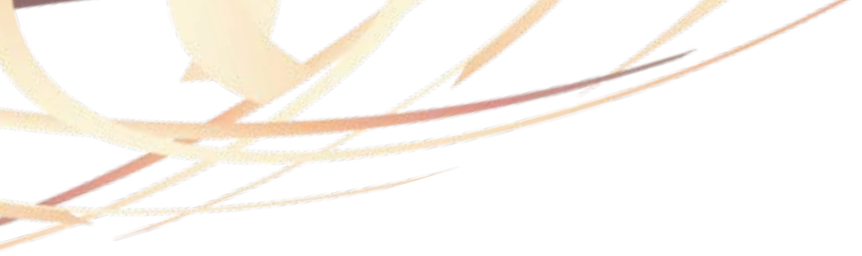



Annual Performance Plan

2012/13-2014/15

health

Department:
Health
REPUBLIC OF SOUTH AFRICA



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ACRONYMS

AG	Auditor-General
AMC	Academic Medical Center
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Antiretroviral Treatment
BoD	Burden of Disease
CCOD	Compensation Commission for Occupational Diseases
CEO	Chief Executive Officer
CHC	Community Health Center
CHW	Community Health Worker
CMS	Council for Medical Schemes
CPIX	Consumer Price Index
CRA	Comparative Risk Assessment
CSIR	Council for Scientific and Industrial Research
CTOP	Choice of Termination of Pregnancy
DBE	Department of Basic Education
DBSA	Development Bank of Southern Africa
DHA	District Health Authority
DHB	District Health Barometer
DHIS	District Health Information System
DOH	Department of Health
DSD	Department of Social Development
EDMS	Electronic Document Management System
EEL	Essential Equipment List
EMS	Emergency Medical Services
FBO	Faith-Based Organisation
FCTC	Framework Convention on Tobacco Control
FIT	Facility Improvement Teams
GDP	Gross Domestic Product
GP	General Practitioner
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counselling and Testing
HDACC	Health Data Advisory and Coordination Committee
HSRC	Human Sciences Research Council
HST	Health Systems Trust
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IUSS	Infrastructure Unit Support Systems
KZN	KwaZulu-Natal
LBW	Low Birth Weight
MAC	Ministerial Advisory Committee
MBOD	Medical Bureau for Occupational Diseases
MCC	Medicines Control Council
MDG	Millennium Development Goal
MEC	Member of the Executive Council
MISP	Master Information Systems Plan
MMR	Maternal Mortality Rate
MRC	Medical Research Council

MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NHLS	National Health Laboratory Service
NHRC	National Health Research Committee
NHREC	National Health Research Ethics Committee
NICD	National Institute for Communicable Diseases
NIMSS	National Injury Mortality Surveillance System
NSDA	Negotiated Service Delivery Agreement
NSP	National Strategic Plan
OPV	Oral Polio Vaccine
OSC	Office of Standards Compliance
OSD	Occupation Specific Dispensation
PHC	Primary Healthcare
PMTCT	Prevention of Mother to Child Transmission
PPIP	Perinatal Problem Identification Programme
PPP	Public Private Partnership
QIP	Quality Improvement Plan
SADHS	South African Demographic and Health Survey
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SDA	Service Delivery Agreement
SMOE	Essential Steps in Managing Obstetric Emergency
SRH	Sexual and Reproductive Health
STATSSA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YFS	Youth Friendly Services

FOREWORD BY THE MINISTER OF HEALTH

As the custodian of the health system, the Department continues to implement a number of interventions to holistically address the health needs of all South Africans. These interventions are guided by Government's commitment to achieve a long and healthy life for all South Africans.

Within the context of the quadruple burden of disease, HIV, AIDS and TB continue to cause high rates of morbidity and mortality in the country. None the less, tremendous progress has been made in combating HIV and AIDS through increasing the number of people tested, increasing the treatment threshold to those with a CD4 count of 350 or less and the antiretroviral (ARV) treatment programme has been expanded to include over 1.6 million people since its inception. However, there is still more work to be done. A key intervention would be to ensure HIV testing are routine. HIV and AIDS still account for a significant proportion of maternal deaths. The Department will continue to expand access to Highly Active Antiretroviral Therapy (HAART) for pregnant women.

Our maternal mortality ratios have been revised downwards compared to what was previously reported to be the ratio for the country. Despite this, the revised maternal mortality figure is still high for a country with our level of development and resources in the health system. Our aim is to reduce maternal deaths significantly so as to meet the Millennium Development Goals. Key strategies to achieve this include the roll-out of dedicated obstetric ambulances, maternity waiting homes and accelerated training and scale up of the programme for Essential Steps in Managing Obstetric Emergency (ESMOE). These interventions form part of a proactive approach to address maternal health challenges that will at first focus on the 25 districts with poor maternal and child health outcomes and will be rapidly rolled out to cover the whole country.

Similarly the under five and infant mortality rates are also projected to be lower than what was originally reported, even though these figures still remain high. To help address our child mortality challenges, we have implemented a policy to promote exclusive breastfeeding as a mechanism to assist in improving child survival. Recent scientific evidence clearly indicates that exclusive breastfeeding is beneficial for infants. This intervention and the success of our Prevention of Mother-To-Child Transmission of HIV (PMTCT) programme are at the core of our response to reducing infant and child mortality. The increased immunisation

coverage of the pneumococcal conjugate vaccine and rota virus vaccine are also yielding positive results as respiratory tract infections and diarrhoeal diseases among infants and children are on a downward trend.

Non-Communicable Diseases (NCDs) are a major problem, globally and within the South African context. Unhealthy diets and lifestyles are a major cause of NCDs such as obesity, hypertension and diabetes. Our strategies to address NCDs focus on four key factors namely reducing tobacco smoking, reducing harmful alcohol consumption, promoting physical activity and addressing unhealthy diets. As part of building a social compact on health, we will work with all our stakeholders in implementing necessary legislation and supporting regulations to control trans-fatty acids in food stuffs. In the coming financial year we will strengthen monitoring of industry compliance to the regulations through sampling of relevant food stuffs and independent laboratory analysis. Other regulations that will be introduced relate to reducing salt intake by targeting six food items namely brine in chicken, bread, cereal, spices, soups and snacks. The last set of interventions targeting NCD risk factors focus on promoting physical activity in schools, with the collaboration of the Departments of Basic Education and Sports and Recreation to design a programme of compulsory physical education in schools. This programme will be launched early in the coming financial year as part of the School Health Services programme.

Violence and injury have been identified as another significant contributor to the country's burden of disease. We recognise that this requires a broader societal approach. The Department has adopted a partnership approach to developing policies and strategies to respond to this challenge. The Department will implement the Strategic Framework for the Prevention of Injury in South Africa, which incorporates a plan for response to violence. This Framework was developed in collaboration with key stakeholders and is an integrated and intersectoral response to the burden of disease emanating from violence and injury.

The interventions mentioned above are well described in the Negotiated Service Delivery Agreement (NSDA) of the Health sector. Our success to tackling these immense challenges is conditionally dependent on the existence of a functional health system. The thrust of our actions in this financial year are also directed at strengthening the functioning and performance of the health system.

One major component of the health system that will be strengthened further is infrastructure management. To improve the performance of the health infrastructure programme we have established the Infrastructure Unit Support systems (IUSS) as part of a turnaround strategy to accelerate health infrastructure delivery. The IUSS will continue to provide support to provinces to improve coordination and expenditure on the health infrastructure grants. The priority infrastructure projects in 2012/13 will include renovation, refurbishment and/or the complete rebuilding of about 122 nursing colleges to enhance their student intake and training capacity. Infrastructure in the 25 priority districts will be prioritised towards maintenance and refurbishment, focusing on clearing backlogs, employment of engineers and

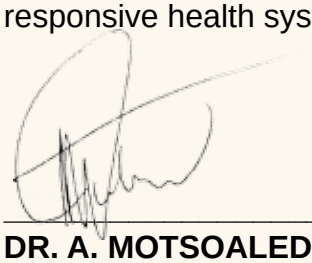
technicians as well as establishing functional maintenance workshops in facilities.

The National Health Amendment Bill was tabled in Parliament in January 2012. The Amendment Bill provides for the establishment of the Office of Health Standards Compliance, which will enforce norms and standards for quality of care. As part of the interventions to enhance quality of care and health facility performance, Health Facility Improvement teams will be sent to identified priority districts to help with quality and management improvement initiatives.

