance. o Establish stronger feedback mechanism between tertiary hospitals and lower levels of care • **Improve linkages between maternity waiting homes, and facilities** to improve access and uptake. Where possible, identify sources of support for provision of meals	• Prioritize EMS delays for mothers and newborns as a key professional issue *KZN Promising Practice: Newborn retrieval teams are used to stabilize and transport newborns before referral*	• Keep an audit of the response time at facility level • Feedback regularly on EMS problem cases in weekly unit meetings where the EMS are present • Best Practice at Brits hospital (not part of review though)	• Establish communication mechanism between health manager and facility board to **convey any delays in EMS transport arrivals**

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facility	Civil society
5. Support further education and training at all levels	• Provide training on youth-friendly maternity services to retain young women in care	• Support communities to identify and respond to danger signs for mothers and babies • Provide training on youth-friendly maternity services to retain young women in care • Rotation of advanced midwives between hospitals and CHC/Clinic birthing units to improve ESMOE skills *EC Promising Practice: Birthing unit for high-risk patients at regional hospital managed by advanced midwives who are able to retain their skills.* *MP Promising Practice: Advanced Midwife (Focal Nurse) permanently assigned to birthing unit at CHC and not rotated in CHC in order to provide expertise and training for other staff*	• Ensure that neonatal nurses are supported to learn and perform the basics right, which covers the 8 high impact factors to reduce perinatal deaths • Ensure that pre-service curriculum for health professionals includes ESMOE-EOST	• Ensure that the national training HBB and MSSN has >80% coverage at facility level • Prioritise the midwives in labour wards for HBB and the nursery nurses for MSSN	• Promote idea that "MNCH is everyone's business" and that patients have the right to seek and receive respectful, quality care • Involvement of men as partners in MCH, promote early pregnancy identification, recognize and respond to danger signs for mothers and babies *NW Promising Practice: Traditional healers serving on hospital boards and being trained on what care to provide (and not provide) to pregnant women and newborns*

Under-5 child health

After remarkable reductions between 2006 and 2011 in under-5 and infant mortality, both rates stagnated in 2012. The achievement of MDG 4 by end-2015 is therefore unlikely. Case fatality rates for diarrhoea, pneumonia and severe malnutrition are decreasing but have not reached targets. There has been some improvement in exclusive breastfeeding rates at 14 weeks. Supplementary feeding is inadaquately provided for children who are failing to thrive. Routine immunization coverage remains sub-optimal in most districts. Delivery of other preventive strategies such as growth monitoring, vitamin A supplementation and deworming is also poor. IMCI has not been widely adopted as standard practice at all primary level facilities despite considerable investment in training. Increased coverage of ART for pregnant women has resulted in substantial reduction in HIV transmission at six weeks of age although longer-term (18 month) outcomes are uncertain and ART coverage in children remains low.

The review has identified some overarching recommendations that cut across under-5 child health and align with existing recommendations including the push to accelerate progress ahead of the MDG deadline, and the impetus to improve health within the sustainable development goals.

These recommendations, with specific actions for various constituencies include

1. **Service Delivery:** Identify and support a preferred model of service delivery for sick and well children at primary health care and hospital level
2. **Planning and budgeting:** Annual national, provincial and district health plans must include child health activities with targets and an associated budget
3. **Norms and Standards:** Establish human resources and paediatric equipment norms and standards
4. **Human Resources:** Decentralise HR management functions to district and hospital level, and ensure adequate supervision and mentoring
5. **Delivery of PHC re-engineering strategy:** Define the roles and responsibilities of WBOTs, DCSTs and school health teams in the provision of child health services
6. **Respond to data:** Establish provincial and district child health fora for the regular review of, and response to, district and hospital performance
7. **Communication:** Develop a national child health communication strategy directed both at health professionals and population level

Top line recommendations and key actions by constituency

Recommendations for under 5 health are provided with key actions for decision makers at national level, district level, health professionals and associations, and civil society, including families. The action is placed where most relevant for the decision-makers but many of the actions overlap actors.

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
1. Service delivery Identify and support a preferred model of service delivery for sick and well children at primary health care and hospital level	• Identify and declare 5-10 priority objectives and activities within the current strategic plan • Develop a national consensus on whether IMCI is a prescribed, preferred or a discretionary option • Define IMCI's role in the management of children arriving for well-baby services (e.g. immunization) • Provincial head offices must relinquish their stranglehold on hospitals and insistence on micro-management, and concentrate instead on policy, strategy and the monitoring of management performance	• Strengthen the implementation of IMCI (through in- service training, supervision, mentoring and evaluation) • Improve vehicle fleet management and maintenance at district management level • Expand 24-hour specialised emergency transport services for emergency obstetric and neonatal care to include paediatric care, particularly for the inter-facility transfer of critically ill children	• Support IMCI-trained nurses to remain in the paediatric service and practice IMCI where this is not happening • Expect doctors and professional nurses to use national (or provincial, if applicable) reference guidelines in management of common conditions • Improve linkage and collaboration between CHWs and clinic staff to ensure functioning referral chain and continuum of care (especially c-IMCI) • Institute measures and procedures that ensure accountability from support staff, health professionals, managers and administrators, recognising that few have succeeded to date	• Enforce "every day is an immunization day" philosophy • Demand Road to Health booklets at every visit and insist that health care workers fill them • Conduct nutritional assessment of every child at every visit, and ensure an appropriate response, including food supplementation (where necessary) • Establish an 'IMCI excellence' accreditation system • Institutionalise a "red flag" system of identifying critically ill children in hospitals who need to be reviewed at night or over weekends by a doctor • Provide catch-up of incomplete vaccination upon discharge from hospital	• Invite involvement of other government sectors and community representative in the district health forum • Strengthen the community component of IMCI through involvement of WBOTs and CHWs in implementing community IMCI (c-IMCI) • Include crèches, day care centres and Grade R into C-IMCI programme to reach children who are unavailable during home visits • Strengthen linkages between clinics and the community through clinic committees as a platform for highlighting gaps and providing feedback for taking actions

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
				• Revise guidelines and strategy to ensure identification and testing for HIV of all sick children 0-5 years accessing health care • Focus efforts on minimising postnatal HIV transmission secondary to breastfeeding, by ensuring ART provision • Establish mechanisms to more readily identify the estimated 50% of infants who are HIV-infected but not on ART • Identify undiagnosed HIV positive children older than 18 months • Increase access to higher levels of care for children who require additional or more specialised care but who cannot access it either because of the dysfunctions in the system or lack of space for them at the next level of care	

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
2. Planning and budgeting Annual national, provincial and district health plans must include child health activities with targets and an associated budget	• Annual provincial health plans must have a section on child health, indicating priority programmes/ interventions, with targets	• Annual district health plans must have a section on child health, indicating priority programmes/ interventions, with targets		• Authorise hospital managers to run their own hospitals and be held accountable for this without undue interference from head offices, according to agreed business, budget and performance plans • Base hospital organisational structures on clear operational units. A unit such as paediatrics should have clear lines of authority and accountability with silo disintegrated functions • Specifically define and increase expenditure within hospital budgets for paediatric care	• Allow civil society access to all health plans and budgets, and encourage active discussion and critical feedback

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
3. Norms and standards Establish HR and paediatric equipment norms and standards. Encourage wider use of protocols and guidelines.	• Develop a set of core minimum standards for the health care of children in clinics, CHCs, emergency units and wards in public and private hospitals • Resource the office of health standards compliance to develop a national repository of norms, standards and guidelines • Support the same office to oversee the development and implementation of more effective and affordable service, quality and clinical care guidelines • Establish HR norms and standards for WBOTs, DCSTs and school health teams	• Implement norms and standards • Implement national or provincial (if available) reference guidelines in management of common conditions	• Doctors and professional nurses should be expected to use national (or provincial, if available) reference guidelines in management of common conditions	• Expect each facility to be clearly aware of its own compliance with HR and equipment norms • Expect each facility to have a plan as to how it intends on meeting norms and standards • Paediatric ward or section to be staffed by professional nurse at all times	• Encourage civil society organisations to critically engage in the process of defining norms and standards, and in evaluating compliance with these at all levels of the health system

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
4. Human resources Decentralise HR management functions to district and hospital level, and ensure adequate supervision and mentoring	• Decentralise HR and equipment management functions to district and hospital level where this is not happening • Make the necessary political and financial commitments to assess current staffing levels, determine appropriate staffing levels and take budgetary and policy action to address gaps, including: ○ establishment of adequate positions ○ filling of vacant positions, ○ ensuring that health workers are consistently paid • Increase the capacity of pre-service training institutions and facilitate increased enrolment to address the critical supply shortage of health professionals (doctors, nurses, midwives, pharmacists, lab technicians, etc.)	• Support districts to manage their own HR needs • Conduct a rapid situation analysis to evaluate the existing HR capacity for MNCWH and N services • Adequate supervision and mentoring is required as a follow-up to training to ensure effective implementation of services • Develop the WBOT support system to allow community-based frontline health workers to help "plug the holes" in the MNCWH and N cascade and support caregivers and families outside of the clinic setting • Employ nurse auxiliaries to assist with managing vaccine supply and maintaining cold chain • Consider introducing targeted incentive systems (financial or non-financial) to reduce attrition and improve performance	• Identify and implement policies and legal systems required to extend and indemnify scope of practice for nurses, clinical associates and community health workers, and motivate professional bodies such as nursing, health professional and pharmacy councils to accept the need for the change with respect to scope of work and/or task shifting. • Expand task shifting/ sharing, training and accreditation of different cadres of facility and community based health workers to deliver the services required • Develop a comprehensive MNCWH-N curriculum that can be integrated into pre-service training of nurses and midwives to build their capacity in MNCWH-N • Review the training strategy and develop a national guideline for coordination of training related to child health (including HR issues)	• Achieve the recommended staffing norms of health facilities for specific critical skills (paediatricians, doctors, nurses, lab technicians, and pharmacists) • Minimize staff rotations amongst health facilities	

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
	• Forge ways to retain trained staff within MNCWH and N, such as agreements not to transfer newly trained staff for a minimum period of time • Commission an analysis of current systems for management and deployment of health professionals, including criteria for deployment, performance management, training and continued learning, focusing specifically on the human resource needs for a fully functional MNCWH and N system • Expand the regulatory framework to include more support cadres, such as clinical associates, counsellors, peer supporters, mentor mothers, and expert clients • Strengthen management and supervision, update performance management and performance evaluation systems and reward mechanisms to recognize not only good clinical practice but also compassionate and responsive care				

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
	• Provide decentralised authority to recruit and supervise employees, change deployment practices to match individual skills and experience to the needs of each health facility • Provide support systems for health workers ("caring for carers") that provides psychosocial support as well as other specialised clinics that allow health workers to receive services in a confidential space, separate from their clients • Implement standardised employment and remuneration mechanisms for WBOTs				

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
5. Delivery of PHC re-engineering strategy Define the roles and responsibilities of WBOTs, DCSTs and school health teams in the provision of Child Health services	• Define the roles and responsibilities of WBOTs, DCSTs and school health teams in provision of child health care • Construct a clearly defined scope of practice; CHW and WBOTs tasks need to be clarified including protocols for structured household visits and outreach services • Redefine roles and task allocation of school health staff to ensure effective use of available skills and competencies • Strengthen links between school health teams and existing PHC services at facility level • Define prescribed model of service delivery of sexual and reproductive health services to school-aged children • Systematically review the district clinical specialist team initiative and provide guidance on how their function within districts should be organised and optimised	• Organise and co-ordinate WBOTs activities and support their ability to deliver basic MNCWH and N services through training, supervision, mentoring, equipment, etc. • Adopt the guidelines as recommended by NDoH in the 'Community Care givers Manual on maternal, newborn, children and women's health' nationally and ensure uniformity in its implementation	• Recognize the identity and role of CHWs as important contributors to managing a child at community level and increase coordination and communication with them. • Review current ISHP school health staff skills mix and task allocations as limited number of full-time dedicated ISHP staff are employed across provinces	• Organise and co-ordinate WBOTs activities and support their ability to deliver basic MNCWH and N services through training, supervision, mentoring, equipment, etc. • Strengthen links between school health teams and existing PHC services at facility	• Ensure active involvement of communities to ensure support to promote use of WBOTs by community members; and promote referrals and linkages for sick children between the community and clinics

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
6. Respond to data Establish provincial and district child health fora for the regular review of, and response to, district and hospital performance	• Establish a provincial child health forum for the quarterly review of, and response to, district and hospital performance data based primarily on child dashboard indicators • Strengthen M&E system for quality data submission at all levels • Regularly update data and feedback toall levels (community, facility, district, province and national)	• Establish a district health forum for the quarterly review of and response to child mortality data; hospital based workload, morbidity and mortality indicators; and PHC child health programme indicators such as PMTCT, EPI or nutrition.	• Train health workers in basic data interpretation	• Monthly mortality audits made compulsory at hospital level, preferably using cPIP • Monthly review of dashboard data, exhibition of performance to the public (on waiting area noticeboards, for example) • Integrate child PIP into quarterly improvement processes at hospital and district level • Review facility level data collection practices and implement data validation and improvement processes	• Invite other government sectors and community representatives to take part in the district and provincial child health forums

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
7. Communication Develop a national child health communication strategy directed both at health professionals and at a population level	• Identify specific key messages for child health • Ensure children (5-10) are included in the development of key messages • Determine and prioritize national level activities	• Ensure availability of all the relevant child health guidelines and protocols at all facilities and that staff are adequately trained and competent to implement guidelines	• Encourage professional associations to engage in the national communication strategy development • Expect professional associations to be partners in delivery of the strategy	• Simplify the information disseminated to lower levels by translating policies and guidelines into protocols or SOPs, and preferably complement these with visual aids such as wall charts that are easily accessible • Simplification in content and layout of guidelines, as well as re-orienting guidelines for multi-sectorial issues (such as nutrition) along a life-cycle continuum, rather than by intervention • Develop implementation guides, such as toolkits, checklists and job aids to guide health workers in the delivery of behaviour-based interventions	• Link with community-based organization for the implementation of the communication strategy • Recruit mothers and caregivers into organised support groups as part of the delivery strategy

Women's health

Statistics South Africa 2013 mid-year population estimates report that South Africa has a total population of approximately 53 million people, 51% of which are female. There are approximately 14,670,000 women of reproductive age, making up 28% of the total population. HIV-positive status in the 15-49 years age group is 18.8%, with females 1.6 times more likely than males to be HIV positive. This difference is more pronounced in the 15-24 year age group, with 2.9% of men and 11.4% of women testing HIV positive. The women's health pillar within the MNCWH and N strategic plan deals with contraception, termination of pregnancy, adolescents, cervical screening and gender based violence. A separate working group and assessment was formed for adolescent health.

The review focused on the following areas, as reflected in the Strategic Plan: (i) Contraception; (ii) Termination of pregnancy; (iii) Cervical screening; (iv) Gender based violence and post rape care; and (v) Nutrition in relation to women's health.
The review has identified some overarching recommendations that cut across women's health and align with existing recommendations including the push to accelerate progress ahead of the MDG deadline, and the impetus to improve health within the sustainable development goals.

These include

1. Develop and implement a defined package of integrated women's health services
2. Review women's health data sets to ensure more effective monitoring, to identify gaps and improve service delivery.
3. Improve referral pathway and service provision for cervical screening- from primary level to referral centre
4. Expand access and reduce waiting times for TOP
5. Develop a comprehensive operational implementation plan for the Contraception and Fertility Planning Policy
6. Completion of policies and guidelines (accompanied by dissemination, training and change management)
7. Improved access and quality of care for GBV and post rape care

Topline recommendations and key actions by constituency

Recommendations for women's health are provided with key actions for decision makers at national level, district level, health professionals and associations, and civil society, including families. The action is placed where most relevant for the decision-makers but many of the actions overlap across actors. Examples of promising practices are provided in the women's health best practices addendum (one pager series).

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
1. Develop a defined package of integrated women's health services	• Develop guidelines on an integrated package for women's health care, with targets and standards of care; indicating opportunities for integration at different levels of care: for services including HIV, CFP, TOP, cervical and breast cancer; sexual assault /GBV • Revise Women's health card to reflect this package of care; popularize health card, and emphasize the importance of Women's Health • Ensure appointment of MNCWH and N/women's health coordinators • Develop integrated package of training with Regional training centres with modules and accreditation	• Implementation of women's health card • Determine the percentage of facilities that provide the full range of women's health care, as deemed appropriate to level of care; identify gaps in service provision – these activities should form part of the District Health Plan • Appointment of MNCWH and N/women's health coordinators • Identify integrated package of training, with modules and accreditation	• Assist with the development of an integrated package of training, with modules and accreditationwith further education institutions (Nursing colleges, medical schools) and regional training centres • Training needs analysis should be conducted for women's health • Ensure pre-service and in-service training for all aspects of the women's health package	• Assess opportunities for integration of various components of women's health. • Have Women's Health Wellness Days – especially to target women who are not pregnant or of reproductive age • Utilize waiting rooms for the promotion of different aspects of women's health • Promote use of Women's Health Card	• Strengthen public-private partnerships in areas where the public sector is unable to address unmet needs for safe and legal TOP services or where there are delays • Promote awareness about women's health and wellness services, together with the women's health card • Develop a simple document with key women's health messages for civil society organizations and WBOTs • Outreach services to women's meetings/ structures/church groups etc.