In this financial year, we will roll-out the three streams of the re-engineered Primary Health Care (PHC) namely, the district clinical specialist teams; municipal-ward based PHC outreach and School Health Services. The district clinical specialist support teams will be prioritised for the 25 districts with poor maternal and child health outcomes. The revised School Health Policy and integrated school health services will be launched in partnership with the Department of Basic Education and the Department of Social Development in the first half of the coming financial year. Schools in quintile1 and 2 (the poorest schools) will be prioritised for implementation of a comprehensive package of preventative and minor curative services. Services to be provided will include screening for barriers to learning such as impaired vision and hearing, assessment of cognitive development and oral health services. These services will support the foundation and early childhood development phases in a child development. For the adolescent group in high school, the focus will be on HIV prevention, counselling and testing, prevention of teenage pregnancies and drug abuse prevention.

Finally, the Department will commence with the phased piloting of the National Health Insurance (NHI) in 10 health districts. The focus of the pilot districts will be to test various components of the NHI including the health service delivery platforms, private provider contracting models and improved health facilities management. The pilot districts will be rolled out in some of the 25 priority districts so as to ensure consistency in interventions implemented to address maternal and child health problems, infrastructure improvement initiatives and the implementation of the three PHC streams.

The above mentioned matters indicate the key priority areas for the Department of Health in the 2012/13 financial year, including the latter years of the MTEF. Together with MECs at provincial level and other Ministries that signed the NSDA for the health sector I believe we are better positioned to respond to the legitimate expectation of the South African population in our quest for an effective and responsive health system.



DR. A. MOTSOALEDI, MP
MINISTER OF HEALTH
DATE:04-03-2012

OVERVIEW OF PERFORMANCE IN 2010/11 AND PRIORITIES FOR 2011/12 to 2013/14

In the last financial year the Department has provided leadership and oversight through the implementation of some major reforms in the health sector. The National Health Act, 2004 (No. 61 of 2003) was assented into law on the 23rd July 2004. Since then, not all sections of the Act were operational. As at 1st March 2012, the National Health Act (NHA) has come into force in its entirety except for Section 36. The proclamation of various sections of the NHA and the publishing of regulations in relation to Section 35 and Section 68 has provided an opportunity for the Department to pursue some of the major reforms that were intended when the NHA was developed. In this coming period, we will increase the pace of reform and move towards implementing the policies and plans developed in the previous financial year as a result of the proclamation of these sections of the NHA.

The organisational structure of the National Department of Health was transformed in 2011/12 to be aligned to the four priority outputs of the Negotiated Service Delivery Agreement and to improve its oversight function across the health system. The revised organisational structure was approved by the Department of Public Service and Administration. The focus of the Department will continue to be results-based management. The Department further introduced an electronic system of performance management and development and has improved its turnaround times in the assessment of the performance of its personnel.

The Human Resource for Health (HRH) Strategy was launched by the Minister of Health in October 2011.The publication of the HRH strategy has allowed us to plan ahead as we now know the gaps in key professional categories and the required skills mix. The focus of the HRH strategy is on increasing the intake of students and the throughput of health workforce training at university and college level to ensure responsiveness to the burden of disease and legitimate expectations of citizens. In this respect the Department of Health has proactively engaged with a number of health science faculties to increase the intake of medical students and this will be extended to other health professional categories. The training of Medical specialists in the disciplines where it will have the greatest impact on the burden of disease will also be increased. The HRH strategy also focuses on the improvement in the management of public hospitals and clinics. The training if Hospital Chief Executive Officers and District Managers have been prioritised.

To this end the Department will establish an Institution for Management and Leadership Development.

Strengthening of health information systems is another key priority for the health sector. During the 2011/12 financial year the Department developed the Health Information Management Policy. The E-health strategy for South Africa was developed and will be launched early in the new financial year.

The use of information in health planning and evidence based decision making had been identified as a challenge. To address this the National Department of Health has developed a National Health Information Repository and Data warehouse (NHIRD) which integrates data from the various specialist information systems that exist so as to be able to develop composite indicators (i.e. staff workloads, HR headcounts, cost per patient seen, among others) and to compare and understand the status of health services from multiple perspectives. The system is able to display data stored on a central server and can be accessed through web technology. All public health facilities in the country have been geo-mapped to determine their location for the purpose of accessibility, travel distances and the determination of catchment populations. The Department has started the process of rolling out this system to the nine provinces. To date the roll out in five provinces has been completed. It is envisaged that the full rollout to all nine Provinces will be completed by the end of March 2012.

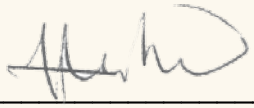
During the past financial year the Department has also undertaken a comprehensive audit of all public health facilities to assess infrastructure suitability, equipment functionality, the availability of human resources and the level and quality of services provided at each facility. To date 3,370 facilities have been audited, and the data is currently being validated. It is envisaged that the audit of all 4,200 facilities will be completed at the end of April 2012. In response to the results from the Facilities Audit, the National Department of Health with support from Provinces has developed a project that will focus on addressing the critical shortcomings identified through the Audit. This involves the establishment of facility improvement teams that will be district-based. The core business of the teams will be to support the health establishments within identified districts to develop and implement quality improvement plans and initiatives and to design interventions to address gaps across districts and within health establishments.

The theme of accelerated implementation will permeate all our programmes as we lay the foundation for the phased implementation of the National Health Insurance (NHI). Progress has been made in the development of the policy on NHI. The Green Paper on NHI was released for public consultation in August 2011 and we have received an overwhelming response from the public. Following the closing date for public comments, we have setup a technical team composed of Department officials and leading health policy, planning and financing experts from research and academic institutions to comprehensively review the comments and integrate them into the NHI policy paper taking into account submissions and inputs received from stakeholders and the general public.

We have also made progress in developing criteria for selecting the NHI pilot districts as well as in addressing other health system interventions that will be essential in ensuring the smooth roll-out of NHI. These include focusing on improving the management of health facilities and health districts including hospital CEO's, quality improvement programmes, infrastructure development and maintenance, improvements to medical equipment and supplies, human resources planning, training and development, information management and system support.

In the coming financial years, we will accelerate our collaboration with other government departments, such as Human Settlements, Correctional Services, Water Affairs and Cooperative Governance and Traditional Affairs. This collaboration will be directed at ensuring that all our policies and interventions are aligned towards achieving Outcome 2: A Long and Healthy Life for All South Africans through collectively addressing the social determinants of health.

I am certain that the turnaround strategies and the interventions outlined above for achieving improvements in our health system's performance and overall population health will be sustainable through a well-integrated and comprehensive system of planning, implementation, monitoring and evaluation.



MS MP MATSOSO
DIRECTOR-GENERAL
DATE:04-03-2012

OFFICIAL SIGN-OFF

It is hereby certified that this Annual Performance plan was developed by the management of the National Department of Health under the guidance of Dr A Motsoaledi , Minister of Health.

Takes into account all the relevant policies, legislation and other mandates for which the National Department of Health is responsible.

Accurately reflects the performance targets which the National Department of Health will endeavour to achieve given the resources made available in the budget for 2012/13 financial year.

MR I VAN DER MERWE

Chief Financial Officer **Signature**

MS M WOLMARANS

Director Planning **Signature**

MS MP MATSOSO

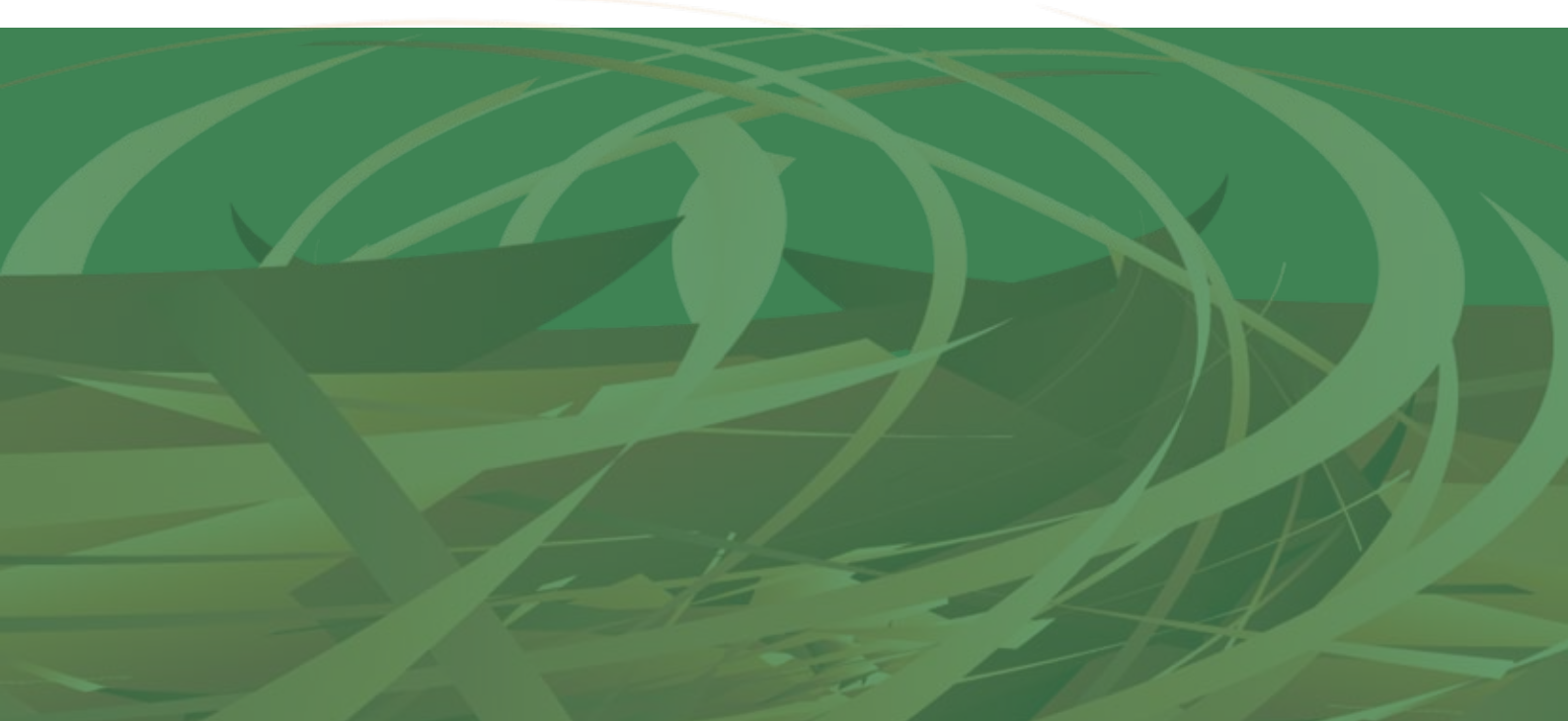
Director General **Signature**

Approved by:

DR A MOTSOALEDI

Minister of Health **Signature**

PART A:
STRATEGIC OVERVIEW



VISION

A long and healthy life for all South Africans.

MISSION

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

2. SITUATION ANALYSIS

2.1 DEMOGRAPHIC PROFILE

The mid-year population estimates released by Statistics South Africa (StatsSA) in July 2011 indicate that South Africa's population grew slightly from 49,811,195 in 2010 to 50,270,497 in 2011. This reflects an overall population growth of 1.87% between 2010 and 2011midyear population estimates. This is reflected in Table 1 below.

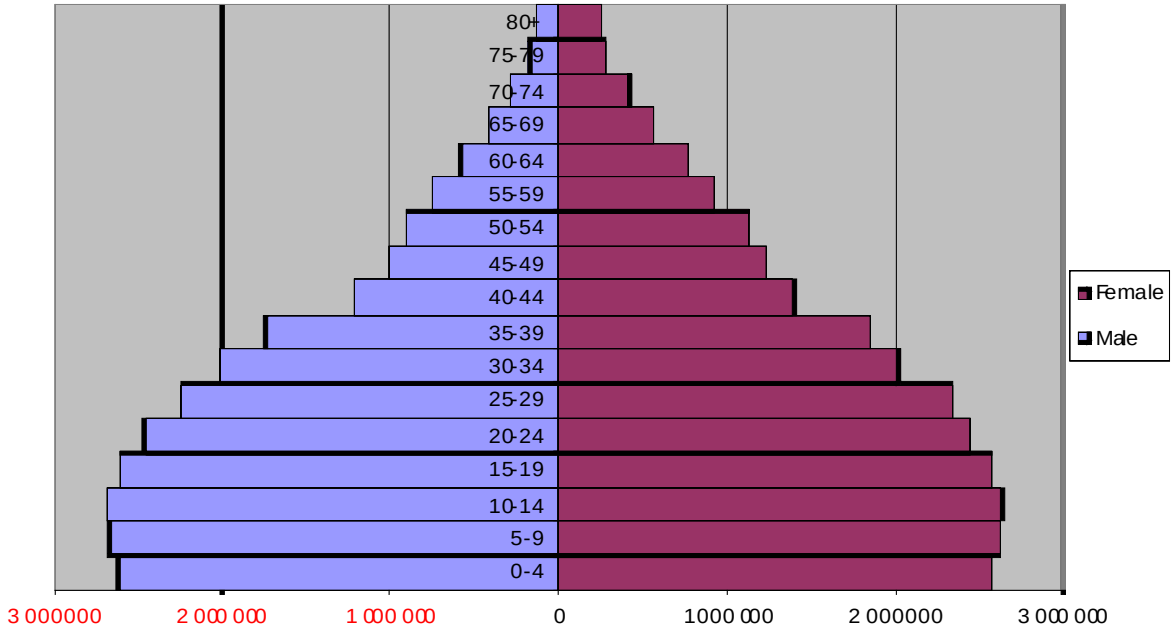
Table 1: South Africa's Mid-year Population Estimates for 2011

Province	Population Estimates	% of total population
Gauteng	11 328 203	22.39
KwaZulu Natal	10 819 130	21.39
Eastern Cape	6 829 958	13.50
Western Cape	5 287 863	10.45
Limpopo	5 554 657	10.98
Mpumalanga	3 657 181	7.23
North West	3 253 390	6.43
Free State	2 759 644	5.46
Northern Cape	1 096 731	2.17
South Africa	**50 586 757**	100.0

(Source: Mid-year population estimates 2011 (StatsSA, 2011), July 2011)

Gauteng comprises the largest share of the South African population. Approximately 11.3 million people (22.4% of the national population) live in this province. KwaZulu-Natal is the province with the second largest population with 10.8 million people (21.4%) living in this province. With a population of approximately 1.1 million people (2.2%), Northern Cape remains the province with the smallest share of the South African population.

2011 Mid-Year population estimates in South Africa : *Source StatsSA 2011*



The age specific population estimates for South Africans in 2011 are shown in the population in Figure 1. Just over sixty percent (60.1%) of the population are aged under 30 years, with the highest percentage being in the 20-24 year age band (10.5%) There is an almost fifty percent split between males and females within all age groups except in the 80+ age group where the females outnumber the males by 62.4% to 37.6%.

Most developing countries are facing a transition in their epidemiological profile from high fertility rates and high mortality caused mainly by communicable diseases to a combination of lower fertility rates and changing lifestyles which has led to an aging population combined with lifestyle related diseases such as diabetes and hypertension, cancer and other chronic ailments. South Africa is also in the midst of this transition. However, we also continue to have a significant burden of communicable diseases (mainly HIV, AIDS and TB), in combination with chronic diseases as described in the section discussing the quadruple burden of disease.

1.1.1 Epidemiological Profile

The country faces a quadruple Burden of Disease (BoD) consisting of (1) HIV and AIDS and TB; (2) High Maternal and Child Mortality; (3) Non-Communicable Diseases; and (4) Violence and Injuries.

This situation is exacerbated by adverse social determinants of health such as poverty and inadequate access to essential services including proper sanitation and access to potable water. It is further aggravated by the inequitable distribution of human and financial resources between public and private sector.

The poor health outcomes can be attributed to a number of factors but are evidenced through reduced life expectancy. Maternal mortality and peri-natal mortality have increased not only due to HIV but also as a result of other structural issues such as poor management of facilities and infrastructure, lack of transport in emergency cases and delay in ART initiation for pregnant women and children.

In 2010 the WHO/UNAIDS EPP and Spectrum models estimated that the HIV prevalence in the general population was 17.9% and the number of people living with HIV in South Africa for 2010 are 5.575 million. Of these an estimated 518 000 were children under 15 years and 2.95 million were adult females over 15 years. The UNAIDS model also estimates that there were 3,332,512 new infections in adults above 15 years. South Africa is one of 12 countries globally that are classified as having a high burden of Tuberculosis (TB). Tuberculosis is remains a major public health programme in South Africa because 73% of TB patients are HIV positive.