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
2. Review data sets for more effective monitoring, to identify gaps and improve service delivery	Review overall monitoring/data sets for the women's health programme **Contraception:** • Improve centralised systematic data and monitoring for the introduction of contraceptive implants • Set targets and a dashboard to monitor percentage changes in expanded method mix provision. Establish targets for increasing new FP acceptors focusing on adolescents • Emergency contraception needs to be captured in the register and monitored • Add: new acceptors of FP, clients switching methods; age disaggregated data **Cervical cancer:** • Review the targets for cervical screening • Establish a screening register that can be linked to cancer registry to better understand outcomes of failed screening or vaccinations • Consider surveillance of vaccinated cohorts	• Set district based targets as per national and provincial targets for key aspects of the women's health programme; reflect these in the Annual District Health Plan. • Create simplified women's health register • Develop women's health dashboard key indicators (currently only CYP and cervical cancer coverage) • Conduct audit to determine reasons for designated TOP sites not being operational • Review the quality of data (e.g.data collated for post rape care) • Strengthen training and capacity on the use of data for quality improvement • Strengthened supervision on monitoring and quality data collation, the use of data to identify gaps and institute measure to close gaps	• Ensure all management staff and data capturers are trained in understanding the data sets; target setting and using data to improve gaps in service delivery • Orientation and capacity building on the development of simple graphs to track priority indicators • Ensure supervisors are trained in M&E; interpreting data; audits to check the quality of data; and giving feedback to staff about trends, gaps and improvements	• Strengthen engagement and interaction with data by staff • Set facility-based targets • Provide regular feedback to all staff; use simple visual aids to monitor, track targets, gaps and achievements (graphs, posters with QI interventions)	• Engage with NGOs, partners, clinic health committees and WBOTs about targets and to strategize ways to meet targets • Provide regular feedback to community about selected indicators – linked with campaigns, use simple visual aids to monitor, track targets, gaps and achievements

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
	TOP: • Establish sentinel sites to monitor contraception before and after TOP • Ensure TOP data is disaggregated by age • Improve TOP data to inform better planning and provision of TOP services - Classification of data in terms of the gestational age by weeks and method - Record complication from unsafe, illegal or self-induced abortions and disaggregate from miscarriage complication • Record deaths from unsafe abortions **Post rape care:** • Review the quality of data (e.g.data collated for post rape care)				

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
3. Improve referral pathway and service provision for cervical screening- from primary to referral centre	• Research and consider alternative approaches such as 'screen and treat' • Explore visual inspection with acetic acid (VIA) • with cryotherapy as an option • Provide guidance to ensure that screening is still prioritised despite vaccine program (will ensure that unvaccinated/older women will be picked up in future years)	Improve linkages and access to care within district through: - Routine screening at PHC level as per DoH guidelines to be monitored against established targets - Backlogs for colposcopy, LEEP or cryo and other further need to be mapped and documented • Training of district clinic support teams in the management and treatment of abnormal pap smears	• Improve quality of screening through: training, supervision • Consider the cost effectiveness of training medical officers at larger clinics to perform colposcopy and LEEP • Training of district clinic support teams in the management and treatment of abnormal pap smears	• Improve quality of screening through training; supervision • Improve quality of screening through: training, supervision and calculate the cost of improved spatulas, for example, the 'broom'. • Compare costs of improved spatulas with the cost of repeat smears and risk of loss to follow-up • Improve linkages and access to care within the district through: - Routine screening at PHC level as per DoH guidelines, monitored against established targets - Backlogs for colposcopy, LEEP or cryo and other services need to be mapped and documented	• Increased community education on the link between cervical cancer and HPV infection and the relationship between secondary prevention (screening) and primary prevention (vaccines); regarding campaigns and outreach activities, raise awareness concerning the need for screening and follow up on abnormal pap smears

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
4. Increased access to TOP and reduced waiting times for TOP services	• Strengthen management support for TOP: Develop a strategy for training in values clarification, attitude transformation and 'health workers for change' – for all levels of health providers including management • Consider ways to expand access and provision of TOP services for example re-examine standards underpinning designated sites; strengthen public-private partnerships in areas where the public sector is unable to address unmet need for safe and legal TOP services or where there are delays; encourage integration of package of women's health services (see 1) • Provide guidance for expanding medical abortion services to all provinces	• Strengthen management support for TOP: Implement a strategy for training in values clarification and attitude transformation – for all levels of health providers including management • Train appropriate members of district clinic support teams to support clinical management of TOPs • Review percentage of designated sites functioning; monitor caseloads; waiting times; delays in access to services and develop measures to deal with gaps in service provision • Ensure all TOP sites have full methods and mix of contraception available, with staff trained on all methods,an emphasis on choice and informed-decision-making • Establish MOUs with private providers/ partners where there is limited access for TOPs	• Strengthen management support for TOP: Include values clarification and attitude transformation in further education training institutions as part of SRHR • Include TOP into medical and nursing school curriculum • Train doctors in second trimester TOP management • Participate in training in values clarification and attitude transformation – for all levels of health providers including management • Ensure all TOP healthcare providers are able to provide all contraceptive methods including IUD and implants	• Healthcare providers should be encouraged/ supported by management to attend TOP values clarification and attitude transformation workshops • Ensure pregnancy screening and testing is available at facility; early detection; counselling on alternatives to TOP • Ensure there are referral systems to designated sites with minimal delays in accessing TOP to reduce second trimester TOPs	• Community outreach using NGOs, partners, WBOTs to educate community on: o Prevention of unintended pregnancy, emergency contraception o Importance of early detection of pregnancy; counselling on alternatives to TOP and rights linked to TOP o Work with supportive NGOs

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
5. Ensure the revised Contraception and Fertility Planning Policy is being implemented and monitored	• Develop a comprehensive operational implementation plan which draws together different initiatives currently being undertaken into a comprehensive plan, to include: training, supervision, mentorship; implementation of implants and IUDs; the national family planning campaign; quality and standards of CFP services; M&E and redefining data sets for the CFP programme • Provide a forum to review indicators and targets for CFP • Improve national female condom programmatic coordination	• Ensure National CFP policy and service delivery guidelines and clinical guidelines are available at all facilities • Provide input into the development of a comprehensive operational plan; ensure sub-districts; frontline health workers contribute to the plan • Oversee the implementation of the comprehensive operational implementation plan once developed • Develop a cyclical training for new methods and in-service refresher training on CFP; standardise assessment of competencies • Strengthen and monitor systems for contraceptive commodity supplies and equipment • District to coordinate and guide the implementation of the family planning campaign	• Healthcare providers at all levels of care develop competencies in provision of all methods, with an emphasis on newly introduced LARC methods (implants and Cu IUDs); balanced counselling; and all other methods in the CFP, including male and female condoms. Ensure cyclical refresher courses • Systems of mentorship and supervision need to be strengthened; to ensure adequate competencies for implant and Cu IUDS training standardised • Training and information to be provided to health workers about female condoms – use, choice, allergies, lubrication options	• Health care providers contribute to the development of an integrated operational plan, and participate in the implementation thereof • Ensure national CFP policy and service delivery guidelines and clinical guidelines available at all facilities • Targets should be set at facility level • Both contraception and planning for healthy conception should be emphasised to health workers/patients • Stock management systems for all methods and equipment needs to be strengthened to prevent stock outs • Information, education and communication material on CFP should be provided	• Family planning campaign promoted through community health workers, partners, NGOs, WBOTs and clinic outreach • Informed choice, information about different methods, and dual protection should be promoted to communities • Information dissemination should be conducted to promote female condoms

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
		• Guidance and support to be provided to RTCs regarding the selection criteria of participants, site readiness assessment, creating adequate demand for practicum and adequate supply of commodities	• Strengthen supportive supervision visits (post-training: 6 weeks post training to ensure quality of service delivery) counselling, infection prevention and control measures, actual insertion/removal of implants, availability of commodities, accurate data collection of all contraceptive methods, contraceptive uptake; identifying challenges and quality improvement action plans with service providers	• Facilities provide the interface between the community and the health service to implement the family planning campaign at facility and community level; maximize on opportunities for the promotion of CFP in clinic waiting areas • Promotion, discussion, counselling and provision of female condoms should be conducted at facilities	

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health Facilities	Civil society
6. Completion of policies and guidelines (accompanied by dissemination, training and change management	• Finalise and launch sexual assault/post rape care policy and guidelines • Coordinate development of an operational plan to disseminate, implement and monitor post rape care policy and guidelines • Finalise and launch cervical cancer policy and guidelines • Coordinate the development of an operational plan to disseminate, implement and monitor cervical cancer policy and guidelines	• Oversee implementation of operational plan to disseminate, implement and monitor post-rape care policy and guidelines • Oversee implementation of operational plan to disseminate, implement and monitor care policy cervical cancer and guidelines	• Strengthen training on post-rape support and forensic nurse training • Strengthen capacity of healthcare providers to provide cervical screening and cervical cancer clinical management appropriate to levels of care.	• Ensure that the sexual assault policy is available at all facilities • Ensure that systems are developed to set targets and monitor the provision of the full package of sexual assault/post-rape care, including ensuring that effective referral and quality of care is monitored • Ensure that the cervical cancer policy is available in all health facilities • Systems should be developed to set targets and monitor the provision of cervical screening and management	• Ensure that key elements of the policies are communicated to the community • Ensure that communities are made aware of their rights and where and how to seek help for their health in relation to sexual assault/post rape care • Ensure that communities are made aware of the importance of prevention, follow up of results and retention in care if receiving treatment
7. Improved access and quality of care for GBV and post-rape care	• National audit of availability of Thuthuzela centres or other dedicated centres needs to be conducted in order to identify gaps in access	• Support the audit to determine the availability and gaps in GBV/post-rape care services • Identify gaps in service provision	• Train local staff to provide services	• Where there are gaps in the provision of dedicated post-rape care support centres, ensure identified facilities can render services and referral mechanisms are in place	• Ensure that the community is made aware of the location of post-rape care centres and the nature of services provided

Women's Health: Key recommendations and action points by level of care

Key: National (N) Provincial (P); District (D); Hospital (H); Community Health Centre (CHC); Clinics (PHC); Community (Com)

Key recommendation Women's health	
Develop **a defined package of integrated women's health services**, highlighting opportunities for programmatic integration. Coupled with this, re-introduce a common women's health card reflecting integrated services (national has developed such a card) – needs to be utilised	N, P,D
Key recommendations: Contraception	**Level of care**
Availability of contraceptive services: According to the MNCWH and N Strategic Plan (2012-2016) Strategies 2 & 6 identify the following objectives: Increase the % of PHC facilities which provide the full range of services outlined in the PHC package and decrease the percentage of PHC facilities which experience stock-outs of essential drugs. Up to date data needs to be collated on the following: • Percentage of facilities that provide a full range of contraceptive methods • Stock-outs of contraceptive commodities to align supply and demand	N, P, H, CHC, PHC
An integrated strategic and operational plan with time lines and targets – for the implementation of the CFP Policy and Service Delivery Guidelines: to include – The National Family Planning Campaign, training, curriculum revision and provision, monitoring and evaluation – with targets and refined indicators; priorities such as contraceptive and fertility planning services for HIV positive women; models and systems of integration, rights (e.g. informed decision making, contraceptive and fertility choice, informed sterilization); commodity supply; community outreach strategies.	N, P, D
Training: A sustained and cyclical programme of training for contraception and fertility planning, including methods as appropriate to levels of care, with a focus on building capacity for mentors/ supervisors for implant and Cu IUD training. Also need training on the key issues identified in the CFP Policy and Service Delivery Guidelines e.g. other methods, integration, fertility and health conception counselling and balanced counselling. Guidance and support to Regional Training Centres (RTC) in preparation: selection criteria of participants, site readiness assessment, creating adequate demand for practicum and adequate commodities supplies.	N, P
Strengthen and expand National Family Planning Campaign: There was very little awareness about the campaign when the midterm review assessment was done, need to popularise messages, engage communities. Need provincial and district targets which go beyond numbers trained in implants. Proposals to reintroduce contraception motivators; more presence in clinic waiting rooms recommended.	Leadership from N, all levels involved
Distribution of CFP policy: Make National CFP Policy and Service Delivery Guidelines and Clinical Guidelines available at all facilities	P
Improve data collation and monitoring: Improve centralised systematic data and monitoring for introduction of contraceptive implants. Set targets and a dashboard to monitor percentage changes in expanded method mix provision. Emergency contraception needs to be captured in the register and monitored. Add: new acceptors, clients switching methods; age disaggregated data (especially adolescents).	N, P, H, CHC, PHC
Demand creation on EC: improve demand for EC and use it as an entry point for the provision of contraceptives	D, CHC, PHC
Key recommendations: TOP	
An **integrated strategic and operational plan** with time lines and targets – for the strengthening of TOP services	N , P, H, CHC, PHC
Training: Attitude change: A strategy for training in values clarification and attitude transformation – for all levels of health care providers, including management; Include TOP into medical and nursing school curriculum; train doctors in second trimester management. SRHR course to be developed that includes a continuum of services (TOP, IUCD insertion, contraception etc)	Leadership N; implementation P and D;

Medical abortion: The feasibility of rolling out medical abortion in all 9 provinces and monitoring acceptability and impact. The effect that medical abortion may have on provider willingness is also a key research area which requires a more in-depth understanding. An audit to determine reasons for designated TOP sites not being operational	N, P, H, CHC
TOP and HIV: Further research and guidelines for the provision of TOPs for HIV positive women – best protocols? MVA or MA? Provision of antibiotics? Implications of these guidelines if status unknown?	
Expand access: Consider ways to expand access and provision: e.g. re-examine ideas underpinning designated sites; Strengthen public-private partnerships in areas where the public sector is unable to address unmet need for safe and legal TOP services or where there are delays. Provide same day service for first trimester to reduce second trimester TOPs	N, P, D, H
Provision of post abortion contraception: Ensure TOP services are able to provide on-site post abortion contraception. If not possible, ensure that referrals are made and clients are encouraged to be initated onto a method.	H, CHC, PHC, Com

A priority action: Complete and implement the following policies: Cervical screening, breast cancer and GBV & sexual assault policies. For the future, the MNCWH and N Strategic plan needs to include the following additional women's health issues:

- Fertility planning
- Breast cancer: are we seeing an emerging epidemic e.g. 100 patients per day at HJH including Ca and TB, need standardised screening and increase access to treatment,
- STIs
- HSV2 – note ANC data
- Obesity and women's health: NCDs, cancers

Overall, cross cutting recommendations:

- Update and release pending policy revisions
- Implement change management with new policies and programmes, with the associated health systems to support implementation and clear quality of care standards.
- Newly trained staff require supervision, mentorship and support
- Data is not a bureaucratic requirement – data need to assist in planning , identifying gaps and monitoring and evaluation. Need to service, include critical data to assist in programmatic monitoring and accountability.
- Dashboards a success – build and expand to strengthen programmes
- More work required to identify priority areas for SRH integration, more guidance defining an essential package of womens health services – beyond reproductive health.
- WBOTs provide an excellent opportunity to promote key women's health issues, need to include a simple document with key messages.

Adolescent health

The population between ages 10-24 years of age is estimated to make up one-third (30.4%) of the total population according to 2011 mid-year population estimates. The size of this population in itself indicates the need for the prioritization of adolescent and youth health. This places an increasingly heavy responsibility on the health and education sectors to ensure that adolescents and young people are adequately equipped with knowledge and information about sexual and reproductive health and that the provision of dolescent- and youth-friendly services SRH services is enhanced. Many young people in South Africa face various life changing challenges such as teen pregnancy, HIV, GBV, drug and alcohol abuse, fuelled by complex and interconnected social determinants such as high risk sexual practices, poverty and unemployment, socio-economic inequalities, stigma and limited access to adolescent friendly health services among others. These can have serious implications for their health, wellbeing and developmental outcomes. Although non-communicable diseases are relatively uncommon in adolescents, the increasing prevalence of high risk factors such as over-nutrition, sedentary lifestyles and substance abuse among young South Africans is set to fuel the ongoing increase in the prevalence of lifestyle diseases.

The review has identified five overarching recommendations that cut across adolescent and youth health and align with existing recommendations, including the push to accelerate progress ahead of the MDG culmination point in 2015, and the impetus to improve health within the context of other sustainable development goals.