Non-communicable diseases (NCD's) include chronic conditions such as hypertension, diabetes and obesity. Around 35% of all deaths in South Africa result from non-communicable conditions. Over the next 10 years deaths due to NCDs, notably cardiovascular diseases, cancer, diabetes and respiratory diseases are projected to increase by 24%. Globally and in South Africa, it has been identified that the lack of focused disease prevention programmes and interventions, poor health seeking behaviour and late detection of diseases are some of the factors contributing to the high burden of non-communicable diseases. Consequently, healthcare costs, morbidity and mortality associated with the management and treatment of NCDs will increase.

Violence and Injury also contribute significantly to the burden of disease. The National Injury Mortality Surveillance System (NIMSS) 2005 report indicated that unintentional injury deaths accounted for 44% of all injury-related deaths when the manner of death was known. The most recent Burden of Disease data for 2010 indicates that in South Africa, road traffic accident injuries are ranked 5th and interpersonal violence is ranked 8th with respect to the leading causes of years of life lost (YYL)[1]. The South African annual road traffic fatality burden was

[1]HST - DHB 20010/11

estimated to be in the region of 18,000 with road traffic deaths of 43 per 100 000. Among road traffic-related deaths, the leading external cause was pedestrian injury (42%) while burn injury was the leading cause among 'other unintentional injury' deaths.

South Africa- Health Impact Indicators

Health indicator	MDG target	Data Source : Health Data Advisory and co-ordination committee report
Maternal Mortality Ratio	38/ 100 000	2008 baseline: 310/100 000 live births
Infant Mortality Rate	18/1 000	2009 baseline: 40 /100 live births
Under five Mortality Rate	20/ 1000 (StatsSA) 21 (UNICEF)	2009 baseline: 56/1000 live births
Life expectancy	70 year - Life expectancy at birth for males and females	Baseline 2009: 54 for males 59 for females

In October 2010, South Africa's Millennium Development Goals (MDG) Country Report was submitted to the United Nations (UN). This report reflects that the country is on track towards achieving two targets towards MDG 4, namely: (1) fully immunising all children under the age of one against all vaccine preventable diseases and (2) immunising all children under the age of one against measles. However, we have achieved slower than expected progress towards meeting other MDG goals particularly with respect to maternal and child mortality.

HIV prevalence measured among pregnant women attending public health antenatal clinics has increased from 0.7% in 1990 to 30.2% in 2010. The Provincial trends in HIV show variations across provinces, districts and age groups. In 2010, the highest provincial HIV prevalence was recorded in KwaZulu-Natal (KZN) which increased from 38.7% in 2008 to 39.5% in 2009 and stabilized at 39.5% in 2010. Provinces with 'higher' HIV prevalence estimates compared with 2009 are: Eastern Cape (29.9%), Gauteng (30.4%), Limpopo (21.9%), Mpumalanga (35.1%), Northern Cape (18.4%), and Western Cape (18.5%). These small increases fell within the expected sampling variability. The provinces with 'lower' HIV prevalence estimates compared with 2009 were: North West (29.6%) and Free State (30.6%). Their estimates were also within the expected sampling variability, which means that the HIV prevalence is stabilising, but there are statistical differences which are significant in the ante natal survey HIV prevalence between provinces from a low of 18.4% in the Northern Cape to a high of 39.5% in KwaZulu-Natal.

In 2009, all five of these districts were also located in KwaZulu-Natal, with the highest estimate being recorded in uThukela (46.4%). In 2010 five districts recorded an ante-natal HIV prevalence above 40.0%. They were all located in KwaZulu-Natal namely: Umkhanyakude (41.9%), eThekwini (41.1%), uMgungundlovu (42.3%), iLembe (42.3%) and Ugu (41.1%). The district level HIV epidemic is significantly heterogeneous, with prevalence ranging from a low of 8.5% in Central Karoo in the Western Cape to a high of 42.3% in uMgungundlovu and iLembe. The number of districts recording ante-natal HIV prevalence between 30% and 40 % has increased from 14 out of 52 in 2009 to 21 out of the 52 districts in 2010.

Key Strategic Issues: Health Sector 10 Point Plan

SYNOPOSIS OF PROGRESS TOWARDS THE 10 POINT PLAN

The 10 Point Plan 2009 – 2014 consists of the following priorities:

1. Provision of Strategic leadership and creation of a social compact for better health outcomes;
2. Implementation of National Health Insurance (NHI);
3. Improving the Quality of Health Services;
4. Overhauling the health care system by:
    a. Refocusing on Primary Health Care (PHC);
    b. Improving the functionality and management of the Health System
5. Improving Human Resources, Planning, Development and Management;
6. Revitalisation of infrastructure, with a focus on:
    a. Accelerating the delivery of health infrastructure through Public Private Partnerships (PPPs);
    b. Revitalising Primary Level Facilities;
    c. Accelerating the delivery of Health Technology and Information Communication Technology (ICT) infrastructure
7. Accelerated implementation of HIV and AIDS and Sexually Transmitted Infections National Strategic Plan, 2007 – 2011 and reduction of mortality due to TB and associated diseases;
8. Mass mobilisation for better health for the population;
9. Review of the Drug Policy; and
10. Strengthening Research and Development

PROVISION OF STRATEGIC LEADERSHIP AND CREATION OF A SOCIAL COMPACT FOR BETTER HEALTH OUTCOMES

Ensure unified action across the health sector in pursuit of common goals

The key focus of the Ministry of Health during the first half of the 2009 – 2014 MTSF period has been to strengthen the governance of the national health system; to unify the entire health system to focus on the achievement of newly outlined goals, and to assert greater stewardship over the entire health system. The National Health Council (NHC) has served as an important vehicle for political

oversight over the health sector. Between 2009 and 2011, the Ministry of Health charted a new course on HIV and AIDS based on a scientific approach, which has altered public perceptions in the management and treatment of this pandemic.

Mobilize leadership structures of society and communities; and Grassroots Mobilization Campaign

During the period, 2009/10–2010/11, the Department implemented advocacy programmes and initiatives that included mobilising communities and health sector partners, through major social mobilisation campaigns. Key strategic achievements of the Department include the implementation of the largest HIV Counselling and Testing (HCT) campaign globally; mass campaigns to immunise South African children against diseases that are leading causes of child mortality such as measles and polio; and increasing the early detection and diagnosis of TB through intensive case finding by visiting homes of known TB patients. The latter has also been complimented by the purchasing of GeneXpert which has resulted in significant gains in the diagnosis of TB patients. The combination of these interventions and initiatives will over time contribute to improving the health status of all South Africans.

A national nursing summit was held in August 2011, which attracted 1,800 participants from all nine Provinces. A nursing compact was adopted at the closure of this summit. A Non-Communicable Diseases (NCDs) summit was held in April 2011, which drew various interest groups and beneficiaries to agree on targets for combating NCDs. In an attempt to improve child health, a breastfeeding summit was held in August 2011. In addition, various consultative meetings were also held to introduce the Green Paper on NHI to stakeholders as well as to elicit comments from them as part of the public comments process.

IMPLEMENTATION OF NATIONAL HEALTH INSURANCE (NHI)

The process of introducing NHI has been initiated. The goal of NHI is to ensure that all South Africans, irrespective of their socio- economic status, have access to good quality and affordable health services. NHI seeks to eradicate barriers limiting access to health care, and ensure financial risk protection from catastrophic health-related expenditures for households and individuals through a prepayment system.

The draft NHI Policy document was submitted to Cabinet for approval and it was gazetted. On 12th August 2011, the Ministry of Health released the Green Paper on NHI for public consultation. The Green Paper on NHI outlines the key principles and proposals for the implementation of NHI in South Africa and phases over which it will be implemented.

The public consultation process extended over a period of four and a half months and ended on 30th December 2011. The Department has consulted in excess of a hundred stakeholder groups including health professional associations; provincial summits; provincial legislatures and portfolio committees; the Finance

and Fiscal Commission; Appropriations Committee; Organised Labour; political parties; hospital boards; other Government Departments; general practitioners (GPs) and civil society organisations. As part of the public consultation process, the Department also hosted a National Health Insurance Conference, themed "Lessons for South Africa" on the 7th and 8th December 2011 addressed by international and local experts as a national health consultative forum. The purpose of the Conference was to create a platform for South Africans to engage with these experts in the areas of health financing and health systems reforms and how these have been undertaken in other contexts to ensure that universal coverage to quality health services is achieved for the entire national population. Furthermore, additional community dialogues on the NHI Policy are planned for 2012 – 2013. To-date, the Department has received in excess of one hundred and fifty written submissions and these submissions are currently being evaluated.