These recommendations, with specific actions for various constituencies include

1. Finalise and disseminate the current draft of the Adolescent and Youth Health Policy
2. Strengthen and expand adolescent and youth programmes, including
    - Scale up the implementation of the ISHP package beyond screening to include all defined services
    - Strengthen referral systems between the ISHP and PHC teams
    - Review and disseminate an adolescent and youth health service package aligned to the core AYFS standards
    - Institutionalise a fast tracking system for adolescent and youth i.e. happy hour, evening clinics, adolescent and youth targeted services
    - Strengthen implementation of evidence informed community-based ASRH interventions i.e. parent-child, school governing bodies, traditional leaders, faith-based organisations, and local government engagement
    - Review and confirm departmental structure for integrated planning and implementation of adolescent and youth health programmes, specifically ISHP, MNCWH, HIV/AIDS and STIs, and including the appointment of adolescent and youth focal points at all levels
3. Implement adolescent and youth dual protection Social Behaviour Change Communications (SBCC), including
    - Designing a mobile app linking adolescent and youth to available SRHR services nationally
    - Developing a dual protection SBCC programme that integrates interpersonal communication and social media
    - Set targets at all levels for priority services for adolescents and youth, in particular reducing unmet need for family planning among youth, HCT, TOP and tailored services for young Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people
4. Ensure inclusion and disaggregation of adolescent and youth health indicators in the DHIS
5. Establish an adolescent and youth advisory panel for the NDoH to facilitate effective youth participation and engagement in programming, implementation and monitoring

Topline recommendations and key actions by constituency

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
1. Finalise and disseminate the current draft adolescent and youth health policy	• Provide leadership in finalising the draft policy • Provinces to endorse the policy • Dissemination of the finalized policy (all levels and all stakeholders)	• Sensitise districts to the key elements of the adolescent and youth health policy	• Sensitise health professionals and professional associations to the key elements of the adolescent and youth health policy	• Sensitise health facilities to the key elements of the adolescent and youth health policy	• Sensitise civil society partners to the key elements of the adolescent and youth health policy • Create demand around key components of the policy
2. Strengthen and expand adolescent and youth programmes, including: • Scale up the implementation of the ISHP package beyond screening to include all defined services • Strengthen referral systems between the ISHP and PHC teams • Review and disseminate an adolescent and youth health service package aligned to the core AYFS standards	• Undertake an assessment of where topics covered in the life orientation programme at primary and secondary school level overlap with health education components of the ISHP and determine ways to streamline and harmonise these to strengthen comprehensive sexual education, and avoid unnecessary duplications	• Ensure that referral mechanisms between the ISHP and hospital/ clinic based SRHR services for adolescents and youth are clearly defined in policies and SOPs • Ensure that all ISHP data are captured in the DHIS retrospectively per district, and where this is not happening provinces should provide adequate reasons and propose solutions • Strengthen referrals between schools and health facilities for continuity of services	• Ensure that human resource gaps of well-trained school health nurses, health promoters and specialists such as dieticians, audiologists and optometrists are addressed • Ensure that school health nurses receive the national training course for school health nurses, together with resource manuals and job aids • Ensure the provision of age appropriate HIV and sexuality education and services in both education and health facilities, and that they are delivered in a non-judgemental, gender responsive and supportive environment as a priority for adolescent girls	• Ensure that referral mechanisms between the ISHP and hospital/ clinic based SRHR services for adolescents and youth are operational	• Ensure that provincial and district mechanisms are in place to facilitate strong collaboration with civil society and community based organisations so that the ISHP can be more effectively implemented • Collaboration with community based outreach teams, for example ward based teams, peer educators and groundBreakers, to serve as health promoters allowing health care workers to focus on service delivery

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
• Institutionalise fast tracking system for adolescent and youth i.e. happy hour, evening clinics, adolescent and youth targeted services • Strengthen implementation of evidence informed community based ASRH interventions i.e. (parent-child, school governing bodies, traditional leaders, faith based organisations, local government engagement)	• Development of standardised information, education and communication materials aligned to the package of service both for the learner as part of empowerment for demand generation and harmonised communication for the peer educators and health care workers • Ensure that specialised ISHP mobiles (park homes) that are being procured to for the NHI districts are expanded beyond NHI districts • Ensure expansions to the ISHP programme are designed with adolescents in mind, e.g. ensuring adolescents have access to information and services that deal effectively with issues of confidentiality, privacy and informed consent	• Strengthen the capacity of Thuthuzela care centres located in district health facilities to ensure that they are fully capacitated to manage sexual violence cases involving adolescents in an age appropriate manner			• Explore the use of the media and social media (especially online and on mobile phones) for providing information as a means of promoting and influencing the health seeking behaviour of adolescents and youth

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
• Review and confirm departmental structure for integrated planning and implementation on adolescent and youth health programmes, specifically ISHP, MNCWH, HIV/AIDS and STIs, and including the appointment of adolescent and youth focal points at all levels	• The ISHP and the AFYS should have Non-Communicable Diseases (NCD) prevention and control plans integrated into their annually reviewed strategic plans • Ensure that PHC, AYFS and ISHP packages of services include screening for domestic violence and child abuse, counselling and referral to Thuthuzela care centres and mental health services				
	• The implementation of the AYFS programme within the re-engineering of PHC and the ISHP requires further evaluation to ensure adequate scale up and good communication between programmes • Strengthen and facilitate inter-sectorial collaboration between the DoH, the DBE and the NYDA to promote AYFS • Initiate a ministerial committee on adolescent and youth Services	• Ensure that district level policies and strategies highlight the need for AYFS and SRHR services to be youth friendly and embrace confidentiality and privacy • Expand access to quality HIV prevention services, including HCT, STI treatment and dual method contraception (via site-level and referral services) targeting adolescents • Strengthen and facilitate inter-sectorial collaboration between the DoH, the DBE and the NYDA to promote AYFS	• Synergies between directorates responsible for AYFS, ISHP and mental health should be strengthened so that the different programmes address adolescent and youth mental health challenges in a streamlined and coordinated manner	• Strengthen referral facilities or specialty clinics for particular groups such as children and adolescents, especially those with complicated medical cases	• Collaboration with community based outreach teams, for example ward based teams, peer educators or groundBreakers, to serve as health promoters allowing health care workers to focus on service delivery

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
	• Improve infrastructure at PHC level to deliver AYFS services that comply with the minimum standards • Institutionalize AYFS coordination among departments and partners forum for collaborative planning, implementation, monitoring and reporting of A&Y interventions • Develop and pilot a new strategic approach to strengthen AYFS. Emphasis should be on improving access to SRH service needs that are private, by competent and friendly (non-judgemental and respectful) staff, with comprehensive SRH information, reliable supply of drugs and equipment, youth participation should be encouraged, including ability to provide feedback about user friendliness of services via SMS or online, as well as multi-sectorial linkages and continuous evaluation	• Identify PHC facilities with infrastructure needs for prioritization • Accelerate the implementation of AYFS in all PHC facilities	• Work with clinic operations managers and district managers to ensure that facilities providing Adolescent and Youth Friendly Services are open during times that are convenient for youth and adolescents such as late afternoon, evenings and/or weekends • Develop mechanisms to assist facilities to fast track adolescents in school uniforms and those referred from ISHP services are fast tracked for service delivery.	• All PHC facilities should have nurses who are trained, sensitized and capacitated to manage HIV-positive adolescents in a gender-responsive manner, including those requiring treatment • Set up youth friendly zones within facilities that can provide tailored and confidential services to adolescents and young people • Identify "youth champions" (PHC nurses) who can provide leadership within the facility for the provision of AYFS	• Strengthen and support clinic committees, CBOs and community structures to ensure the sustainability of AYFS in PHC facilities • Ensure community outreach activities encourage and motivate young people to access health care services using referrals

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
				• Promising practice: Pathfinder programme currently implements youth friendly PMTCT services in five provinces, including HIV counselling and testing and promoting increased access to contraceptive services for young women. Pathfinder also provides training for AYFS providers and ongoing mentorship and supervision to ensure quality service provision to young people • Ensure that facilities providing adolescent and youth friendly services are open during times that are convenient for youth and adolescents such as late afternoon, evenings and/or weekends • Ensure facilities have mechanisms in place to fast track service delivery for adolescents in school uniforms and those referred from ISHP services	

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
3. Implement adolescent and youth dual protection social behaviour change communication, including: • Designing a mobile app linking adolescent and youth to available SRHR services nationally • Developing a dual protection SBCC programme that integrates interpersonal communication and social media • Set targets at all levels for priority services for adolescents and youth, in particular reducing unmet need for family planning among youth, HCT, TOP and tailored services for young LGBTI people.	• Ensure on-going and innovative SBCC interventions for adolescents and youth are prioritised in national and provincial Annual Performance Plans	• In collaboration with civil society partners and education and social development colleagues, district health teams should begin to look at comprehensive SBCC programmes to address critical issues, in particular teenage pregnancy and GBV • Develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of adolescents and young people	• Strengthen biomedical, values clarification and ethical decision-making training programmes for nurses, community care givers and other health care providers in the provision of tailored SRH services to key populations, including young sex workers, IDUs and LGBTI adolescents and youth	• Health facilities in all provinces/districts should be sensitised to the AYFS process and encouraged to engage in training and accreditation processes	• Health authorities at all levels work with CSO service providers to deliver integrated and aligned services for adolescents and youth • Where feasible create delivery synergies between traditional and medical approaches to Medical Male Circumcision interventions • NCD support groups should be formed (with help from NGOs) that will support and assist people already living with chronic diseases to remain healthy

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
4. Inclusion and disaggregation of adolescent and youth health indicators in the DHIS	• The DHIS indicators and other key national indicators should be reflecting trends in the 10 - 24 age group • National, provincial and district level monitoring and evaluation mechanisms should be able to track the resources allocated to adolescent and youth sexual and reproductive health and rights • There should be a stronger emphasis on revisions to the DHIS to track the quality and number of young people reached with a range of key services, including family planning, reproductive health, maternal and child health and HIV/ STI/TB services. Ideally and where feasible indicators should be disaggregated into age bands 10-14, 15-19 and 20-24	• Districts must prioritise the collection of DHIS indicators and other key national indicators that reflect trends in the 10 - 24 age group	• Sensitisation of all health professionals and professional associations to the value and usage of age disaggregated data for evidence based decision making and service provision for adolescents and youth	• Data collection tools and systems at facility level should be streamlined to allow for the collection and collation of DHIS-related data with comprehensive age disaggregation	• CSOs working in collaboration with DoH adolescent and youth health initiatives should align their indicators and data collection tools as far as possible with DoH systems

Recommendation	Actions by actor				
	National and provincial level	District level	Health professionals and professional associations	Health facilities	Civil society
5. Establish an adolescent and youth advisory panel for the NDoH to facilitate effective youth participation and engagement in programming, implementation and monitoring	• The DoH, through the adolescent and youth health sub-directorate, should facilitate the establishment of an adolescent and youth advisory panel that will include participation by young people themselves	• Ensure that all provinces have representation on the adolescent and youth advisory panel, including participation by young people themselves	• Ensure that health professionals associations have representation on the adolescent and youth advisory panel	• Ensure that adolescent and youth health focal points at facility level have representation on the adolescent and youth advisory panel	• Ensure that civil society organisations working in the sector have representation on the adolescent and youth advisory council

Nutrition

While there have been substantial strides made in addressing maternal and child health ooutcomes over the last few years, the recent 2012 South African National Health and Examination Survey (SANHANES) found that on the child nutrition front, South Africa has made no progress since 2005 with still around 1 in 5 (21.6%) children age 0-5 years stunted, while only 7.4% of children aged 0-6 months were exclusively breastfed. For the purpose of this review, the nutrition component only focused on exclusive breastfeeding, Mother-Baby Friendly Initiative (MBFI) and in-patient management of severe acute malnutrition. Sadly, South Africa is not progressing well towards the MNCWH and N targets; moreover, despite a well-established body of evidence South Africa is not implementing what is known to work, as clearly demonstrated in the deteriorating child nutrition indicators. While underweight children are no longer of public health significance in South Africa, both stunting and childhood obesity have increased. Furthermore, South Africa does not currently have a comprehensive implementation plan to address either of these conditions.

The review has identified some overarching recommendations that cut across all the components of the MNCWH strategic plan.

These recommendations, with specific action for various constituencies include

1. Update the current Severe Acute Malnutrition (SAM) in-patient guidelines with the latest WHO, 2013 Technical update
2. Build the capacity of all health workers in the promotion of exclusive breastfeeding and to support mothers through the continuum of breastfeeding from 0-2 years
3. Develop a policy and implementation plan to address overweight and obesity across the continuum of care
4. Develop an HR structure for nutrition programming with an accountability framework especially in view of the current DoH/Health Professions Council of South Africa (HPCSA) deliberations regarding the involvement of mid-level worker in nutrition services
5. Review the relevance of VAS in the context of food fortification programmes

Topline recommendations and key actions by constituency

Recommendation	Actions by actor			
	National and provincial level	District level	Health professionals and professional associations	Civil society
1. Update the current SAM in-patient guidelines with the latest WHO, 2013 Technical update	• Ring-fence and allocate a budget for therapeutic nutrition products • Develop a comprehensive M&E framework for SAM along the continuum of care including case identification, rehabilitation and case-fatality	• Map and define the referral system between facilities and down referrals to the community/household level Promising practices:*KZN has provincial integrated management of malnutrition which is supported with capacity development, monitoring and mentorship.* *KZN has documented implementation in the district of Uthungulu and this can be used for benchmarking*	• Train and implement the SAM guidelines in all hospitals and PHC • Train health workers on the identification, correct classification and management of acute malnutrition at all hospitals and PHC facilities	• Map and define the referral system between facilities and down referrals to the community/ household level
2. Build the capacity of all health workers in exclusive breastfeeding promotion, counselling (NOT breastfeeding education) and to support mothers through the continuum of breastfeeding	• Mainstream MBFI into the South African newborn care plan. *Promising Practice: KZN MBFI Implementation program* • Review and refine the DHIS indicator for exclusive breastfeeding *Promising Practice:* KZN has also validated their DHIS exclusive breastfeeding at DPT3 indicator with a community-based survey • Review and refine the DHIS data elements for child nutrition indicators • Develop appropriate complementary feeding guidelines and job-aids	• Develop appropriate complementary feeding guidelines and job-aids *Promising Practice:In KZN growth monitoring is a non-negotiable for child health and successful task shifting has been undertaken by moving growth monitoring to Phila Mntwana centres by well-trained mid-level workers or CHWs*	• Develop and fast track capacity development programmes for frontline health personnel on the promotion ofexclusive breastfeeding and support of mothers • Develop and implement pre-and-in-service training on basic child nutrition for all health personnel servicing children	

Recommendation	Actions by actor			
	National and provincial level	District level	Health professionals and professional associations	Civil society
3. Develop a policy and implementation plan to address overweight and obesity across the continuum of care	• Operationalize the nutrition roadmap into the next MNCWH and N Strategy • Urgently review South Africa's position on childhood obesity with appropriate inter-sectorial implementation plan with accountability framework			
4. Develop an HR structure for nutrition programming with an accountability framework especially in view of the current DoH/HPCSA deliberations regarding the involvement of mid-level workers in nutrition services	• Set norms and standards for nutrition services • Clearly define the cadre of staff needed to successfully design and implement nutrition programmes • Clearly establish an integrated programme structure for successful implementation • Urgently review the possibility of task-shifting for child growth monitoring and decision process for appropriate nutrition intervention			
5. Review the relevance of Vitamin A Supplementation (VAS) in the context of food fortification programmes	• Review the delivery platform for VAS			

Research agenda

Maternal and newborn health

It is recommended that further research be undertaken to systematically assess issues not addressed by the field visits, using a representative sample of districts and various levels of the health system. While this is a necessary component of the final evaluation at the end of the current strategic planing 2016, it is required now in order to adequately identify gaps and accelerate progress.

Recommendations for further research include

Data gaps

- There has been massive progress and opportunities for triangulation of data with the DHIS but limitations remain in terms of quality and use of data locally. Questions include: what methods are most effective for ensuring that high quality data for maternal and newborn health are collected and used to improve care? Can indicators be further standardised to allow for greater comparability across sources?
- There is a lack of awareness or misinterpretation of data amongst end users. For instance,what is the minimum dataset required in order to limit data collection fatigue, but allow for optimum analysis of service delivery? How can the visual management of data be improved – suggest the creation of a "dashboard" of graphs to make interpretation of the minimum dataset accessible to frontline staff and management, making programme/facility analysis simple so the information can be used for improvement.
- Limited population-based/community coverage data to track high level indicators. For example, how many babies are born in hospital and discharged early, only to die at home? There is an urgent need for a high quality population-based household survey with plans for a follow up survey using a similar methodology in three to five years to track these deaths in the short term. In the long term, the vital registration system must be strengthened and linked to the CHW network in order to gather and track population-based data that will be transmitted to the central database. Research is needed on the feasibility of this and other approaches.

Demand gaps

- While represented in its own pillar, the 'community voice' still seems silent. The strategy appears policy/district/facility-driven at this stage and this is represented in the district health plans. How can communities become more engaged and aware of NDoH commitments and activities? As WBOTs are increasingly rolled out, what is their specific role in drawing out this 'community voice' and what structures can be utilised? How can the linkages between CHWs and clinic committees be strengthened and improved?
- South Africa has many policies, programme and strategies in place that include best practices for nutrition, yet nutrition indicators remain alarmingly low. More insight is needed around what inter-sectoral solutions are needed to operationalise these best practices and to monitor and evaluate programmes. Who are the key people to champion nutrition at all levels of health services?
- What factors are driving adolescent pregnancy and what are the specific barriers to accessing care (from contraception through pregnancy, childbirth and postnatal)? What are specific strategies to reach these young women?

Diffusion and dissemination gaps

- It is unclear how much awareness and ownership exists for the MNCWH and N strategy, national norms and standards, as well as data and indicators collected at district and facility level. Some districts/facilities are better than others in this regard. This is an important area to be explored further and followed up with an aim towards improving sensitisation and increasing ownership of the national strategy and its core activities.

Women's health

1. Contraception

- Lack of contraceptive prevalence data since DHS 2003 (contraception prevalence rate - primary indicator of the Strategic Plan M&E framework)
- Lack of data on additional relevant targets such as provision of services at all levels of care and the incidence of drug stock outs
- Limitations of Couple Year Protection Rate (CYPR) used as a proxy indicator of programme coverage but cannot account for patterns of use; quality of care; no implants; no FC
- Variations in CYP: why? Contributing factors
- Patterns of use: Lack of research on discontinuation and method switching (Baumgartner et al. 2007, Beksinska et al. 2001, Smit and Beksinska 2013)
- Dual protection? important but condoms use complex - MC distribution figures may be misleading since without end-user data the extent of their use as a contraceptive method or for dual protection is unknown
- Patterns of method use in SA: Build on existing knowledge and do more research in relation to client demand and use of methods; Adherence, method switching and discontinuation
- Emergency Contraception: Barriers to effective use of EC; accurate data collection.

2. TOP

- Based on the desk review and the literature consulted, there is an urgent need to remove barriers for facilities with shortages of TOP providers and non-operational, designated facilities due to other operational challenges. To this end the following requires further research:
- The extent of illegal abortion providers in all provinces.
- A needs analysis regarding scale up for training of TOP providers and the provision of values clarification and attitude transformation.
- Monitoring of health care providers who are trained but object to providing TOP services on the basis of conscientious objection due to religious or moral grounds. What element of service delivery do they provide? The impact of conscientious objection on the quality of the service offered particularly whether proper and thorough pre-procedure and post-abortion family planning counseling is taking place.
- The feasibility of rolling out medical abortion in all 9 provinces and monitoring acceptability and impact. The effect that medical abortion may have on provider willingness is also a key research area which requires a more in-depth understanding. Reasons for designated TOP sites not being operational.
- Age disaggregated TOP statistics.
- Sentinel sites to monitor pre and post abortion contraceptive provision and counselling and quality of care.
- Further research to provide evidence-based guidelines for the provision of TOPs for HIV positive women .

3. Cervical cancer

- How often we should screen HIV + women? Does CD4 count or viral load make a difference in screening frequency?
- How can decreased LEEP effectiveness in HIV+ women be addressed with possible adjuvant therapies?
- If a woman has HSIL dysplasia should she start ARVs if CD4 count is above 350? There is some evidence that ARVS may slow progression and may be useful.
- Should we treat any HPV infected, HIV positive woman with cryo, even with no current lesion? Studies are ongoing, but more assessment may be needed.
- Should we treat CIN 1 in HIV infected women? (studies ongoing)
- How can we optimize sensitivity and specificity using VIA so that 'screen and treat' may be possible?

- How can HPV DNA testing be optimally deployed in urban settings, rural settings?
- Prioritise introduction of low cost POC HPV tests.
    - Study the role of HPV vaccinations in: Young women newly diagnosed with HIV
    - HIV positive, HPV negative adolescents (Immunogenicity, duration of immune response)

4. Post sexual assault

- Assess current accessibility and quality of post sexual assault and PEP services at all levels. Includes assessing package of care (rape kits, HIV PEP medications, STI medications and emergency contraception medications, privacy for examination and counselling)
- Assess whether clinical settings not currently providing sexual assault services are providing referrals to settings where appropriate services are available and the accessibility of these services.
- Interrogate current data: Gaps/inaccuracies in the interpretation of data sets; data management around sexual assault reporting and provision of PEP (see: Dashboard indicators HIV, AIDS and STI programme.Reporting period: 1 April 2011 to 30 September 2013;Table 8: Sexual assault prophylaxis rate (%)DHIS (26 February 2014)

Sexual assault prophylaxis rate (%)

Province	Target FY2013/14	FY2011/12	FY2012/13	FY2013/14	Progress
Eastern Cape	**70**	109.1	520.8	58.7	
Free State	**70**	51.7	54.4	56.3	
Gauteng	**70**	63.1	131.2	62.1	
KwaZulu-Natal	**70**	44.9	42.7	45.2	
Limpopo	**70**	64.5	69.5	70.6	
Mpumalanga	**70**	58.4	60.3	64.9	
North West	**70**	70.4	73.4	69.1	
Northern Cape	**70**	89.8	85.2	97.1	
Western Cape	**70**	58.4	Not available	50.7	
National	**70**	**61.4**	**80.8**	**57.5**	

5. Nutrition

Future research targeting strategies to improve nutritional quality of diets of women is recommended. This includes:

- The link between women's nutrition and health consequences, so that political commitment to support an action agenda can be secured.
- The feasibility of screening for high blood pressure at 20 years of age, particularly in obese women, with guidelines to assess frequency linked of level of risk. The early initiation of healthy lifestyle promoting behaviours can ameliorate most risk factors for hypertension and cardiovascular diseases. Studies of the most cost-effective interventions and ways to promote participation in such interventions should be on the research agenda.
- Future research targeting strategies to improve nutritional quality of diets of women is justified. Attention needs to be directed at the link between women's nutrition and health consequences, so that political commitment to support an action agenda can be secured

Child health

- Basic epidemiological research to define the extent of the burden, the relative risks of factors that cause disease and the efficacy of available interventions
- Barriers to the practice of IMCI at clinics by IMCI trained nurses
- Perception and awareness of mothers/caregivers/community on well baby/preventive child health services (do they value the importance of bringing a child for immunization/vitamin A/deworming/)
- Determinants of the failure to initiate ART in children
- Research on health policy and systems
- A comparison of three systems of child heath delivery at primary health care clinics; integrated sick and well child care based on IMCI, vertical (separate) sick and well child care services
- Improving the quality of supervision and mentoring offered to staff delivering child health services
- Can a system for engagement with, and response to, dashboard indicator data at clinic, hospital and district level change child health outcomes?
- Research on improving existing interventions
- Effectiveness of district clinical specialist teams (ward based outreach teams, school health teams) in improving child health outcomes
- Using the Road to Health booklet as a vehicle to optimize delivery of child health services
- Research to develop new interventions
- A model of delivery of child health interventions by the ward based outreach team (school health team, DCST)
- Delivery of a child nutritional programme including the identification and management of moderate malnutrition and stunting at a primary health care and community level

Under-5 nutrition

- Urgently review South Africa's position on childhood obesity with an appropriate inter-sectorial implementation plan with an accountability framework
- Review the relevance of VAS in the context of food fortification programmes
- Evaluation of whether the nutrition agenda in South Africa should look beyond child survival to address an already established paediatric obesity epidemic and increasing NCDs

Adolescents

- Research about personal and professional attitudes of individuals who are currently working in abortion service provision needs to be a focus area. The WHO found that there are complex reasons behind health care providers' decision not to be involved in ToP[6]. Attitudes, experiences and psycho-social needs of health care providers need to be explored because they affect access and provision of abortion services
- Research about illegal abortion and how this affects adolescents
- Research should also focus on encouraging communities to accept and talk about youth SRH and rights. PHC should also be encouraged to be open, friendly and embrace issues of privacy, rights of youth and confidentiality. Such research should be conducted in collaboration with partners who are already working with communities; loveLife, Pathfinder etc.
- What is the current value add of the involvement of CBOs within the ISHP delivery process? To what extent are they involved and how sustainable is their involvement?
- What is the operational and capacity strength of the school-based support team (SBST), which is tasked with ensuring that all components of the ISHP are provided to all learners and that data is efficiently collected?

[6] WHO Social Science Policy Brief

- What is the operational and capacity strength of the school health team based at a PHC facility and tasked with providing services to learners who will have been referred,plus follow-up?
- What is the operational and capacity strength of the district-based support teams who are tasked with developing an implementation plan with clear objectives that should be integrated into the district health plan? To what extent should this team also conduct an audit of the existing capacity to deliver ISHP?
- Is there a way of monitoring the implementation of the SRH package of services through ISHP to determine services offered versus adolescents and youth needs, disaggregated by type i.e. contraception, HCT, STIs etc.?
- Innovative research is needed for understanding and influencing the macroeconomic and social determinants of NCDs and exposure to NCDs risk factors. Research should also focus on promotion of healthy lifestyles, cost-effectiveness best-buys, medicines and vaccines
- A research agenda that focuses on the continuous evaluation of the content of the mental health policy should be supported and funded, its implementation, and the implications it has for adolescents and young people, as well as how it is integrated into other public health programmes should be examined

SECTION 5

Promising practices in MNCWH and N

One of the objectives of the mid-term review was to identify emerging and promising practices from the field specific to the key interventions for improving MNCWH and N outcomes for potential replication and scale up across the country. These practices were initially identified in the desk review phase and some were verified during the field visits. In some cases, further promising practices were identified during the field visits themselves and were documented for further follow up. All are presented in the tables below.

Overall, the term “promising practice” for the purposes of the report representsinnovative strategies that have been used to improve the efficiency and effectiveness of MNCWH and N service delivery. It is important to note that the practices listed have been implemented on varied scales, ranging from small-scale interventions in single facilities to NGO funded programmes. Rigorous assessment and documentation is required for their possible replication.

How to use the tables

The tables present the practices by technical area. They are further categorized according to one of nine key components or enablers listed below:

- Target setting
- Data management
- Communication
- Infrastructure, drugs, equipment
- Human resources (quantity, capacity), supervision and mentoring
- Referrals
- Service delivery platforms linked with communities
- Cascades and pathways
- Transport

The place that the practice occurs (province, national, international) and level of implementation (community, facility, hospital, district etc.) are included. If the practice has been formally documented, the publication reference or source of further information is listed.

Finally, the practices are linked to one of three topline recommendations given in the report, namely

1. Know your issues, track your response, we are accountable: Target setting linked to dashboards and communication strategies linked to these targets (include issues like equity, targets for multi-sectoral work etc.)
2. Getting the basics right, working together: Infrastructure, drugs, equipment, human resources, service delivery platforms, supervision and mentoring systems, staff capacity and competency, attitudes, following guidelines and protocols, prioritization, costing and involving communities
3. Connecting the dots: cascades and pathways and transport and referrals Cascades and pathways, transport referrals

Promising practices: Maternal and neonatal health

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
1	Cascades and pathways	EC	Facility	EC Province developed and is using tracer cards to follow up newborns		3
2	Cascades and pathways	FS	Community	Long term follow up by dietician of KMC babies when discharged home to ensure continuity of care		3
3	Cascades and pathways	NW	Hospital	DHA desk at the hospital that is responsible for ensuring vital registration at birth		2
4	Cascades and pathways	NW	Facility	Admitted mothers are brought into discussions with clinic committee regarding quality of care		2
5	Data management	NW	Hospital	The newly opened maternal section at Brits hospital has institutionalized the process on feeding back on adverse events by having a multi-disciplinary meeting every Monday morning involving ambulance, EMS, obstetrics, paediatrics and nursing		1
6	Human resources (quantity, capacity), supervision and mentoring	MP	Facility	Advanced midwife (focal nurse) is permanently assigned to birthing unit at CHC and not rotated in CHC in order to provide expertise and training for other staff. This ensures a competent, senior person/advanced midwife anchors programme implementation and does not rotate		2
7	Human resources (quantity, capacity), supervision and mentoring	EC	Facility	In some facilities, a dedicated nurse supports and promotes EBF and provides support to women with premature newborns		2
8	Human resources (quantity, capacity), supervision and mentoring	WC	Facility	Scheduled 2 week induction programme is provided which includes a 20 hour MBFI course conducted regularly for new staff to bridge aspects not covered in general pre-service training		2
9	Infrastructure, drugs, equipment	WC	Hospital	Milk banks		2
10	Referrals	EC	Facility	Some referring clinics will contact a hospital by telephone to obtain specific appointment dates for women referred for specialized services in order to strengthen linkages		3

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
11	Referrals	NC	Multiple levels	Written referral system for mother from WBOTS to facility; formal referral system from facility to WBOTS. Communication is facilitated using pigeonholes in clinics for WBOTS to access referral information		3
12	Service delivery platforms linked with communities	Multiple Provinces	Multiple levels	**MomConnect** is an NDoH initiative to use SMS technology to register every pregnant woman in South Africa. Once registered the system will send each mother pregnancy stage-based messages to support her and her baby during the course of her pregnancy, childbirth and up to the child's first birthday The system will also be used to provide feedback (rating, compliments and complaints) about public health services to a central communication centre. From there individual specific information, education and communication messages will be sent out to meet the health needs of pregnant women more promptly	http://www.rmchsa.org/momconnect/	2
13	Service delivery platforms linked with communities	WC	Community	**Philani Project** aimed to improve maternal skills and achieve positive outcomes for pregnant mother and infants from low-income households through a strategy of home visits by trained paraprofessional 'mentor mothers'. These mentor mothers were provided training, materials and skills to address major community health challenges, especially maternal and newborn health They provided support and skills to mothers within their daily lives to implement the recommendations received at clinics. Each at-risk mother received a minimum of four visits during pregnancy and four visits post-partum. Philani project mainly focused on HIV (PMTCT), foetal alcohol syndrome, nutrition support, birth preparedness for pregnant women, reproductive health and mental and physical health during pregnancy Promising improvements in breastfeeding practices, adherence to ART, newborn birth weight and nutritional outcomes have been described with fewer episodes of diarrhoea in infants The project emerges as an example of best practice from South Africa both in terms of 'task shifting' (from doctors/nurses to community health workers/mentor mothers) and 'site shifting' (clinic to community)	le Roux, I. M., et al. (2013). Outcomes of Home Visits for pregnant mothers and their infants: A Cluster Randomized Controlled Trial. AIDS, 27(9), 1461-1471	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
				Additional components of key child health practices including immunization, nutritional counselling for complementary feeding, identification of sick children at a community level (community based IMCI) and influencing the family's health care seeking behaviours could be included in mentor mothers training packages so that they can equip mothers with skills and knowledge about child health practices during home visits	Rotheram-Borus, M. J., le Roux, I. M., Tomlinson, M., et al. (2011). Philani Plus (+): A Mentor Mother Community Health Worker home visiting program to improve Maternal and Infants' Outcomes. Prevention Science, 12(4), 372-388	
14	Service delivery platforms linked with communities	KZN	Community	**Yakhumndeni Mentor Mother Project** operates in Endumeni Local Municipality, in KZN and consists of mentor mothers trained by the Philani child health and nutrition project to do house to house and follow up visits to screen, refer, support, monitor and advise. These mothers screen expectant mothers and malnourished young children within neighbourhoods regarded as vulnerable. They are equipped with precision medical scales, mid-upper arm circumference (MUAC) tapes, cord care and rehydration kits. Caregivers and expectant mothers are advised about nutrition and how to access local services and resources. Linkages are maintained with government via a local project leader who participates in a local task team for operation 'Sukuma Sakhe'. The project still needs to be evaluated for its effectiveness and potential effect on improving child health outcomes	Berry L. et al. South African Child Gauge 2013. Children's institute and the University of Cape Town. http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2013/SouthAfricanChildGauge2013.pdf	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
15	Service delivery platforms linked with communities	EC	Community	**Infant feeding Buddies (PATH)** Home based EBF support programs have been shown to be beneficial for HIV positive mothers. Women in South Africa need extra support to overcome challenges related to adhering to whichever option they chose—formula feeding or EBF A pilot study was conducted in Eastern Cape in 2010 which involved selection of a buddy by HIV-positive mothers who could support them in adhering to their chosen method of safe feeding just as ARV buddies, was a successful strategy for supporting drug adherence in many HIV care and treatment programs. These infant-feeding buddies would accompany the HIV-positive mothers on routine prenatal and post natal clinic visits and PMTCT counselling sessions on safe infant feeding. Buddies supported mothers by reminding them of proper feeding instructions, encouraging them to persevere, offering concrete physical assistance, helping them face stigma and gossip, and acting as educators or mediators with the mothers' families The study concluded that buddies are an effective source of infant feeding support for HIV-positive women in South Africa, although further evaluation is required. Infant feeding buddies can potentially be developed to provide support for child health practices at a community level	Andreson, J. et al. (2013). Infant Feeding Buddies A Strategy to Support Safe Infant Feeding for HIV-Positive Mothers. Journal of Human Lactation, 29(1), 90-93.	2
16	Service delivery platforms linked with communities	WC	Community	WC has begun process of consultation with community organisations/ health committees to incorporate community voice in 2016 provincial health plan		2
17	Service delivery platforms linked with communities	KZN	Community	Dedicated CHW assigned to mother-baby pair for follow up and linkages to the health system		2
18	Service delivery platforms linked with communities	WC	Community	Philani CHWs are trained in cognitive-behavioural strategies which lowered preterm birth rates and risks		2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
19	Transport	KZN	Multiple levels	Newborn retrieval teams are used to stabilize and transport new-borns before referral		3
20	Transport	International	Multiple levels	A project in Sierra Leone provided radios to summon vehicles to take women to hospital in the case of obstetric emergency	RANGE!_ ENREF_99Samai O, Sengeh P. 1997. Facilitating emergency obstetric care through transportation and communication, Bo, Sierra Leone. International Journal of Gynaecology and Obstetrics 59: S157–64.	3

Promising practices: Child health

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
1	Cascades and pathways	NC	Facility	Defaulter tracing register for immunizations		3
2	Cascades and pathways	EC	Province	Provincial birth registration forms implemented to avoid using the RTHC as an identity document to obtain birth certificates, social grants		2
3	Human resources (quantity, capacity), supervision and mentoring	KZN	Multiple levels	Zoe life works in KZN to assist the DoH in adaptation of WHO computerized IMCI-ICATT package training (4 days) (Zoe life). Zoë-Life has developed IMCI work-aids to assist healthcare workers to understand and implement the algorithms using colourful and simple graphics and workflows. They have developed graphic based algorithms that assist nurses and doctors to remember the complex processes more easily.	http://zoe-life.co.za/imci-cimci-i-catt/	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
				The organization provides c-IMCI training to community CCGs or CHWs, teachers and community-based organisations, and provides ongoing support and mentorship to empower families and communities. C-IMCI trained CCGs teach households about key family practices for child health including how to treat infections and when to refer a child on to a clinic or hospital. They have also developed an c-IMCI work-aid to equip community workers to share their knowledge with families and teachers. This includes enabling CCG's and Early Childhood Development (ECD) facilitators to assess nutrition, supply Vitamin A and deworming medication and identify most at risk children. The programme has shown better outcomes in terms of reduced childhood diseases and better management at a community level		
4	Service delivery platforms linked with communities	Multiple Provinces	Community	**Khululeka Community Education Development Centre** offers services such as a pre-school enrichment programme (20 week-long workshop over two years), a family home visiting programme (8 or more visits twice a month) focusing on access to social grants, health and nutrition and caregiver support, and an infant and toddler support programme for caregivers of children aged 0 – 6 years (weekly group sessions for between 16-19 weeks)	Tomlinson, M. (Ed.). (2013). Caring for the caregiver: A Framework for Support. Cape Town: Children's Institute University of Cape Town	2
5	Service delivery platforms linked with communities	NW	Community	**The Early Learning Resource Unit (ELRU) Family and Community Motivator Programme** is being implemented in North West (2011-13) and consists of 20 home visits taking place twice a month, monthly workshops with other caregivers and informal playgroups. The programme provides information on accessing social grants, creating safe stimulating and healthy environments for children and an opportunity for the motivator and caregiver to play with the child using locally made toys. In recent evaluations, both Khululeka and ELRU programs were found to improve parenting, caregiver coping, affectional care, language stimulation and improving safety and hygiene at home	Tomlinson, M. (Ed.). (2013). Caring for the caregiver: A Framework for Support. Cape Town: Children's Institute University of Cape Town	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
6	Service delivery platforms linked with communities	LP	Community	**Partnership approach to link C-IMCI with child survival project in Limpopo.** Global evidence shows that community based health care systems (services and outreach) and participation are the basis of addressing health barriers. Emphasis on partnership alliances has become more and more critical in recent times because it enables each partner to bring their comparative advantage on the table to improve program quality and reach African Medical and Research Foundation (AMREF) implemented a model of Linking Communities with District Health System (LIDS) in Limpopo from 2008-2011 through the Makhuduthamaga child survival project to strengthen the partnership alliances and increase community participation and ownership[7]. This approach linked families to health services in a participatory and user-friendly way The project was implemented through a partnership model that included government departments (DoH, DSD, SAPS, SASSA,DHA), NGOs, CBOs, Makhuduthamaga local municipality - community service unit, traditional leaders, mothers of children under-5 and other community structures AMREF trained a group of CHWs, project steering committee members, child care forums on c-IMCI (content of the training included identification of the sick child, knowledge of 17 key family practices and the referral systems) and they received certificates of attendance as a way of motivating them and recognising their key role in addressing child health problems. CHWs visited households on a daily basis and educated mothers of children under five, caregivers/others who remained with the child about the importance of understanding 17 key family practices. Child care forums under the chair of a social worker ensured that under-5 children receive government services such as child support grant and foster care grant to those who qualified	Sivhaga, K., Hlabano, B., & Odhiambo, P. O. (2012). Using Partnership Approach to reduce Mortality and Morbidity among children under five in Limpopo province, South Africa. The Pan African Medical Journal, 13(Supp 1)	2.