The Green Paper proposes that NHI should be implemented gradually in three phases over a fourteen year period starting in 2012. The first phase, which occurs in the first five years of the rollout, involves policy and legislative reform, strengthening of the health system, improving the service delivery platform and piloting various components of the NHI. The development of NHI legislation will commence once the Green Paper has been revised and finalized into a White Paper.

To implement NHI effectively requires improvements in the manner in which the public health system operates by ensuring that quality health services are delivered in the public sector; the health system is responsive to the legitimate expectations of the population through the reduction in maternal and child mortality rates; the burden of diseases such as HIV, AIDS and TB is combated; and health systems effectiveness is strengthened.

In laying the foundation for the NHI pilots, progress has been made on various aspects proposed as part of the first phase of implementation. These include the establishment of the Office of Health Standards Compliance; the audit of public health facilities aimed at improving quality; appointment of District Clinical Specialist Support Teams; training of Primary Health Care Agents; and improving Information Management and Systems Support.

In the first five years strengthening of the health system in preparation for the full roll out of NHI will focus on improving the management of health facilities and health districts including hospital CEO's; quality improvement; infrastructure development; improvements to medical equipment and supplies; Human Resources planning and development; information management and system support; and in the latter years of the first phase, the establishment of the NHI Fund.

The first steps towards implementation of NHI in 2012 will be through pilot projects in 10 selected districts. In the selection of the 10 priority districts consideration has been given to a combination of factors such as demographics, socio-economic

factors including income levels and social determinants of health, health profiles, health delivery performance and health service management performance. The Department has established a data warehouse which contains profiles in respect of demographic data; socio-economic indicators; disease burden and health indicators; and health system performance for all districts in South Africa. This information has been used in the selection of the pilot districts. The selected pilot districts have been approved by the National Health Council.

The pilot districts will test innovations that are necessary for implementing NHI whilst also strengthening the functioning of the district health system. The pilot districts will undertake real-life demonstration of the key administrative and technical aspects of the NHI to ensure the smooth roll-out of the NHI systems as it matures and as new information becomes available to ensure an effective transition process and the creation of an enabling environment towards a smooth NHI roll out. It will be a real-life demonstration of the key administrative and technical aspects of implementing NHI so as to ensure the smooth roll-out of the systems as it matures and new information becomes available.

To address high maternal and child mortality, district-based health interventions will be implemented in the pilot districts and they will focus on addressing factors that contribute towards high maternal, infant and child related health problems and deaths. This will include deployment of District Specialist Support Teams, School Health Services and Municipal Ward-based Primary Health Care Teams.

The District Specialist Teams will work on reducing Maternal Mortality Rate (MMR) interventions through provision clinical support and oversight at the district level. The NHI pilot districts will target those Districts which are “most in need” for services such as emergency obstetric and neonatal care training because as this will have the most immediate effect on reducing Maternal Mortality Ratio (MMR) and Neonatal Death Rate (NNDR).

The Department has established Task Teams consisting of local and international public health experts. These Task Teams will be working on evaluating of the written comments that have been received on the Green Paper on NHI; further refinement of costing of the NHI; NHI pilots and the relevant governance and institutional arrangements; as well as population registration strategies.

IMPROVING THE QUALITY OF HEALTH SERVICES

The Department commissioned a comprehensive audit of all 4,300 public health facilities across the country. The audit assesses infrastructure, equipment, human resources and the level and quality of services provided. The Department has established National Facility Improvement Teams and these will be extended to Provincial and District levels and will focus on improving quality service delivery in the identified facilities.

Office of Health Standards Compliance

Major progress was made during 2011/12 towards the establishment of the Office of Health Standards Compliance, as an independent National Quality Management and Certification Body. The National Health Amendment Bill was certified by State Law Advisors on 3rd November 2011, and tabled in Parliament on 16th November 2011. This legislation provides for the establishment of the Office of Health Standards Compliance, which will enforce norms and standards for quality.

A team of inspectors has been sent for training in the United Kingdom (UK). Training was provided by the Quality Care Commission, which is the UK's equivalent of the Office of Health Standards Compliance.

OVERHAULING THE HEALTH CARE SYSTEM AND IMPROVING ITS MANAGEMENT

Refocusing on Primary Health Care (PHC)

The Primary Health Care approach recognises the vital role played by social determinants of health in influencing health outcomes and emphasizes an inter-sectoral approach to improving the health status of communities. In this regard, the Ministry of Health participated in the WHO Conference on Social Determinants of Health, held in Brazil in October 2011. At this conference, the Rio Declaration on the Social Determinants of Health was adopted. This declaration will form the basis for the development of a Framework and plan for addressing social determinants of Health in South Africa.

Significant progress has been made towards the development of a re-engineered Primary Health Care (PHC) model for South Africa. The model consists of three streams namely: District Clinical Specialist Support Teams; Municipal Ward-based PHC outreach teams and the School Health Services programme.

Districts Specialist Clinical Support Teams

The scopes of practice of district clinical specialist teams were finalised and adopted by the National Health Council. These teams will consist of: Principal Obstetrician and Gynaecologist; Principal Paediatrician; Principal Family Physician, Anaesthetist; Advanced Midwife; Advanced PHC nurse and Advanced Paediatric nurse.

By the end of October 2011, a total of 1,200 specialists had been recruited, which consist of 1,000 nurses and 200 clinicians. This reflects the massive enthusiasm of medical specialists to work within the public health sector to improve health outcomes. An orientation and induction programme has been developed to ensure that the teams are well geared towards working in a district which is a shift from a hospital based curative model. The primary function of the clinical specialist teams will be to enhance clinical governance and service delivery.

Municipal Ward-based PHC outreach teams

By December 2011, a total of 79 PHC Teams had been established nationally. The teams consist of Professional Nurses; Enrolled Nurses and Community Health Workers (CHWs). The numbers of Family Health Teams created across Provinces were as follows: Eastern Cape (27); Gauteng (6); Free State (5); Mpumalanga (18); and North West (23).

It is estimated that 45,000 CHWs are required to form part of the PHC Teams at the community level to conduct health promotion, disease prevention and ensure appropriate referral of community members to higher levels of care or to social services. In the first preparatory phase, 5,000 CHWs will be employed as part of PHC Teams.

School-based Health programme

The National DoH and the National Department of Basic Education have jointly produced a costed school health policy and implementation plan. This policy will in the first phase target quintile 1 and 2 schools (the poorest schools) of which there are an estimated 8,000 countrywide. The school health policy is a partnership programme by the NDOH, the Department of Basic Education (DBE) and the Department of Social Development (DSD), and will be jointly chaired by DOH and DBE. To date, 397 retired nurses have been registered on the database with a view to assist with the implementation of the programme. The key health workers involved in the programme will be nurses and health promotion practitioners. The norms that have been developed are 1 nurse per 2,000 learners and 1 health promotion practitioner per 10,000 learners.

Services to be provided will include screening for barriers to learning such as impaired vision and hearing, assessment of cognitive development and oral health services. These services will support the foundation and early childhood development phases. For learners in grades 8 to 10 the focus will be on HIV prevention, counselling and testing, prevention of teenage pregnancies and drug abuse prevention.

In an effort to take services to various communities, mobile facilities that can provide a comprehensive health service will be used to ensure that learners do not need to travel long distances to health facilities. Instead mobiles that can provide preventive, health promotion and curative services will be travel to schools to provide these services in or immediately outside school premises. Learners that require higher level services than those offered by the mobile health teams will be referred as appropriate.

Improving the functionality and management of the Health System

The organizational structure of the National DoH has been revised to align it to the health priorities for the 2009 – 2014 terms of office of government. A new performance management system has been implemented, which creates

system-wide links between individual and organizational performance.