[7] (Sivhaga et al., 2012)

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
				The project showed improved child health outcomes such as reduced diarrhoea and pneumonia incidence, increased immunization and vitamin A coverage and improved practice of facility and community based IMCI. The model can be potentially replicated and scaled up at higher levels following further evaluation		
7	Service delivery platforms linked with communities	EC	Community	**The Sobambisana (Ilifa Labantwana) Project** included a stakeholder and community awareness campaign as part of creating an enabling environment for young children in an under resourced area of the Eastern Cape. Regular community report backs brought together community members, government officials and civil society organizations, creating interest in and demand for documents, grants, health and education services. The community became more active in pressing for better conditions for children and government services responded to the call in different ways	Biersteker L. (2012). Early childhood development services: Increasing access to benefit the most vulnerable children. In Hall K, Woolard I, Lake L & S. C (Eds.), South African Child Gauge 2012. Cape Town: Children's Institute, University of Cape Town. Retrieved from http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2012/sa_child_gauge2012.pdf.	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
8	Service delivery platforms linked with communities	Multiple Provinces	Community	**Malamulele Onward** is a NPO that focuses on improving the quality of life for children with cerebral palsy living in remote rural areas in the EC, LP, and KZN (Malamulele Onward). Malamulele Onward works to improve access to rehabilitative health services for hard to reach communities through outreach programs. Their services include providing therapy, supporting hospital staff in improving service efficiency and the training of mid-level workers and parents on providing care to children with cerebral palsy. Most recently a mother-to-mother support and training programme has been introduced. Programme success has been demonstrated by improvements in children's functional abilities and in mothers' mental health and sources of support		2
9	Data management	Multiple Provinces	Hospital	**The Child Health Care Problem Identification Program (CHIP)** assesses the quality of care children receive in South African hospitals through the process of death auditing. The programme provides the structure and tools for careful review of in-hospital paediatric deaths by ensuring that all deaths are identified, assigning a cause to each death, determining the social, nutritional, HIV context and determining modifiable factors in the caring process for each child who died. Health workers collect and enter data onto the Child PIP software program. The data is then analysed at local level, but also sent to a national database. Using this information, interventions at local, provincial and national level, can lead to improvements in quality of care and ultimately to a reduced case mortality among children The decline in the in-hospital mortality rate from 5.0 deaths/100 admissions to 2.9/100 admissions between 2008 and 2011 represents a 42% reduction, and a significant change in outcome for children admitted to hospital. This finding indicates that attention to local modifiable factors can result in improved quality of care	Stephen, C. R., Bamford, L., & Patrick, M. (Eds.). (2011). Saving children 2009: Five years of data: A sixth Survey of Child Health Care in South Africa. Pretoria: Medical Research Council http://www.childpip.org.za	1

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
10	Data management	KZN	Community	**Child Status Index (Zoe Life) Assessment tool** for vulnerable children including comprehensive needs assessments, goal directed action plans, management strategies for monitoring wellbeing of child. The CSI uses data for programmatic and child health decision making at local government and program level	Sabin, L., Tsoka, M., Brooks, M. I., & Miller, C. (2011). Measuring vulnerability among orphans and vulnerable children in rural Malawi: Validation study of the Child Status Index tool. JAIDS Journal of Acquired Immune Deficiency Syndromes, 58(1), e1-e10 http://www.cpc.unc.edu/measure/tools/child-health/child-status-index http://zoe-life.co.za/csi/	1

Promising practices: Women's health

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
1	Cascades and pathways	FS	Facility	Some facilities have a fast lane for issuing contraceptives		2
2	Cascades and pathways	Multiple Provinces	District	**Public-Private Partnership (PPP) referral agreements to ensure timely access to services**		2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
				Marie Stopes South Africa (MSSA) entered into public private partnerships (PPP) with the Eden district in the Western Cape and with selected hospitals in Ethekwini and Ugu districts of KZN to provide TOP services in both of these districts and also to provide post-abortion family planning services in Eden district. The available data suggest that the PPP model with MSSA has alleviated the over-burdened public sector and most public sector TOP procedures have been shifted to the MSSA clinics		
3	Human resources (quantity, capacity), supervision and mentoring	WC	Multiple levels	**Desmond Tutu family planning & HIV integration** The family planning integration into HIV care and treatment Services (FPI) project aims to increase the uptake of effective family planning (FP) services and improve contraceptive coverage to reduce unmet FP needs, and the number of unintended pregnancies among people living with HIV in the Western Cape. Through intensive workshops, onsite mentoring and support and distribution of educational materials, the FPI project is enabling doctors, nurses and NGO counsellors at HIV treatment and wellness clinics to address clients' FP needs during routine HIV consultations, thereby ensuring integration of the two services for the benefit of the client	Desmond Tutu HIV Foundation, Western Cape Department of Health and the University of Cape Town's School of Public Health and Family Medicine	2
4	Human resources (quantity, capacity), supervision and mentoring	GP	Facility	Enrolled nurse trained in family planning and taking of pap smears working under supervision of a registered nurse. Sometimes left to run the clinic and train other students and enrolled nurses		2
5	Service delivery platforms linked with communities	NC	Facility	**Cervical Cancer Screening** In Northern Cape, a CHC promotes Sunday as cervical screening day		2
6	Service delivery platforms linked with communities	MP	Multiple levels	**Mayihlasele Izazi** Girls education/support groups for HIV prevention, speaking out about sexual assault		2

Promising practices: Adolescent and youth health

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
1	Cascades and pathways	LP	Facility	Fast queue for adolescents & flexible/extended hours		2
2	Cascades and pathways	NC	Facility	Youth are coming to facilities for adolescent services after 18:00 when most adult clients have left		2
3	Cascades and pathways	National	Multiple levels	Pathfinder International collaborate closely with provincial and district health officials as well as health facility leadership to support the implementation of comprehensive adolescent and youth friendly services as a means to addressing unmet needs for contraception, reduce HIV transmission and offer treatment and support to young people living with HIV		2
4	Cascades and pathways	Multiple Provinces	Multiple levels	The DBE working with a range of CSO partners have researched and targeted the challenge of teenage pregnancy and associated health and psycho-social issues (Eastern Cape, KwaZulu-Natal)		2
5	Cascades and pathways	FS	Province	Free State was the first province to offer stand-alone AYFS for HIV treatment		2
6	Cascades and pathways	KZN	Facility	**The Adolescent (ALHIV) Transition Clinics** at KwaMashu CHC & PMMH		2
7	Communication	National	Community	**Soul City programmes** focusing on adolescent and youth SRH issues through TV, radio and print media;		2
8	Communication	National	Multiple levels	**A Speak Out handbook** for learners has been developed on how to prevent sexual abuse in public schools. It is designed to help young people handle sexual abuse or any unwanted sexual encounters while at home or at school. Furthermore, a learner-focused website was developed to assist young people with knowledge on the prevention and reporting of sexual abuse		2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
9	Service delivery platforms linked with communities	KZN	Multiple levels	The Reducing Maternal and Child Mortality in South Africa through Strengthening Primary Health Care Programme (RMCH) in partnership with South African Red Cross KZN have hosted a number of learning workshops on teenage pregnancy. These included a closed forum of local youth aimed at gathering their perspectives on the challenges of accessing maternal and child health care services along the continuum of care. Key findings included youth preference for peer education as a means of getting information on family planning, the need for improved peer learning for parents and caretakers, the value in harnessing friendship networks to improve teen demand for services as well as the need to address specific gender issues including gender-based violence, sugar daddies and the pressures faced by boys to be sexually active as well as pay "damages" when they impregnate a young girl		2
10	Service delivery platforms linked with communities	National	Community	**GroundBREAKERs** is a youth development programme funded by loveLife, which is coordinated with the DSD and DoH. groundBREAKERs are young people, aged 18-25, who are placed in a work experience in various loveLife initiatives for a year. They provide peer education and support; represent the needs of young people on the QI team; assist with quality assessments such as focus group discussions, and are involved in a range of outreach activities		2
11	Service delivery platforms linked with communities	National	Multiple levels	The national **loveLife media campaigns, along with the groundBREAKERs outreach activities**, are significant adjuncts to the youth coming to the clinic. The current Nakanjani campaign has created a demand for the loveLife brand that is associated with the YFS clinics and community hubs	http://www.lovelife.org.za/corporate/lovelife-programmes/community-hubs/	2
12	Human resources (quantity, capacity), supervision and mentoring	National	Multiple levels	RMCH have developed a matrix of risk and protective factors for adolescent pregnancy in South Africa that can be used by service providers and provides a quick overview of some of what is known about these risk and protective factors in relation to adolescent pregnancy in the South African context		1

Promising practices: Nutrition

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
1	Cascades and pathways	Multiple Provinces	Multiple levels	KZN and NW have been able to integrate nutrition in child health and function as components of one programme		2
2	Cascades and pathways	KZN	Facility	In KZN growth monitoring is a non-negotiable for child health and successful task shifting has been undertaken by moving growth monitoring to Phila Mntwana centres by well-trained mid-level workers or CHWs		2
3	Cascades and pathways	International	National	Brazil and Mexico have best practices to bench mark against with respect to regulatory systems for the food industry and an ecological approach to preventing and managing childhood obesity		2

Promising practices: Cross-cutting

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
1	Referrals	NC	Facility	Locally developed formal patient referral system linking PHCs to CHCs and to referral hospital in Kimberley, with written feedback on each patient from each level of referral		3
2	Referrals	NC	Facility	Patients from farms for referral to Kimberley are provided with overnight lodging facilities for early morning transfers		3
3	Transport	NC	Multiple levels	Loan schemes or arrangements with local transport agents for low-cost emergency transport	Tlebere P, Jackson D, Loveday M et al. (2007) Community-based situation analysis of maternal and neonatal care in South Africa to explore factors that impact utilization of maternal health services. *Journal of Midwifery and Women's Health* 52, 342–350.	3

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
4	Transport	Inter-national		In Nigeria, a project worked with transport unions to provide reliable and affordable transport. A seed fund for the cost of fuel was provided, which was replenished with contributions from users to address patient cost barriers	Shehu D, Ikeh AT, Kuna MJ. Mobilizing transport for obstetric emergencies in north-western Nigeria. *International Journal of Gynaecology and Obstetrics* 1997; 59 Suppl 2:S173-80	3
5	Cascades and pathways	KZN	Multiple levels	In 2011 KZN's flagship programme **Operation Sukuma Sakhe (OSS)** was launched as a 'whole of Government approach' by the Department of Human Settlements KZN. It focuses on five critical areas, spelling out every initiative and how it links to initiatives being implemented by the different sector departments and the spheres of government. Therefore delivery of services is required through partnership with community, stakeholders, and government "War rooms" were set up to facilitate OSS. War rooms are integrated service delivery structures that comprise government, municipality, community-based organisations (CBOs), business, police, teachers and other stakeholders at ward level. An independent chairperson is elected to head up the war rooms. They identify problems within a particular ward and establish which services (education, health etc.) are required to address the problems and provide feedback to the community In 2013, child and maternal health was made a priority for the KZN provincial government. Following this, the DoH in partnership with the Office of the Premier embarked on an initiative towards the establishment of child community diagnostic centres - called Phila Mntwana centres- in the entire province. These wellness centres serve as health promotion and disease prevention sites for children in the community and are linked to OSS	Department of Human Settlements (Kwa Zulu Natal). Operation Sukuma Sakhe Guidelines. http://www.kzndhs.gov.za/Portals/0/docs/OSS.pdf	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
				To bring child health care services closer to the people, these centres are based at ward level to ensure the provision of immediate interventions and referral of cases that require further interventions to public health facilities. They are operational on a daily basis and are manned by community caregivers. They provide preventive and promotional services, assisted by mobile clinics and family health teams on several occasions The **Phila Mntwana centres** serve to provide the community leadership and war room members with a simple diagnosis of the status of the children in the community, so that corrective measures may be taken when necessary. It also provides a mechanism to monitor the nutritional and health status of all children under 5 years at community level on a monthly basis. They improve access to preventative health services. Each Phila Mntwana centre is linked to a local PHC facility or mobile team		
6	Cascades and pathways	KZN	Facility	The **'Phila Mntwana' initiative** and high level engagement of leaders e.g. Mayor is a champion of the Phila Mntwana Initiative. The establishment of Phila Mntwana centres in the province to provide services including growth monitoring, screening of malnutrition supply of vitamin supplements, promotion of breastfeeding, TB screening, HIV/AIDS support, defaulter tracing, and diarrhoeal interventions	www.kznhealth.gov.za/mediarelease/2013/Launc_of_Phila_Mntwana_centres_31072013.htm	2
7	Cascades and pathways	NC	Facility	Minimising of waiting times for chronic medication repeat scripts: patients hand in scripts; clerks trace files; registered nurse dispenses and the clients collect the following day without standing in a queue		2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
8	Communication	GP	Facility	**Patient Complaint Response System**. In response to the lack of coordination in existing complaint system and inability to address patients' complaints in a systematic and efficient manner, the Gauteng DoH established a 24 hour toll free call centre in 2009. The centre aims to improve the quality of care in health facilities and create an awareness of patients' rights. The toll free number is publicized through posters in health facilities. The call centre is equipped with trained staff including retired nurses and supervisors Each complaint undergoes a systematic investigation, which is documented and a report on the outcome of investigation is communicated to the complainant. In the case of a serious adverse event (SAE), such as the loss of life, the call centre initiates an investigation via the Quality Assurance (QA) manager of the relevant institution. The department claims increased patient awareness and access to information	Documenting Good Practices in the Public Health Sector of South Africa: From Policy to Practice. Health Systems Trust. 2013. http://www.hst.org.za/publications/documenting-good-practices-2013	2
9	Communication	GP	Province	**BANA PELE** (intersectoral initiative DoE, DoH, SAPS, DSD, partners) hold meetings on a quarterly basis, discuss how each stakeholder can contribute to reduce the burden of diseases in children under 5 years (similar to Phila Mntwana in KZN)	Rispel L. Molomo B. Dumela S. Pretoria: Human Sciences Research Council; 2009. South African case study on social exclusion; p. 33.	2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
10	Human resources (quantity, capacity), supervision and mentoring	GP	Facility	**The Queue Marshall programme** has assisted in improved service delivery by reducing patient waiting times at Zola Community Health Centre in Soweto, Gauteng. The queue marshalls are recently graduated community matriculants who showed interest in the health sector. They underwent a 2-day intensive training, which included instructions on Batho Pele principles and the Patients' Rights' Charter. They performed a range of duties including welcoming patients and directing them to appropriate departments, working at help desks and attending to patients' complaints, controlling and maintaining order in waiting areas, monitoring waiting times and resolving conflicts. Other methods used along with this intervention included an improved triage system and better signage The introduction of queue marshalls reduced average patient waiting times and improved patient satisfaction. The programme has the potential for improving quality of MNCWH and N services at health facilities and generates employment for people between 16-24 years of age	Documenting Good Practices in the Public Health Sector of South Africa: From Policy to Practice. Health Systems Trust. 2013. http://www.hst.org.za/publications/documenting-good-practices-2013	2
11	Human resources (quantity, capacity), supervision and mentoring	National	Multiple levels	Advances in training methodologies: **Distance Learning IMCI (d-IMCI) and IMCI Computerized adaptation and Training Tool (ICATT)**		2
12	Human resources (quantity, capacity), supervision and mentoring	EC	Facility	Staff motivation and retention through use of recognition awards, certificates, etc.		2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
13	Infrastructure, drugs, equipment	KZN	Facility	The stock visibility solution enables nurses at 680 clinics in KZN to manage the availability of chronic medication and avoid stock-outs. The stock visibility solution gives the DoH the ability to see where there are stock-outs on any medication and the new mobile-enabled system enables the department to create a JIT (just in time) supply of medications at these clinics. This is a first for the DoH through the Vodacom Foundation	http://www.vodacom.com/com/aboutus/partnersinhealth	2
14	Service delivery platforms linked with communities	KZN	Community	Part of the broader **Ndabezitha Programme**, which is an initiative led by the NPA Sexual Offences and Community Affairs Unit, the **Ndabezitha Izimbizo Project** is a public awareness and legal education initiative aimed at empowering rural communities on the issues of domestic violence.It aims not only to bridge the gap in service provision between urban and rural communities, but also between men and women, and boys and girls. Through the programme, traditional leaders are also trained and sensitised and safety plans and public awareness-raising campaigns have been developed		2
15	Service delivery platforms linked with communities	EC	Multiple levels	The DoH is working closely with ***Imbhumbha ya Makhosikazi*** (wives of the chiefs) to improve community level education, referral of sick children to facilities and this seems to have increased service utilization in the few areas where it being implemented		2

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
16	Data management	FS	Multiple levels	**Advanced Incident Management System (AIMS)**. The AIMS programme is a web-based system introduced in 2008 for monitoring, analysing, reporting and managing problems that range from near misses to sentinel events across the entire spectrum of healthcare. In 2008, the system was implemented in 24 healthcare facilities in the Free State, extended to all 31 hospitals in 2010, and finally included nine CHCs and five EMS stations in 2011 The software was originally developed in Australia and aims to improve quality of health services and reduce incidences due to adverse events. It encourages an environment where staff members feel comfortable reporting service delivery errors. All FS DoH personnel can report problems by making a phone call (on speed- dial at all health facilities) to the call centre. The incidents reported include accidents, occupational issues, blood safety, clinical management, nosocomial infection, medical equipment pathology, security, etc. The system has been effective in managing patient safety and reducing adverse events at health facilities. It can potentially contribute to improving child health outcomes if caregivers utilize the system	Documenting Good Practices in the Public Health Sector of South Africa: From Policy to Practice. Health Systems Trust. 2013. http://www.hst.org.za/publications/documenting-good-practices-2013 http://www.isofthealth.com/en/Solutions/HospitalsandClinics/AIMS.aspx	1

#	Key Component (Enabler)	Site of implementation	Level of implementation	Activity	Publication or further sources	Topline recommendation area
17	Cascades and pathways	WC	Multiple levels	**PHCIS (Primary Health Care Information System) and PREMIS system**. Every person coming into any health facility gets a unique identifier number. The system creates an algorithm to find the person or assigns a new patient number. It also creates a bar coded sticker which goes onto the folder. It uses multiple information systems to track patients through electronic footprint enabling providers to see where they have been, what treatment they received. It provides detailed information on the patient, including pharmacy records		3
18	Data management	WC	Facility	Data harmonisation project trying to link all different data systems in the province – created a way of linking monthly data dumps using the unique identifier – also works on an algorithm basis		1

CONCLUSIONS

The review findings highlight the need for a **Call to Action: To end preventable maternal, newborn, child and women's health deaths in South Africa.**

The MDGs have set ambitious targets and all sectors need to work together to achieve, or get as close as possible to the targets set. This means that government, private sector, civil society organizations and communities will need to come together to address gaps and challenges in organizational effectiveness, functional effectiveness and political effectiveness. Furthermore, efforts should be placed on reaching every women and every child by bringing promising practices to scale, as well as addressing the action points identified during the review and the all district workshops.

SECTION 6

Annexures

ANNEXURE 1: SAMPLING FRAMEWORK

Step 1

Selection of districts was done by scoring performance against the countdown indicators from DHIS selection of better performing and under-performing district per province.

Based on the above, the following districts were selected

Province	District 1	District 2
Eastern Cape	Nelson Mandela Bay	Amathole
Free State	Thabo Mofutasanyane	Lejweleputswa
Gauteng	Johannesburg	Sedibang
Gauteng	Tshwane	
KZN	Ugu	Zululand
KZN	eThekwini	Uthukela
MP	Greater Sekhukune	Vhembe
NC	J T Gaetswe	Pixley ke Seme
NW	Ngaka Modiri Molema	Bojanala Platinum
WC	Overberg	Eden

Step 2

Selection of facilities was based on better performing and underperforming mix per district.

Hospitals selection based on performance for select indicators - still birth rate; early neonatal mortality rate; case fatality pneumonia, diarrhoea and SAM.

CHCs and Clinics initial screening done by headcount to remove facilities with lower head counts.

Performance assessed for five Indicators: ANC attendance before 20 weeks, EBF at 14 w PCR+ at 6 weeks, cervical screening and measles drop out .

For each district, one hospital and a linked clinic, as well as one CHC and one PHC need to be selected.

For the underperforming district,selection to identify:

1. Underperforming hospital
2. Average performing CHC
3. Better performing PHC clinic

For the better performing district, selection to find:

1. Better performing hospital
2. Average performing CHC
3. Underperforming PHC clinic

For hospitals five indicators to be analyzed for the selection:

1. Stillbirthrate
2. Early neonatal mortalityrate
3. Case fatality rates for pneumonia
4. Case fatality rates for diarrhea
5. Case fatality rate for severe acute malnutrition

Each indicator was scored as follows: Score -1 if below district average, + 1 if above and zero if on average.

Choose hospital with lowest scores for underperforming districts and highest scores for better performing. Please send through the first 3 hospitals (As we may need to adjust based on geographical access etc.)

We will liaise with the hospital/district to get the linked clinic.

For CHCs and clinics: need medium to large clinics so screen first with headcount and remove the small clinics and CHCs
Then choose five indicators one from each component and apply same criteria and scoring:

1. Attendance at ANC before 20 weeks
2. EBF at14 weeks
3. PCR Positive at 6weeks
4. Cervical screening
5. Measles drop out

For each of the above indicators we are using the district performance to judge the performance as better/under/average
At least three clinics and three CHC selected in each category, these were then finalized based on geographical access etc.

ANNEXURE 2: LIST OF PARTICIPANTS

2.1 Steering committee members

Name	Organization
Yogan Pillay	NDoH
Peter Baron	NDoH
Gugu Ngubane	RMCH
Shuaib Kauchali	RMCH
Sanjana Bhardwaj	UNICEF
Latasha Treger	UNICEF
Pearl Holele	NDoH
Nonhlanhla Dlamini	NDoH
Navchaa Suren	UNFPA

2.2 Thematic working groups

2.2.1 Maternal and newborn health

Name		Organization
Kate Kerber	Team Leader	UWC
Pearl Holele	NDoH Co-lead	NDoH
Latasha Treger		UNICEF
Ann Behr		NDoH
Sebotse Ngake		NDoH
Thulani Masilela		DPME
Natasha Rhoda		RMCH
Robert Pattinson		MRC
Habib Somanje		WHO
Leonard Kamugisha		UNFPA
Paul Mahanna		USAID
Gilbert Tshitaudzi		NDoH
Mary Mogashoa		CDC
Lesley Bamford		NDoH
Precious Robinson		NDoH
Tshililo Mashamba		NDoH
Gugu Xaba		PATH
David Saunders		UWC
Farzaneh Behroozi		UWC
Thubalihle Mathole		UWC
Ernie Kunneke		UWC
Renee Blaauw		SUN
Chantell Witten		UNICEF
Edelweiss Wentzel-Viljoen		NWU
Johann Jerling		NWU
Tlangelani Shilubane		UNFPA
Lebogang Schultz		UNFPA
Sanjana Bhardwaj		UNICEF
Dorothy Mbori-Ngacha		UNICEF

Name		Organization
Kondwani N'goma		UNICEF
Sarah Rohde		UNICEF
Donela Besada		UNICEF

2.2.2 Under-5 child health

Name		Organization
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Nonhlanhla Dlamini	NDoH Co-lead	NDoH
Andiswa Ngqaka		NDoH
Evasen Naidoo		ITECH
Lindsay Botham		NDoH
Afework Assefa		UNICEF
Sarah Croskell		CDC
Lebo Madisha		NDoH
Mercy Kamupira		WHO
Sipho Ntlangula		ITECH
Elizabeth Maseti		NDoH
Johannn van den Heever		NDoH
Christy Mulinder		USAID
Ann Behr		NDoH
Ozius Dewa		USAID
Rivadeneira Emilia		CDC
Gugu Xaba		PATH
Rina Swart		UWC
Corinna Walsh		UFS
Chantell Witten		UNICEF
Edelweiss Wentzel-Viljoen		NWU
Johann Jerling		NWU
Sanjana Bhardwaj		UNICEF
Kondwani N'goma		UNICEF
Latasha Treger		UNICEF
Sarah Rohde		UNICEF
Donela Besada		UNICEF
Dorothy Mbori-Ngacha		UNICEF
Habib Somanje		WHO
Himani Pandya		Wits
Lindsay Botha		NDoH
Ntombenhle Ngcobo		NDoH
Sarah Croskell		CDC
Wiedaad Slemming		Wits

2.2.3 Adolescent health

Name		Organization
Tlangelani Shilubane	Team Leader	UNFPA
Philip Brown	Team Leader	HDA
Lindiwe Dladla	NDoH Co-lead	NDoH
Pontsho Sepoloane		NDoH

Name		Organization
Kenau Susart		CDC
Leonard Kamugisha		UNFPA
Phuti Masuiane		NDoH
Nomea Masihleho		USAID
Mathata Madibane		USAID
Hilda Maringa		CDC
Lerato Lesole		CDC
Swart Kino Hlamelani		CDC
Salome Kruger		NWU
Maishataba Makwela		UL
Corinna Walsh		UFS
Chantell Witten		UNICEF
Edelweiss Wentzel-Viljoen		NWU
Johann Jerling		NWU
Philip Browne		TSFESA
Zee Ndlovu		Mott-MacDonald
Lebogang Schultz		UNFPA
Sanjana Bhardwaj		UNICEF
Rick Olsen		UNICEF
Kondwani N'goma		UNICEF
Mariette Strydom		UNICEF
Latasha Treger		UNICEF
Sarah Rohde		UNICEF
Donela Besada		UNICEF
Roshnee Ramsay		UNICEF

2.2.4 Women's health

Name		Organization
Helen Rees	Team Lead	WRHI
Melanie Pleaner	Co-lead	WRHI
Nat Khaole	NDoH Co-lead	NDoH
Joan Littlefield		USAID
Suzy Jed		ITECH
Maude de Hoop		NDoH
Mapula Malotte		NDoH
Chantelle Witten		UNICEF
Sphindile Magwaza		CDC
Lebogang Schultz		UNFPA
Nerisa Pileme		USAID
Gilbert Tshitaudzi		NDoH
Thembi Zulu		CDC
Salome Kruger		NWU
Chantell Witten		UNICEF
Edelweiss Wentzel-Viljoen		NWU
Johann Jerling		NWU
Leonard Kamugisha		UNFPA
Tlangelani Shilubane		UNFPA
Sanjana Bhardwaj		UNICEF

Latasha Treger		UNICEF
Sarah Rohde		UNICEF
Donela Besada		UNICEF
Rick Olsen		UNICEF
Kondwani N'goma		UNICEF
Lizzie Moore		MatCH
Jenni Smit		Match Research
Mags Beksinska		Match Research
Lebogang Schultz		UNFPA
Ida Asia		Jhpiego
Jennifer Reddy		UKZN
Mantshi Teffo-Menziwa		MSSA
Valerie Truby		Jhpiego
Caroline Mitchell		MSSA
Marion Stevens		UCT/Wish
Jane Harries		UCT
Mogale Magwentshu		IPAS
Joan Littlefield		USAID
Cindy Firnharber		RTC
Sinead Delany-Moretlwe		Wits RHI
Mapula Malotle		DOH
Sphindile Magwaza		CDC
Suzie Jed		ITECH
Virginia Francis		USAID
Ruxana Jina		Wits
Salome Kruger		
Liana Steenkamp		NMMU
Greta Dreyer		UP
Andrea Thompson		MSSA
Karen Trueman		IPAS
Jane Harries		UCT
William Mntambo		DOH
Nkhensani Mathabathe		UNAIDS
Thembi Zulu		DOH

2.2.5 Nutrition

Name		Organization
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Chantell Witten Team Lead	Co-lead	WRHI
Ernie Kunneke		UNICEF
Renee Blaauw		SUN
Salome Kruger		NWU
Maishataba Makwela		UL
Rina Swart		UWC
Corinna Walsh		UFS
Edelweiss Wentzel-Viljoen		NWU
Johann Jerling		NWU
Sanjana Bhardwaj		UNICEF
Latasha Treger		UNICEF

Sarah Rohde		UNICEF
Donela Besada		UNICEF
Roshnee Ramsay		UNICEF
Kondwani N'goma		UNICEF

2.3 Provincial field review leads and co-leads

Province		Name	Organization
Eastern Cape	Lead	Kondwani N'goma	UNICEF
	Co-lead	Mary Magashoa	CDC
	Co-lead	Lebogang Schultz	UNFPA
Gauteng	Lead	Innocent Nuwagira	WHO
	Co-lead	Natasha Rhoda	RMCH
	Co-lead	Himani Pandya	WITS
Free State	Lead	Chantell Witten	UNICEF
	Co-lead	Sharlene Govender	I Tech
		Roshnee Ramswamy	UNICEF
KwaZulu Natal	Lead	Dorothy Mbori-Ngacha	UNICEF
	Co-lead	Tlangelani Shilubane	UNFPA
		Mercy Kamupira	WHO
Mpumalanga	Lead	Kenau Swart	CDC
	Co-lead	Kenanao Mothloiwaco	UNICEF
Limpopo	Lead	Nkhensani Mathabathe	UNAIDS
	Co-lead	Lore Classens	UKZN (20000+)
Northern Cape	Lead	Haroon Saloojee	WITS
	Co-lead	Melanie Pleaner	WITS RHI
North West	Lead	Habib Somanje	WHO
	Co-lead	Joan Littlefield	USAID
Western Cape	Lead	Adegboyega Tunde	WHO
	Co-lead	Christy Mulinder	USAID
	Co-lead	Lerato Lesole	CDC
		Philip Browne	had
National		Latasha Treger	UNICEF
		Shuaib Kauchali	RMCH

2.4 Admin support team

Name	Organization
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Ntsehebo Mabitle	NDoH
Laila Slade	NDoH
Maholodi Masermule	NDoH
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Mamaite Nyathi	NDoH
Duke Sathekge	NDoH
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Gwen Wilkins	RMCH
Jess Muzvidzwa	RMCH
Mercia Saudi	UNICEF
Mariette Strydom	UNICEF

2.5 Review design, report collation and finalisation

Thematic team leads

Name		Organization
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Mickey Chopra		UNICEF
Latasha Treger		UNICEF
Donela Besada		UNICEF
Sarah Rohde		UNICEF
Gugulethu Ngubane		RMCH
Shuaib Kauchali		RMCH
Kate Kerber	Maternal and newborn Health	Save the Children
Natasha Rhoda	Maternal and newborn Health	RMCH
Haroon Saloojee	Under five child health	WITS
Helen Rees	Women's Health	WRHI
Melanie Pleaner	Women's Health	WRHI
Tlangelani Shilubane	Adolescent Health	UNFPA
Philip Brown	Adolescent Health	HDA
Johann Jerling	Nutrition	NWU
Chantel Witten	Nutrition	UNICEF

ANNEXURE 3: MTR TERMS OF REFERENCE

MID-TERM REVIEW OF THE NATIONAL STRATEGIC PLAN FOR MATERNAL, NEWBORN, CHILD AND WOMEN'S HEALTH AND NUTRITION (MNCWH AND N) 2012 – 2016 AND IMPLEMENTATION OF THE CARMMA[1] IN SOUTH AFRICA

1. Background

South Africa is committed to working towards achieving the Millennium Development Goals 4 and 5 to reduce maternal newborn and child mortality. The national MNCWH and N 2012-2016 strategic plan launched in 2012 has shared objectives with the Campaign on accelerated reduction of maternal newborn and child mortality in Africa (CARMMA).

The National MNCWH and N strategy 2012-2016 and South Africa's response to the CARMMA campaign outline key strategies and targets for the country. There have been substantial strides made in addressing maternal and child health outcomes over the last few years. The country has dramatically scaled the HIV/ART programme with increasing numbers of women reached through the PMTCT programme and more numbers of HIV positive children receiving treatment. These efforts have likely contributed to increased life expectancy, but more still needs to be done to reduce avoidable causes of death of mothers and children.

The National Department of Health is commissioning a mid-term review of the maternal, newborn, women and child health and nutrition programmes in the health sector in 2014. The review will be conducted under the leadership and overall coordination/management of the NDoH drawing on technical experts and financial resources from multiple development partners in MNCH and nutrition, globally, regionally and in country. These include the UN agencies in the country, USG agencies, DFID, Gates, etc.

The review will evaluate implementation progress against 8 strategic pillars of the MNCWH and N strategy and CARMMA objectives; identify and analyse critical factors of success, best practices and lessons to the effective delivery of the plan. The review will also support drawing up a list of implementation recommendations to assist provinces and districts for the 2015-2016 Annual Performance Plans (APP) and District Health Business Plans to include specific activities for MNCWH & N and look forward at opportunities and challenges to implementation that will inform the next 5 year strategic plan of 2017-2021.

2. Policy Context

The review will consider the strategic plan within the context of other relevant national health policies such as the Negotiated Service Delivery Agreement for Health (NSDA), PHC re- engineering policy, the new Contraceptive and Fertility Planning Policy, Infant and Young Child Feeding Policy, Medium Term Strategic Framework (MTSF) 2009-2014, to improve the health profile of all South Africans and the Strategic Plan of the National Department of Health, which is aimed at creating a well-functioning health system, the Road Map for Nutrition in South Africa.