Hospitals Management Strengthening

Skilled and competent health management will contribute towards sustained delivery of quality health care for all. In 2009/10, the National DoH commissioned the Development Bank of Southern Africa (DBSA) to conduct an assessment of the functionality, efficiency and appropriateness of the organisational structure of hospitals, the appropriateness of the delegations given to hospital managers and the qualifications of each Hospital CEO and District Manager. This assessment was completed in all nine Provinces in 2011/12. Based on the DBSA process, the regulations of the National Health Act of 2003 aimed at providing clear designations to managers and CEOs of different categories of hospitals, and the required skills and competencies for managing hospitals, were published on 12 August 2011 in Gazette No. 34521. The regulations provide criteria for the classification of five categories of hospitals namely: District Hospitals; Regional Hospital; Tertiary Hospital; Central Hospitals and Specialized Hospitals.

The National DoH also produced a National Policy on Regulating Management of Hospitals, which was published as regulations of the National Health Act of 2003 (Government Gazette No 34522, Vol. 554, 12 August 2011). The policy is aimed at ensuring that the management of hospitals is underpinned by the principles of effectiveness, efficiency and transparency. The Department is in the process of recruiting 105 Chief Executive Officers for different categories of hospitals.

The National Policy on Regulating Management of Hospitals also seeks to strengthen the governance of health facilities. It provides the criteria for the selection for Hospital Board Members, and outlines the functions of Hospital Boards.

Health Information Management Strengthening

The Department will continue with the development of a comprehensive and integrated Monitoring and Evaluation function, with the required Health and Management Information systems. A National Health Information Management policy was developed. This policy clearly defines the roles of national, provincial, district and local levels for the management of health information. Going forward the focus will be on the uniform implementation of the policy at all levels of the health care system. The National e-health strategy will be launched during this financial year. The Department will continue with the design and implementation of a national patient based information system.

IMPROVED HUMAN RESOURCES PLANNING, DEVELOPMENT AND MANAGEMENT

The Human Resources for Health (HRH) Strategy 2012–-2016 was launched by the Minister of Health in October 2011. The HRH strategy addresses the

production, recruitment, management and retention of health workers of 27 diverse categories. The HRH strategy will for the first time be linked to the output of health workforce at tertiary institutions to ensure that universities are responding to the health system needs taking into consideration the burden of disease and legitimate expectations of citizens. The launch of the HRH strategy also coincided with a WHO-AFRO workshop on finding solutions to the HR challenges facing the continent.

To ensure sufficient availability of adequately trained, appropriately skilled, suitably placed, highly motivated and properly remunerated health care providers, the HRH strategy focuses on 8 strategic objectives namely: (1) Leadership and Governance; (2) Intelligence and Planning for HRH; (3) A workforce for new service strategies; (4) Up-scaling and revitalizing education training and resources; (5) Academic training and service platform interfaces; (6) Professional Human Resource Development; (7) Quality Professional Care; and (8) Access in Rural and Remote Areas.

Various categories of health workers have been prioritised. Targets have been set to aggressively increase the intake of various categories of health sciences students, including nursing; medical and pharmacy students. The eight (8) medical schools in the country have been approached to increase their intake. All of them have already submitted their proposals to the Department. The University of Witwatersrand already increased their intake of medical students by an additional 38 students for the current academic year.

A total of 42 technicians have been trained at Tshwane University of Technology, in response to the need for clinical technicians for the maintenance and repair of equipment in health facilities. This will reverse the current trend where equipment is replaced at huge cost.

Appointment of data capturers in health facilities across the country is essential for the production of comprehensive, good quality and reliable health information for planning, monitoring and reporting on the performance of the health system. During 2010/11, a total of 786 data capturers were employed in different Provinces. The medium-term aim is to appoint data capturers for all public health facilities in the country.

Re-opening of nursing schools and colleges

A Ministerial Nursing Task Team on nurse education and training was appointed to implement the recommendations of the nursing summit. The refurbishment of Nursing Colleges is an important intervention by the National DoH to create a conducive environment for the production of nurses in South Africa. At the beginning of 2011/12, a business plan for the revitalisation of these colleges was produced.

Four hundred and fifty million over the MTEF has been mobilised to fund the refurbishment of existing nursing colleges and nursing schools that need minor

repairs.

REVITALIZATION OF INFRASTRUCTURE

The timely completion of well-designed and well-constructed facilities improves access to health care services for communities. It also contributes to improving the communities' perspective on the quality of care as well as enhancing the morale of health workers.

Strengthening Public Health Sector capacity to manage Infrastructure Delivery

With leadership from the National DoH, the public health sector has adopted an integrated approach to the delivery of health facilities, incorporating physical infrastructure, health technology, and human resources. The intention is to use this as a mechanism for contributing effectively towards providing an enabling environment for delivering quality services to all communities.

During 2011, a total of 1,967 infrastructure projects were being implemented in the health sector, funded from three sources namely: the Hospital Revitalisation Grant; Health Infrastructure Grants and the Provincial Equitable Share. The latter is managed by Provinces.

The resources from the Hospital Revitalisation Grant were spent on 389 projects covering 52 hospitals in all provinces. Revitalisation projects were completed in 6 hospitals namely, Chris Hani Baragwanath, Mamelodi, Dilokong, Nkhensani, Vryburg and Moses Kotane. A total of 29 other hospitals are under construction, while 17 others are in the planning and design stage. Specific units at the historical Chris Hani Baragwanath Hospital, which is one of the six Flagship Tertiary Hospitals, will be refurbished at a cost of R150 million.

Accelerating the delivery of health infrastructure through Public Private Partnerships

The Feasibility studies in three of the five PPP flagship projects namely Chris Hani Baragwanath Academic Hospital, Limpopo Academic Hospital and Dr George Mukhari hospital are progressing well, and construction is expected to commence by the last quarter of financial year 2012/2013.

Strengthening the delivery of Health Technology

Health Technology plays a critical role in enhancing the quality of health services and improving the morale of health care providers. In July 2011, the National DoH published for public comment the Medical Devices Regulations, released in terms of the Medicines and Related Substances Act of 1965 (as amended). Once finalised, the regulations will promote the safety, efficacy, quality and performance of all medical devices in the health sector. This will have a direct impact on the quality of health services provided.

A register of all medical devices is currently being developed for the country. The register will ensure the sale of unsafe and unregistered medical devices will be prohibited. All medical device manufacturers and importers will also be appropriately licensed according to clearly set out criteria. The regulations also impose duties to all those who hold licenses to distribute medical devices. This will ensure that the country is always assured of quality and professional after sales service.

The Department has also completed the Essential Equipment Lists (EEL), and disseminated these for comment and input by critical stakeholders. The EEL is one of the important standards and will form the basis for planning for health technology across levels of care.

ACCELERATED IMPLEMENTATION OF HIV AND AIDS AND SEXUALLY TRANSMITTED INFECTIONS NATIONAL STRATEGIC PLAN, 2007-2011 AND REDUCTION OF MORTALITY DUE TO TB AND ASSOCIATED DISEASES

The public health approach emphasizes the need to adopt a holistic approach to reducing the occurrence of new cases of any condition, rather merely focusing on an exclusively treatment based approach. With respect to HIV, prevention remains the mainstay of efforts to combat HIV, AIDS and STIs.

With respect to HIV Counselling and Testing, the previous trend in South Africa was that only two million people on average would volunteer for HIV counselling and undergo HIV testing every year. However, the HIV Counselling and Testing (HCT) campaign officially launched by the President of South Africa in April 2010 changed this significantly. Between April 2010 and end of June 2011 a total of 15million people volunteered for HIV counselling, and 13.7 million of these had agreed to be tested. Two million people tested HIV positive, which translated to a positivity rate of 16%. During 2011/12, the HCT campaign was incorporated into the routine services provided in the public sector. Even as part of routine services, the uptake rate of HCT showed a sharp increase. For the three month period July – September 2011, the HCT target was to provide counselling to 1,993,695 people across the nine Provinces. This target was exceeded when a total of 2,504,423 people received counselling, and 2,145,270 people accepted for HIV testing. Going forward people must be routinely tested for HIV.

Empirical evidence points to a link between male medical circumcision and a reduction in susceptibility to HIV. The uptake of male medical circumcision has continued and by the end of September 2011, a total of 213,094 Male Medical Circumcisions had been performed, since this intervention started in 2010.

Progress has been made towards improved access to ART for adult South Africans living with HIV and AIDS. By the end of March 2011, the country's Antiretroviral Therapy (ART) programme had reached a total of 1.4 million people since its inception. This marked an increase from the 1.1 million people who were on treatment by the end of March 2010. By September 2011 a cumulative total of 1.6 million patients (adults and children) had been initiated on ART. As a result of this,

South Africa has the largest number of patients on ART in the world.

Given the high co-morbidity of HIV and TB in South Africa, screening for Tuberculosis (TB) was a key component of the HCT Campaign. From April 2010 to the end of June 2011, a total of 8 million people were screened for TB. Of these, 1 million were referred for further diagnoses and management at relevant health facilities.

In order to improve TB outcomes, one of the key interventions is to reduce the TB defaulter rate (i.e. those patients who not complete treatment). By the end of September 2011, the defaulter rate was 6.4%.

At the end of September 2011, the TB cure rate was 70 %, against the WHO target of 85%. Additional strategies were developed and implemented to increase the early detection and diagnosis of TB through intensive case finding by visiting homes of known TB patients and utilisation of a new technology called GeneXpert to ensure early diagnosis and detect resistance to one of the TB drugs (Rifampicin), which is a proxy for MDR-TB. Plans are underway to ensure that each district has a GeneXpert machine by the end of the 2011/12 financial year.

MASS MOBILIZATION FOR BETTER HEALTH

Increasing Life Expectancy

Increasing life expectancy is an important priority stipulated in the NSDA 2010–2014. During the period under review, the health sector improved the quality of data on life expectancy, and also implemented interventions that collectively contribute to enhancing life expectancy.

Improving South Africa's data on Life Expectancy

The Health Data Advisory and Coordination Committee, which consists of scientists and researchers from within and outside government was established by the National DoH in October 2010. The purpose of the Committee was to improve the quality of data on health outcomes. The Committee submitted its final report to the Ministry of Health on 03rd November 2011.

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

Health Sector's Interventions contributing to increasing Life Expectancy

In addition to interventions to combat HIV, AIDS and TB, the health sector has also focused on strategies to address Non-Communicable Diseases and Communicable Diseases.

In August 2011, the Ministry of Health convened a South African Summit to bring all stakeholders on board to promote the coordinated prevention and control of non-communicable diseases and to hear from health service workers, users and experts on how non-communicable diseases can be combated. In addition, South Africa has chosen to include mental disorders, oral and eye diseases and musculo- skeletal conditions as important conditions that must be focused on in the fight against non-communicable diseases.

The August 2011 South African NCD Summit set the following targets:

- Reduce by at least 25% the relative premature mortality (under 60 years of age) from Non-communicable Diseases by 2020;
- Reduce by 20% tobacco use by 2020;
- Reduce by 20% the relative per capita consumption of alcohol by 2020;
- Reduce the mean population intake of salt to less than 5grams per day by 2020;
- Reduce the percentage of people who are obese and/or overweight by 2020;
- Screen all men above 40 years of age for prostate cancer by 2020;
- Increase the percentage of people controlled for hypertension, diabetes and asthma by 30% by 2020; and
- Increase the number of people screened and treated for mental health by 30% by 2030.

In order to meet these targets major emphasis has to be shifted to preventive efforts involving Departments such as Trade and Industry, Agriculture, Sport and Recreation, Basic and Higher Education, Social Development and others. Behaviour change and lifestyle change are extremely important in combating Non-Communicable Diseases. This implies emphasising the need to increase physical activity, improving diets and dietary habits, reducing tobacco use still further and reducing alcohol intake in communities and among individuals.

With respect to the impact of diet on NCDs, draft regulations to decrease trans-fats in food have been produced. A Chronic Disease Register has also been produced for implementation in public health facilities, to ensure that these diseases are detected early on and managed appropriately.

Increased focus has also been placed on enhancing the mental health of all South

Africans. In 2011, a Mental Health Care Policy Framework for South Africa was produced, which will provide guidance to Provinces for mental health promotion, prevention of mental illness, treatment and rehabilitation.

A holistic government approach to combating all conditions, including NCDs, will contribute to increasing the life expectancy of South Africans.

Gender based violence (GBV) is a public health challenge and contributes to the quadruple burden of disease. GBV is multifaceted and complex as it carries health consequences and conditions associated with trauma, injury, mental health and chronic illnesses. The sector is fulfilling its constitutional mandate through gender based violence response as follow:

- The Department is part of the multi-sectoral approach in addressing gender based violence;
- The Department has a package to mitigate risks associated with GBV through Medico Legal evidence and Post Exposure Prophylaxis;
- Commitment to provide a victim friendly health services the Victim Empowerment Programme; and
- Training of nurses on sexual assault act.

Combating Malaria

Malaria is a major cause of morbidity and mortality globally and particularly on the African continent. The disease is endemic in three of nine provinces of South Africa, namely: in Limpopo; KwaZulu-Natal and Mpumalanga Provinces. These provinces share borders with malaria endemic neighbouring countries such as Swaziland and Mozambique.

The long-term objective of the National DoH is to eliminate malaria in South Africa by the year 2018 by reducing the local transmission of malaria cases to 0 per 1000 population at risk, through the implementation of the malaria the National Elimination Strategy. Measures were put in place to track the occurrence of malaria cases at two levels, the first being confirmed local malaria cases, and the second being an aggregate sum of the local cases and cases of unknown origin.

During 2010/11, malaria control in South Africa continued to be a beacon of success. The local malaria incidence was reduced to 0.6 per 1,000 population at risk, which was in line with the national target of 0.66 per 1,000 population at risk. Some of the key interventions that contributed to the reduction of local malaria cases included a robust Indoor Residual Spraying programme, which reached a coverage of 90% of the 2,252,406 structures that were targeted, exceeding the WHO's recommended target of 80%. Other factors that contributed to this success included effective case management by ensuring definitive diagnosis and treatment with combination malaria therapy and conducting epidemic

preparedness workshops. Importation of malaria cases, especially through transmission arising from neighbouring higher endemic countries is a key challenge to preventing the reintroduction of the disease into South Africa. A joint strategy for eliminating malaria has been developed between South Africa and seven other SADC countries.

Child Health

Improvement of child health outcomes is an important priority encompassed in both the 10 Point Plan 2009–2014 and the NSDA 2010–2014.

Improving South Africa's data on child health indicators

With regard to Child Health, the Health Data Advisory and Coordination Committee concluded in its November 2011 report that:

- The baseline Under-5 Mortality Rate (U5MR) of South Africa is 56 per 1,000 live births. This is lower than the 104 per 1,000 reflected in the MDG country Report 2010. The realistic target for 2014/15 should be to reduce the U5MR from 56 per 1,000 live births to 50 per 1,000 live births (a 10% reduction); and
- The baseline Infant Mortality Rate (IMR) is 40 per 1,000 live births. The target for 2014/15 should be to decrease the IMR to 36 per 1,000 live births (10% reduction).

The results of the work of the Health Data Advisory and Coordination Committee have far reaching implications, not only for the health sector, but also for government as a whole, as for the first time there is agreement amongst scientists on what the appropriate baselines and realistic targets are.

During the period under review, evidence-based interventions were implemented to improve child health. A key highlight of efforts to decrease child mortality rates was the significant reduction in the mother-to-child transmission rates of HIV. A study conducted by the Medical Research Council found that mother to child transmission rates of HIV amongst 6-week old babies had decreased from about 8% to 3.5% across all Provinces. KwaZulu-Natal registered the most significant reductions.

Breastfeeding is an important element of the child survival strategy. During 2010/11, data from the Human Sciences Research Council (HSRC) reflected that about 25% of infants 0-6 months were exclusively breastfed, which exceeded the target of 10% set for the financial year. A total of 131 district hospitals implemented the WHO's Ten Steps for the Management of Severe Malnutrition, which exceeded the 2010/11 target of 118 district hospitals.

Addressing challenges of malnutrition and stunting amongst children will require a concerted effort and partnership with other government departments, civil society

and development partners.

Maternal Health

Improvement of maternal health outcomes is an important priority encompassed in both the 10 Point Plan 2009–2014 and the NSDA 2010–2014.

Improving South Africa's data on Maternal Health Indicators

With respect to the Maternal Mortality Ratio (MMR), the Health Data Advisory and Coordination Committee acknowledged the huge uncertainty associated with measuring this indicator, which is a challenge internationally. Based on its review of empirical evidence, the Committee concluded that the baseline MMR of South Africa (2008 data) is 310 per 100,000. The figure of 310 per 100,000, although still high, is significantly lower than the baseline figure of 625 per 100,000 reflected in Millennium Development Goal (MDG) Country Report 2010 and the NSDA 2010-2014. The Committee recommended that the target in the Health Sector's NSDA 2010 – 2014 should be to reduce the MMR to not more than 270 per 100,000 (i.e. 10% reduction). With the rapid implementation of the policy to initiate Antiretroviral Treatment at a CD4 count of 350, further decreases in the maternal mortality rate should be achieved.