The extent to which established institutional structures enable effective coordination between these different policy documents and strategies will also be assessed so as to contribute to a comprehensive coordinated national framework.

[1] CARMMA: Campaign for Accelerated Reduction for Maternal and Child Mortality in Africa 2013-2017. The review will also look at the interventions outlined in the Countdown to MDG report for South Africa (Feb 2014). A further list of relevant and related policies is attached in Annexure 3.

3. MNCWH&N Strategy Overview

Vision: **Accessible, caring, high quality** health and nutrition services for women, mothers, newborns and children

Mission: To reduce mortality and to improve the health and nutritional status of women, newborns and children through promotion of healthy lifestyles and provision of integrated, high quality health and nutrition services.

Overall goals:

- To reduce the maternal mortality ratio and neonatal, infant and child mortality rates by at least 10% by 2014[2]
- To empower women and to ensure universal access to reproductive health services
- To improve the nutritional status of all mothers and children ***8 key strategic pillars within the MNCWH and N Strategic Plan***
  a. Addressing **inequity** and the **social determinants** of health
  b. Development of a **comprehensive and coordinated framework** for provision of MNCWH & N services
  c. Strengthening **community-based MNCWH & N interventions**
  d. Scaling-up provision of key MNCWH & N Interventions at **PHC level**
  e. Scaling-up provision of key MNCWH & N Interventions **at district hospital level**
  f. Strengthening the **capacity of the health systems** to support the provision of MNCWH & N services
  g. Strengthening **human resource capacity** for delivery of MNCWH & N services Strengthening **systems for monitoring and evaluation** of MNCWH & N interventions and outcomes

4. Scope of the Review

The review will focus on health sector related MNCWH and nutrition related programme activities at community, facility, district, provincial and national levels. The review will build on the work done for the Countdown to MDG 4 and 5 report of the National Department of Health, February

2014 and focus on issues critical to effective delivery of high impact MNCWH and nutrition services. It will assess progress made against specific targets, identify challenges, lessons and best practices for potential replicability and scale up as well as identify approaches to support delivery of integrated quality care to improve MNCWH and nutrition outcomes. It will also inform the planning and budgeting for the 2015/2016 budget cycle. Additionally, this review will critically analyse and update the guiding principles and critical success factors identified in the Strategic Plan, determining whether these remain critical and identifying any additional success factors that need to be prioritised.

As this review is being conducted at the mid-point of the Strategic Plan, it will be a process review, rather than an impact evaluation. A detailed methodology is presented below; however the scope of work will be addressed in two phases, with an initial **desk review** and **key informant consultations** followed by a more **in depth implementation assessment** involving visits to all provinces, selected districts and facilities.

The review will use both existing data sources and targeted field visits to assess implementation of the strategy at community, facility, district, provincial and national levels. It will provide an overview of performance against key programme elements in the four identified technical working groups on **maternal and newborn health**, **Infant and U5 Child Health, Adolescent and Youth Health and Women's Health** (listed in Annex 1) and will assess progress against the MNCWH&N

[2] As assessed by the National Health Data Advisory and Co-ordination Committee (HDACC) in the Report of 2011. HDACC considered a 10% reduction in mortality of all these rates was feasible by 2014.

and CARMMA dashboard indicators (attached as Annex 2), where data is available. A key function of the review will be to assess whether the monitoring and evaluation framework intended to be a key part of the Strategy has been taken forward and seek to identify additional monitoring and evaluation requirements in order to maximise learning from the on-going implementation of the plan.

The review will assess the stewardship of the plan and key institutional structures that support the implementation of plans at sub national levels including promoting approaches to address the broader determinants of health.

Limitations in scope

The MNCHW and Nutrition programme includes a wide range of strategic areas and over 50 priority actions. It will not be possible for the study to comprehensively evaluate progress against all of the priority actions, however, the desk review will focus on reviewing various activities that effectively illustrate key implementation challenges, and should use case histories to illustrate areas of success and areas of on-going challenge for delivery of the plan.

5. Objectives of the review: Key objectives:

i. To review progress towards achieving the targets to date as outlined in the MNCWH and N strategy 2012-2016 (8 strategic pillars) and CARMMA (6 strategic objectives) focusing on high impact but poorly implemented interventions (reviewing the ones outlined in the Countdown to MDG 4 and 5 report for South Africa (Feb 2014) but not limited to these alone). The key elements of success and barriers to progress will be identified and the stewardship functions and institutional structures supporting implementation mapped and recommendations made to maximise high level coordination in support of delivery.

ii. To identify key implementation challenges on the ground including the human resource capacity for implementation of the Strategy, considering staffing numbers and distribution, training and continuing professional development, and to consider the sustainability of current capacity building initiatives and how these might be institutionalised in future, including a broader consideration of the role of professional bodies, such as academia (medical and nursing schools), professional accreditation bodies (HPCSA and Nursing Boards), professional societies (South African Society of Obstetric and Gynaecology and South African Paediatric Association), and Unions (SAMA, and DENOSA, etc), among others, in supporting capacity building of key skills and competencies. Assess the impact of challenges on quality, access, service utilization and coverage issues leading to specific time bound actions towards achieving expected results

iii. To conduct in-depth analysis of critical systemic bottlenecks (barriers to access) reducing effective coverage of high impact interventions and to evaluate the quality and effectiveness of MNCWH and N services and the extent of the evidence base, evaluation findings and confidential review findings from the three ministerial committees informing recommendation and action to improve quality. The review will also consider the implications of other relevant health policy priorities that are informing and shaping service delivery, such as primary health care re-engineering and how this might maximise effective use of available HR capacity.

iv. To identify best practices and lessons learnt from the field specific to the key interventions for improving MNWCH and nutrition outcomes for potential replication and scale up across the country

v. To assess the current level of technical assistance and support for the implementation of the strategy, identifying priority areas for on-going technical support.

vi. To assess the extent to which the existing indicators and systems for monitoring and evaluation are helping inform plan implementation, suggesting any necessary improvements to strengthen the M&E system.

6. Expected Deliverables

The expected deliverables of the review are:

1. A detailed desk review report synthesizing current data and reports on the implementation of the MNCWH and N strategy outlining the priority bottlenecks for implementation of high impact interventions in four technical areas, namely, Maternal and newborn health, under-5 child health, adolescents and women's health.
2. Field Report summarizing the in-depth assessment of systemic bottlenecks across the 9 provinces - district, provincial and national level report, based on facility visits, stakeholder consultations and key informant interviews which explore in greater depth the issues and best practices identified during the desk review.
3. Set of case studies/best practices which illustrate successes and challenges in strategy implementation to inform future planning
4. Final report per technical area highlighting key bottlenecks, best practices with clear set of recommendations towards achieving the expected targets.

The review is proposed in three phases between March and July 2014:

A. Desk review:

The scope of the desk review will include review of existing documents and data relevant to the objectives to assess the extent to which the MNCWH and N and CARMMA Strategic Objectives have been taken forward; evaluate the quality of the Provincial Annual Performance Plans (APP) and District Health Plans (DHP) to assess inclusion of MNCWH and N key priority interventions and plans; evaluating progress from existing data (dashboards) of elements that are underway, and identifying barriers and constraints to implementation through key informant interviews. Findings of the desk review will inform development of field tools and further inform key questions to be answered during field visits.

The desk review will be completed in four technical areas (Maternal and newborn health, under-5 child health, women's health and adolescents) against targets and against the 8 strategic pillars in the MNCW and N Strategy.

Specific areas of focus within the four technical areas are:

- To understand the stewardship and governance structures that support policy and programme implementation as well as considering the contribution of development partner funded support.
- Assess the institutional structures to support integrated planning, which bring together health services, school services, ward based services, nutrition and women's empowerment interventions
- Complete a broad resource allocation/gap analysis of the provision of MNCWH and N services.
- Identify issues emerging from related programme reviews, surveys and assessments that may be funded directly by development partners Documents to be reviewed include:
    - National policy and programme documents (Annexure 4 provides links to some)
    - Progress reports: provincial quarterly reports, District quarterly reviews
    - Provincial Annual Performance Plans and District health plans (DHP). A more detailed methodology accompanies this ToR as supplementary document in annexure 5
    - Survey reports and research papers,
    - Reports of the three Ministerial Committees ("Saving Mothers, Saving Babies, and Saving Child Reports")
    - Media reports (where relevant)
    - Any other data sources.

Key steps:

1. Identify Technical leads and finalize membership of the technical teams for each programme component:
    - The technical lead supported by a team of 10-15 members' together form the Technical Team. These members will be drawn from various partner organizations as well as experts in the field. The composition of the technical teams will be finalized by the technical lead working closely with the DoH.
    - Each technical team will have a co-lead from the DoH and will be supported financially (as per need) from a lead partner organization. (A table that gives further details on the Technical Teams (TT) is attached as an annex.)

2. Agree on scope and steps for desk review: A workshop will be held at NDOH on the 11th April 2014 to brief all technical teams on the TOR and expectations from the teams and to agree on the desktop method, reporting template, etc.

Proposed steps for the desk review:

i. Understanding the progress towards reaching the targets as outlined in the MNCWH and N strategy 2012-2016 for their programme component area at national and for each of the nine provinces by analyzing key indicators.

ii. Key indicators to understand the progress will be agreed on jointly with the DoH. The indicators will be a mix of impact (eg, MMR, NMR etc) and process indicators (as per the strategy document). It is proposed to review the 18 interventions as outlined in the Countdown to MDG 4 and 5 report of the DoH, February 2014, and the corresponding DHIS indicators agreed by the DoH and track progress over the last 2 years for each of them. The TT may review additional indicators based on the felt need and relevance for their respective programme areas.

iii. Through the process of the review of data, patterns/trends on progress or lack of progress will be identified, and narrowed down to district level in each province. The exercise should result in a list of districts (and where possible facilities) where progress has been made and where there is lack of progress (or a downward trend).

iv. The next step will entail getting a better understanding of the underlying factors that will help to explain the above variation. Key areas to be looked at include, Human Resource (numbers, capacities), Systems like referral/transport, Leadership and management, Community involvement, Financial etc. Root cause analyses that also detect the soft issues.

v. In areas where progress has happened, the desk review process will look in depth at how the particular problem was addressed looking at four areas (enabling environment, quality of services, supply and demand) including an understanding of what were 6 possible leverage points used (example - peer recognition, accreditation, direct supervision and command, partner support).

vi. In areas where there is lack of progress, the desk review process will look at common threads of issues/barriers identified in national reports (Saving mothers, other surveys, the HIV/TB/PMTCT review etc), and in what degree these are relevant to the particular case at facility/district level under review.

Agree on expected results at the end of the desk review Report back date to NDoH: 9th May 2014. The report from the desk review for each technical area will share:

- Understanding of the progress in key indicators at national, provincial level
- List of districts (facilities) where progress is seen and where there is lack of progress
- In cases where progress has happened and where there is lack of progress – analysis of underlying factors, with key recommendations for further exploration during the field visit
- Clear recommendations for which areas/factors need to be explored further during the field visit.

B. Field Visits

The field visits will be used to collect information from health workers, facilities, district and provincial managers. Where community consultations have been undertaken on related MNCWH and N issues, these will be analysed in order to determine the need for any additional community level consultation. Facilities will be visited to observe the provision of services with particular emphasis on the key strategic pillars under the four technical programme areas being assessed in this review.

National consultation with national stakeholders, provincial managers and supporting development and implementing partners will be held in mid-May 2014 and field work is anticipated to be conducted between 17 and 27 of June 2014.
Provincial level: All 9 provinces will be visited and interviews will target provincial programme managers and key stakeholders identified with the provinces.

Districts: At least two districts will be selected for site visits through agreed criteria by the review technical working group, but will ensure a mix of rural, urban/peri-urban, high/low disease burden; strong/weak performers; etc. In each district at least four **facilities** (including a regional, district hospital, community health centre (CHC) and PHC clinic) will be visited to observe the services and interview users and providers. KZN is proposed to select 4 districts of 11 and GP 3 districts to accommodate the vastness of these provinces. The other 7 provinces will select 2 districts each, making a total of 21 districts that will be part of the review.

Provincial and district feedback

A feedback session with all districts in the province will be organized at the end of the field visit in each province. Findings from the field visits as well as an understanding of key bottlenecks in each district and priority actions will be completed and included as part of the final report.

Key Steps for the Field Visits

This phase will have six components:

2a. **Validation of the desk review findings**

Date: 13 and 14th May 2014

The findings of the desk review will be shared with the key stakeholders from national and provincial levels in a two days meeting. (Participation from all 9 provinces – MNCH managers).

This will help in validating the desk review findings with practitioners from the field and further help in narrowing the focus for further in depth analysis during the field review.

Before the commencement of the field visits there will be a national interprovincial meeting where the MCWH managers from the provinces, implementing partners & developmental partners will attend. The objectives of this meeting are to inform attendees on the findings of the desktop review presented and discussed as per TT divisions. Based on these discussions; agreement on areas of focus for the field visits and recommendations on the districts to be visited.

On returning to their provinces, managers to ensure that their provinces and districts are ready for the visits.

2b. **Finalization of the sampling frame and 2c. Finalization of the field visit tools Date: 15 and 16th May 2014**

The sampling frame will be drawn from the desk review with a list of districts and facilities to be visited based on the list where progress has been made and where there is lack of progress. We will use MCWH dashboard over time; district hospital mortality data over time as proxies for progress.

The field tools will be finalized drawing from the list of key questions from the desk review.

It is proposed that the field visit will be a mix of quantitative and qualitative methods, which includes focus group discussions with senior managers/CEOs etc, as well as facility visits to get field level data.

2c. **Field - testing of the tools and finalization of tools Date: 27, 28 and 29 May 2014**

A two days visit to a selected district for field - testing the tools. A sub-team from the desktop review panel will be nominated to complete the piloting of the tools in a district.

This will be followed by a one day debrief at national level with the technical leads and lead partner organizations to finalize the tools based on the feedback.

2d. **Finalization of the teams for the field visits Dates: 19th May to 30th May 2014** There will be 22 teams for the field visits. These are:

National – 1 team, NW, WC, MP, EC, FS, NC, LP – 2 districts each = 14 teams GP: 3 districts = 3 teams KZN: 4 districts = 4 teams Total = 22 teams Each team will be composed of six persons:

1. Team leader
2. Deputy team leader
3. Team members – 4 persons – at least 1 member will be from NDoH and 1 member from provincial DoH, 2 members from partner organizations

The team leaders and deputy team leaders will be drawn from the technical teams (persons based in South Africa from partner organizations).

Total persons needed for the field visit: 22 teams * 6 persons per team = 132

Persons from partner organizations: 88 (will be at least 22 from within country as team leaders and 66 can be from within country or outside)

Persons from NDoH = 22 Persons from Provincial DoH = 22

The finalization of teams will be coordinated by the secretariat – RMCH supported by UNICEF and approved by the steering committee for the review.

Invite letters to team members to be sent out by the secretariat and confirmation of participation received by 30th May.

6th June 2014: meeting of team leaders and presentation to Steercom; plans for field visits.

2e. **Field visits**

Dates: 17th to 27th June 2014: The proposed field visit schedule is as follows:

17th June, Tuesday:

Introduction and briefing meeting 830 hrs to 1400 hrs at NDoH

Field teams depart for the respective provinces: 1400 hrs onwards

Please note: Team members to arrange their own travel to the provinces (tickets/accommodation/meals).

The vehicle/s hire at the provincial level for the field visits will be coordinated by the Secretariat for the review.

Each field review team is expected to stay at a common venue (list of venues to be shared by the Secretariat for the provincial headquarters and the district – based on the selected districts). A conference/meeting room to be arranged for each team to work on the provincial report on 21st and 22nd June.
A team will be assigned to interview NDOH officers as an additional "field visit".

18th June, Wednesday: at provincial headquarters

Meeting with the HOD and briefing with the provincial team -0830 1030 hrs Stakeholder consultations at provincial level – 1100 to 1330hrs (to arrange at provincial offices or a conference room based on availability).

The stakeholder consultations will be better defined after the desk review (including numbers and types of consultations and participants).

The teams for each province (namely 2 teams for the 7 provinces, 3 teams for GP, and 4 teams for KZN will be together till this point)

18th June, Wednesday pm: teams travel out to districts – teams split up and each team travels to the respective district as per the agreed sampling frame

Field visits to facilities including district offices based on the agreed sampling frame. This will be province specific and each province will have a specific plan.

19th Thursday and 20th June, Friday: field visits to sites/consultations **21st June, Saturday and 22nd June, Sunday**: Report writing

All district teams come together at the provincial headquarters to collate findings and work together to finalize the provincial report as well as specific technical area reports.

23rd June, Monday and 24th June, Tuesday: Feedback and planning workshops All districts in the province come together for a two days workshop to receive the feedback from the review, understand the findings and agree on next steps/action.

These workshops will be conducted at the provincial head quarters, and venue/accommodation for participants will be arranged by the Secretariat for the review.

Field review teams travel back to Pretoria on 24th June, Tuesday, after 1600 hrs.

25th and 26th June, Wednesday and Thursday: Finalization of report at national level

The review team members from partner organizations (88) and DoH colleagues (22) come together for 2 days to share findings from the field visits and collate findings.

Oversight to the final collation of the report to be provided by UNICEF supported by the 4 technical leads and the lead partner organizations (UNFPA and USAID).

27th June, Friday: Presentation of the preliminary report

Report back to NDoH – steering committee and key stakeholders of the final report of the review.

This will collate the desk review and the field - visit findings.

C. Report and action plan:

The final phase of the review will include the finalization of report with key actions and best practices including wide dissemination with all stakeholders and agreement on key action points at field level including scaling up best practices. UNICEF will support the final coordination and collation of the report. This will be a full report bringing together the desk review and the field review findings with specific recommendations (evidence based, time bound and linked to specific results).

The final report will be formally presented to the NDoH in August 2014.

7. Organisation and management

The Review is being carried out under the overall direction of the Deputy Director- General, Strategic Programmes, Dr Yogan Pillay. A Steering Committee is established for oversight and technical leadership and comprises of senior managers of development partner organizations and NDOH programme managers from the four key programme areas.

7.1. Project Management

RMCH program will serve as the secretariat for the review. This will be supported by UNICEF. The logistics support will be provided by a specific agency/institution identified for the same with overall coordination provided by NDoH.

7.2. Project Steering Committee

The Steering Committee will be responsible for the overall oversight in the planning, coordination and execution of the Review. It will also be responsible for taking forward implementation of the recommendations of the review. The Committee is chaired by Deputy Director-General Dr Yogan Pillay, assisted by Chief Directors of relevant Clusters in the NDOH. UNICEF will support the steering committee in the design and implementation of the review. Other members will include major MNCWH&N partners in the country identified by the DOH. The Steering Committee will send out invitations to external review members to participate in the review technical working groups that have been identified.

7.3 MNCWH and N Review Technical Working Teams

The main technical working group comprises NDOH Programme Managers and all the development partners including UNICEF, UNFPA, UNAIDS, USAID, CDC, WHO, DFID, etc.

There are five technical working sub-groups, the membership of which will be approved by the Steering Committee. Technical leads of each technical working group will be nominated by Dr Pillay assisted by development partners and do not necessarily need to be from the department. Each group will have an NDOH programme manager representative. The technical working groups are namely:

i. **Maternal and Newborn Health**: Led by UNICEF, Dr Pearl Holele (NDOH) and Dr Lesley Bamford (NDOH)
ii. **Infant and Child Health (Under-1 and Under-5, excluding Newborn health):** Led by UNICEF and Dr Nonhlanhla Dlamini (NDOH)
iii. **Adolescent and Youth Health:** Led by UNFPA and Lindiwe Dladla (NDOH)
iv. **Women's health:** Led by USAID/CDC and Nat Khaole (NDOH)

v. **Nutrition:** led by UNICEF and Dr Nonhlanhla Dlamini (NDoH) HIV/AIDS will be represented in all five technical areas since it is cross cutting. **Time lines:**

A. Preparatory phase: February/March2014

- Finalise TOR of the review
- Conduct the stakeholder meeting
- Formulate the working group

B. Finalise the methodology for MTR: Mid February to mid-March 2014 - Identify technical leads for the technical working groups

C. Drafting of project plan: February/March 2014

- **Develop Gantt Chart**
- **Budget/Costed estimates of activities**

D. Desktopreview:MarchtomidMay2014

- Complete a desk review (literature review/data analysis etc) for each intervention that focuses upon the human resources, key supplies, access, utilisation, continuity of care, quality of care bottlenecks that have the potential to reduce coverage and effective coverage in each province. Important sources of information will include the HMIS, PiPP, MMRs etc
- DDG to inform NHC Tech of the review - Letters to inform provincial HODs
- Draft methodology for DR
- Share examples of HIV/TB desktop review
- Review data collection and collation
- Data analysis and report writing
- Conduct national consultations of provincial stakeholders to agree on results of desk review and identify the most critical bottlenecks and best practices that need further analysis/fact finding at field level
- Finalise desktop review report

E. Prepare for Field Visit – May 2014

- District preparation for review
- Communication: Letter to HD by YP
- Workshop to finalise data tools and sampling area for the review (for example, transportation and referral system; motivation and performance of health workers; supervisory system etc)
- Get authorisation from NDoH
- Constitute assessment teams and nominate team leader
- Develop district visit schedules (When, who, and where)

F. Field work/Data Collection: June 2014

- Finalise tools for field review for systematic review of systems that underlie potential bottlenecks
- Printing of data collection tools
- Pre-testing data collection instrument
- Finalisation of data collection tools and system to be used
- Field visits
- Conduct provincial feedback meetings presenting key findings including potential of introduction/scale up of innovations to address key bottlenecks

- National dissemination of the review findings after the field visits: Agree on key action points at field level including scaling up best practices

G. Final Report and action plan: July to August 2014

- Finalisation of report

H. Recommendations/Plan of action: August/September 2014

- Presentation and dissemination with all stakeholders

8. Resources

The resources for the Review will be provided as in-kind contribution from development partners. UNICEF and DFID to support project management. Additional resources will be used directly by other development partners to provide TA for desk review and field work and to finance field work. UNICEF, USAID, CDC, WHO and UNFPA have expressed interest and pledged support.

9. Development Partner Contributions to the Strategic Plan

Some elements of the Strategic Plan are supported or financed by Development Partners (including UN agencies, US Government agencies, the UK's Department for International Development and the European Union). Not within the scope of this review, but other future evaluations that might be considered include:

- A separate evaluation to be conducted to assess the contribution of donor funded programmes. The purpose is to assess whether donor funded project and programme support are aligned with national priorities, effectively building national capacity and sustainable beyond the current phases of donor funding. The evaluation will also assess the financial contribution of current externally funded programmes as part of an overall evaluation of likely future additional resource needs to fill the funding gap for full delivery of the National Strategy.
- A review of school health implementation since the national launch of the ISHP policy in October 2012 which has impact on MNCWH outcomes as it relates to Adolescent and youth health, early childhood development and U5 child health
- Review of the national DCST programme implementation
- Costing of MNCWH&N plan and building an investment case for SA

10. Post Review Plan

- The Steercom will present the findings and recommendations to the NHC
- NDOH will respond to each finding and recommendation and provide an action plan that will be communicated back to the national MNCWH forum for provincial programme managers and plan district based dissemination plan to communicate these

Annexure 1: Terms of Reference: MNCWH&N Strategic Plan Review: Technical Working Groups

Four groups: Maternal and newborn health, Under 5 child health, adolescents and women's health and nutrition

A. Scope of Work

The TWG will complete the desktop review and support the field visits and finalization of the final report.

Key tasks include:

- Assessment of the MNCWH&N strategy and CARMMA, and the Countdown interventions, guided by the strategies on key focus areas in each technical working group
- Looking at existing data from 2012-2014 to assess status of implementation, use DHIS data, 3 Ministerial Committees, Save the mothers and children reviews, and any other survey, APP and DHP to assess the quality of plan and coordination framework to include key MCH priorities to reduce maternal and child mortality
- Assessment of what was done and how well or badly was it done – coverage and quality
- Assessment of what was not done and give detail of why and recommend how it can be done; Diagnose the problem and analyse it
- Using the bottleneck analysis framework used previously in the PMTCT programme evaluation
- Evaluating what is working and how can it be scaled up. Is the strategy we have able to make us reach the targets and what should be done to improve this?
- Each group to look at the continuum of care to connect and link dots/gaps
- Evaluating health system enablers and bottlenecks, reviewing the WHO Health System Framework's 6 building blocks. This will require engagement with other national clusters and directorates such as DHS and PHC services (Jeanette Hunter) and Hospital Services (Terence Carter)
- Analysing and making recommendations to change/ improve the service delivery platform Planning for discussion forums of technical groups: to discuss what works and what needs to be done differently to make change. Share a modelling tool or recommendations to assist districts on what needs to be done differently to move things

B. Key Issues to bead dressed in each technical work stream by the technical working groups

Desktop Review

- Use existing data, reports and previous research to assess status of maternal newborn and child health, progress of implementation of key elements under each technical programme area, identify key bottlenecks and key success factors
- Identify best practices or case studies already reported to improve outcomes in each technical area
- Identify areas for further in-depth analysis for the field work interviews and observations

Progress on 8 Strategic Pillars of the MNCWH and H strategy

- Identify the extent to which each element has been prioritised to date. Document progress against indictors where possible and identify barriers and challenges to implementation.
- Assess the extent to which stewardship functions recognise and support progress on all strategic areas, and whether the balance between health system objectives and broader health determinants has been realised.
  Identify major challenges and opportunities to achieving the Strategy and any implications for other key policies, such as Primary Health Care Re-engineering and the Road Map for Nutrition. ***Human resource capacity of implementation***
  Identify key cadres of staff and competency sets necessary for implementing the strategy and their distribution at various levels of the health service. Consider whether effective delivery of the strategy requires redistribution of skills and responsibilities with reference to health service restructuring and primary care re-engineering
- Identify examples of good practice in human resource management and deployment which illustrate how different staffing structures can impact on service delivery – particular attention should be given to identifying how to maximise every districts capacity to deliver the 7 signal functions for 24 hour Emergency Obstetric Care
- To consider the role of the Health Professional Council of South Africa, Medical boards and other professional bodies role in support of the Strategy through accreditation and support of professional training on MNCH. Discuss with key stakeholders frameworks form reinforcing professional accountability and continuing professional development and the scope for making aspects of MNCH training mandatory.

Quality and effectiveness of MNCWH and N services

- Assess quality assurance processes operational at key levels of service delivery – this should include levels of training and mechanisms to support continuing professional development, provincial and district level Human Resource planning and systems in place for maintaining clinical standards from a service delivery perspective.
- To look at monitoring and supervision functions and the effectiveness of DCSTs in supporting quality of care

Communication of Policies and Strategy Objectives

- Assess the extent to which Strategy Objectives have been communicated to and are understood at different levels of the health services – looking at process of cascading policy 17 priorities and supporting documentation and guidelines which reinforce strategy implementation
- Consider the role of national, provincial and district levels in agreeing and promoting strategy objectives, and how to maximise national delivery of the plan given the level of autonomy of the Provinces in determination of provincial level priorities

Levels of Technical Assistance

- To assess the level of technical capacity required at national, provincial and district level in order to support implementation and mechanisms for bringing in additional capacity, as needed
- Consider the level of technical assistance currently provided by direct commissioning by NDOH, and by development partners and identify areas of priority for on-going support.

Monitoring and Evaluation

Assess the completeness and utility of the 19 indicators of the strategy, determining whether additional or different indicators would strengthen monitoring. To look at established M&E approaches and assess the extent to which these are actively informing strategy implementation

To identify additional M&E needs, with a view to supporting an impact evaluation of the programme prior to 2016.

Composition of the TWG

- Each working group will have an identified lead from the DoH and a technical lead from an organization/institution as nominated by the Steering committee.
- The technical leads will draw in other members – experts in that area from academia, practitioners, global organizations, partners etc.
- Each group to consist of 10-15 members
- The group can work electronically, as well as face to face meetings based on the decision of the technical team leads.

Deliverables

1. Desk review report (agreed template common to all 4 groups) outlining progress, bottlenecks, best practices and lessons learned
2. Inputs to the field tools – including indicators, list of best practices to be visited etc
3. Inputs to the final report for the specific technical area

Members of the technical group will participate in the field review, however, other experts/practitioners may be drawn in for the field visits.

Annexure 2: Reference material

Summary of key objectives of the MNCWH&N Strategic Plan by strategic area:

Maternal Health

- Basic Antenatal Care (four visits for every pregnant women beginning during the first trimester)
- HIV testing early in pregnancy (14 weeks) and at 32 weeks with initiation of ART
- Improved access to care during labour through introduction of dedicated obstetric ambulances and establishment of maternity waiting homes (where appropriate)
- Improved intrapartum care (with specific focus on the correct use of the partogram, and standard protocols for managing complications)
- Training in essential steps in the management of obstetric emergencies
- Post-natal care within six days of delivery

Newborn Health

- Promotion of exclusive breastfeeding
- Provision of PMTCT
- Resuscitation of newborns
- Care for small/ill newborns according to standardized protocols
- Kangaroo Mother Care for stable LBW infants
- Post-natal visit within six days

Child Health

- Promotion of breastfeeding
- Provision of preventative services (immunisation, growth monitoring, vitamin A, regular deworming)
- Correct management of common childhood illnesses (IMCI)
- Early identification of HIV-infected children and management
- Improved hospital care for ill children especially for those with common conditions using standardised protocols
- Expansion and strengthening of school health services
- Developing services for children with long-term health conditions

Adolescent and Youth Health

- Access to Youth Friendly services
- Access to SRH 19

Women's Health

- Access to contraceptive services, including pregnancy confirmation, emergency contraception and a full range of contraceptive methods
- Post-rape care for women and children (PEP)
- Improved reproductive health services for adolescents through provision of youth-friendly counselling and reproductive health services at health facilities and as part of school health services
- Improved coverage of cervical screening and strengthening of referrals
- Provision of a package of community-based MNCWH services by generalist CHWs working as part of municipal ward-based PHC outreach teams

Community Interventions

- Multi-sectoral action to reduce poverty and inequity, and improve access to basic services, especially improved water and sanitation
- Implementation of a MNCWH communication strategy at all levels

CARMMA

- Exclusive breastfeeding
- Improved contraceptive services
- Improvement of the PMTCT programme
- Improved outcomes for babies and mothers
- ESMOE (Essential steps in the mgt of obstetric emergencies)
- KMC (kangaroo mother care)
- Obstetric waiting homes
- Improved transport (obstetric ambulances)

Annexure 3: Monitoring and Evaluation Framework CARMMA Dashboard

No.	Key Component	DHIS Performance Indicator	Baseline (2012/13)	Target	Performance 2013/14					Comments
					Q1	Q2	Q3	Q4	Annual	
1	Strengthening access to comprehensive SRHR services, with specific focus on family planning	Couple year protection rate Delivery in facility under 18 years rate[4]			-					
2	Advocacy and promotion of early antenatal care attendance/ booking Early postnatal care within 6 days after delivery	Antenatal 1st visit before 20 weeks rate Mother post natal visit within 6 days rate			-					
3	Improve access to skilled birth attendance through: • Allocation of obstetric ambulances to every facility where deliveries are conducted • Establishment of maternity waiting homes (MWH), where necessary	Delivery in facility rate (annualized)								
4	Strengthening human resources for maternal and child health through: • Training on Essential Steps in Management of Obstetric Emergencies (ESMOE) for doctors and midwives • Strengthening midwifery education and training	Number of doctors and midwives trained in ESMOE (cumulative)[5]			-					

[4] Indicator selected to monitor access to family planning services for adolescents
[5] This output indicator is not in the NIDS (DHIS); ESMOE training should be coordinated, monitored and reported by the DHMT (District Trainer, MNCWH Coordinator and DCST) at the district level.

No.	Key Component	DHIS Performance Indicator	Baseline (2012/13)	Target	Performance 2013/14					Comments
					Q1	Q2	Q3	Q4	Annual	
5	Improve child survival through: • Promotion of breast-feeding, • Provision of facilities for lactating mothers (boarder mother) in health facilities where children are admitted • Promotion of Kangaroo Mother Care (KMC) for low birth weight babies • Advocating for appropriate care and support of pregnant women and lactating mothers in the workplace • Improving immunization coverage rates	Infants exclusively breastfed at Hepatitis B 3rd dose Proportion of facilities offering inpatient newborn care providing KMC[6] Measles 2nd dose coverage (annualised)								
6	Intensifying management of HIV positive pregnant women and mothers and HIV infected and affected children through: • Improved access to HIV treatment for both mothers and children • Improved management of co-infections • Elimination of mother to child transmission of HIV by 2015	Infant 1st PCR test positive around 6 weeks rate			-					

Annexure 3: Monitoring and Evaluation Framework MNCWH and N Dashboard

Programme	Indicator	Measure	Baseline (2012/13)	Target	Q1	Q2	Q3	Q4	Annual
EPI	Fully immunized at one year* Drop-out rate (DaPT-Hib-IPV3 to Measles1)	%							
Nutrition	Vitamin A coverage 1 - 5 years Severe Malnutrition Case Fatality Rate	%							

[6] This indicator is not in the NIDS (DHIS). This is a critical output indicator to monitor the implementation of CARMMA and National Newborn Care Improvement Action Plan/Framework

Programme	Indicator	Measure	Baseline (2012/13)	Target	Q1	Q2	Q3	Q4	Annual
Diarrhoea	Incidence of diarrhoea with dehydration Inpatient case fatality rate	Cases per 1,000 U5s %							
Pneumonia	Incidence of pneumonia Inpatient case fatality rate	Cases per 1,000 U5s %							
HIV	PCR coverage at around 6 weeks PCR positivity rate at around 6 weeks*	%							
Hospital care	Inpatient under-one case fatality rate Inpatient under-five case fatality rate	%							
ANC	Early booking rate (<20 weeks)* Proportion of eligible women started on HAART	%							
Intrapartum care	Delivery rate in facility under supervision of trained personnel* Stillbirth rate in facility Post-natal care within 6 days	% Per 1,000 births							
Newborn Care	Neonatal mortality rate Low Birth Weight rate	Per 1,000 live births %							
Women's Health	Couple year protection rate* Cervical screening coverage rate	%							

Annexure 4: Reference material

Links to key National Health Policies and Strategies

- Adolescent and Youth Health Policy 2012
- CARMMA Roadmap to 2014
    - CARMMA South Africa Strategic Plan
    - Contraception and Fertility Policy and Service Delivery Guidelines 2013
    - Implementing PHC Re-engineering
    - Infant and Young Child Feeding Policy
    - Integrated School Health Policy
    - MNCWH and Nutrition Strategic Plan 2012-2016
    - MNCWH and Nutrition Strategic Plan Presentation at MCH Indaba
    - National Evaluation Policy Framework
    - National Core Standards for Health Establishments 2012
    - National PMTCT Plan
    - NDoH Annual Performance Plan 2012-2015
    - School Health Policy and Implementation Guidelines
    - Policy of District Health System

Other National Level Resources

- National CMAP Primary Health Care Report
- Every Death Counts – Saving the Lives of Mothers, Babies and Children in South Africa

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