The implications of the results of the work of the Health Data Advisory and Coordination Committee with respect to Maternal Health are that: The Maternal Mortality Ratio is actually lower than the original estimates and therefore baselines reflected in the health sector's NSDA 2010 – 2014 need to be revised to enhance their accuracy. Similarly, targets should be made more realistic. During the period under review 2009 – 2011, the health sector implemented targeted interventions to improve Maternal Health care through improving access to antenatal services for pregnant women and postnatal services for new mothers. The interventions included increasing the health seeking behaviour by encouraging women to present early to the health services. This was coupled with increasing the proportion of deliveries that happen in the formal health establishments and reducing home deliveries. Other interventions included increased access to antiretroviral treatment (ART) for HIV positive pregnant women resulting in improved coverage. All these interventions contribute towards the reduction of maternal and child mortality rates.

During 2010/11, a total of 72% of primary level health facilities provided Basic Antenatal Care (BANC), which exceeded the set target of 60%. This also reflected an improvement from the 2009/10 performance, where only 30% of maternity facilities provided BANC.

During 2010/11, a total of 96.9% of pregnant women agreed to be tested for HIV and were tested. From the prevention of mother to child transmission (PTMCT) program, there were also major improvements with 79.4% of eligible HIV positive pregnant women were placed on HAART, which exceeded the target of 70%. This also exceeded the 76.6% recorded in 2009/10.

Despite the significant progress made between 2009/10 and 2010/11, there were also areas of slow progress. Only 81% of maternity facilities reported that they conducted monthly maternal and perinatal morbidity and mortality meetings, against a target of 100%. Furthermore only 29.9% of newborn babies and 27% of mothers were reviewed within 6 days post-natal (following discharge from health facilities) during 2010/11. These challenges are being addressed in the course of the 2011/12 planning cycle and beyond.

Interventions to improve maternal health were further strengthened in 2011/12. Between July – August 2011, a total of 42.7% of antenatal clients (pregnant women) visited public health facilities before reaching 20 weeks of pregnancy, exceeding the set target of 38% for the second quarter of 2011/12. This is one of the key interventions in reducing maternal deaths as risky pregnancies can be referred to higher level care early on, to maximize the survival of both the mother and the baby.

Between July – September 2011, a total of 90.4% of deliveries took place in public health facilities, which was consistent with the target of 90% for the year. A total of 63% of mothers and baby pairs were seen at public health facilities within 6 days following delivery. This performance exceeded the 50% target set for the second quarter of 2011/12. Should this performance be sustained during 2011/12, it will exceed performance during 2010/11, when only 29.9% of new-born babies and 27% of mothers were reviewed within 6 days post-natal (following discharge from health facilities).

For cervical cancer, a screening rate of 57.6% was achieved between July – September 2011, which exceeded the set target of 50% for this period. This is one of the commonest cancers among women in South Africa and efforts are being made to improve coverage and detect cervical cancer early when it is still possible to intervene.

The campaign in response to the African Union resolution that requires all member states to strengthen maternal and child health interventions, called the Campaign on the Reduction of Maternal Mortality in Africa (CARMMA). Our campaign which will end in 2015 to coincide with the end point of the Millennium Development Goals, will consists of the following components: strengthened family planning services using a five point plan; elimination of mother to child transmission of HIV; expanding access to maternity waiting homes; increasing the number of lactating mothers' lodges and ensuring that all facilities practice kangaroo mother care; expanding access to obstetric ambulances; training of all midwives and doctors involved in maternal care in the essential steps in the management of obstetric emergencies; and training of more midwives. These interventions together with the PHC re-engineering which is described below will strengthen maternal and child health.

REVIEW OF THE DRUG POLICY

During the period under review, several significant historic milestones were achieved in ensuring the availability of safe, good quality and affordable medicines for all South Africans.

The Drug Policy was reviewed in 2009. Key areas of interventions were the development and passing of legislation to improve the performance of the Medicines Control Council.

The second area of focus was the reduction in the prices of medicines. Major reductions in the prices were achieved for TB medicines and antibiotics.

Furthermore, during 2010/11, the Minister of Health, on the recommendation of the Pricing Committee implemented the following interventions to regulate costs of medicines in the private sector:

- Published a maximum dispensing fee for pharmacists;
- Published a maximum dispensing for other health professionals;
- Determined that there shall be no increase in the single exit price for 2011 due to the favourable exchange rates and consumer price indices;
- Published draft regulations for the international benchmarking of originator medicines;
- Published draft regulations on the maximum logistics fees that may be charged by wholesalers; and
- Published draft guidelines on the submission of pharmaco-economic analyses.

These interventions serve to improve transparency in the pricing of medicines and improve affordability of medicines. The health sector will establish a Central Procurement Agency to improve the efficiency of the procurement system and leverage on the economies of scale. The Global Fund has provided seed funding for this work.

STRENGTHENING RESEARCH AND DEVELOPMENT

With respect to research and development, the key highlight of the reporting period was the National Research Conference held in July 2011, which involved over 300 stakeholders from research institutions, academia, other government departments and non-governmental organizations. The objectives of the summit were to identify priority areas for health research, linked to the four outputs of the NSDA 2010 – 2014. In December 2011, the National Health Research Committee (NHRC) will produce a set of priorities for health research in South Africa.

The NHRC was established by the Minister in terms of the National Health Act of 2003. The functions of the NHRC are to: (1) determine the health research to be carried out by public health authorities; (2) ensure that health research agendas and research resources focus on priority health problems; (3) develop and advise the Minister on the application and implementation of an integrated national strategy for health research; and (4) coordinate the research activities of public health authorities.

In 2011/12, the Department entered into a Memorandum of Understanding (MoU) with the Human Sciences Research Council (HSRC), through which the Department would co-fund two national surveys namely, the SABSSM4 and SANHANES. The two surveys will provide data on health outcomes indicators, which are normally collected through the South African Demographic and Health Survey (SADHS), which was last conducted in 2003. Pilot studies for the SABSSM4 were completed in April 2011. Research tools for the SANHANES were also finalized.

A need exists for South Africa to develop a model for the translation of evidence generated through empirical research into national health policy. In an iterative manner, research must also review health policy implementation.

Key Strategic Issues: Health Sector Negotiated Service Delivery Agreement

Government has adopted an outcome-based approach to service delivery, which consists of 12 outcomes. This is articulated in the revised Medium Strategic Framework (MTSF) for 2009-2014.

The 12 Outcomes are as follows:

- Improved quality of basic education
- A long and healthy life for all South Africans
- All people in South Africa are and feel safe
- Decent employment through inclusive economic growth
- A skilled and capable workforce to support an inclusive growth path
- An efficient, competitive and responsive economic infrastructure network
- Vibrant, equitable and sustainable rural communities with food security for all
- Sustainable human settlements and improved quality of household life
- A responsive, accountable, effective and efficient local government system
- Environmental assets and natural resources that are well protected and continually enhanced

- Create a better South Africa and contribute to a better and safer Africa and World
- An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship

The health sector is responsible for the achievement of Outcome 2 namely: A long and healthy life for all South Africans.

The focus of the health sector over the planning cycle 2011/12 – 2013/14 will therefore be on the four outputs entailed in the Minister's Performance Agreement with the President of the Republic, and elaborated on in the Negotiated Service Delivery Agreement for 2010 – 2014. These are (1) Increasing Life Expectancy; (2) Reducing Maternal and Child Mortality Rates; (3) Combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis and (4) Strengthening Health System Effectiveness. Strategies for achieving these are reflected in the relevant medium term plans of the National and Provincial Departments of Health.

Major targets include the following:

- Life expectancy must increase from 54 years for males and 59 years for females in 2009 (HDACC report 2011) to 56 years for males and 61 years for females by 2014/15.
- South Africa's Maternal Mortality Ratio (MMR) must decrease from 310 per 100,000 (HDACC report 2011) to 270 per 100,000 live births by 2014/15.
- The child mortality rate must decrease from 56 per 1,000 live births (HDACC report 2011) to 50 deaths per 1,000 live births by 2014/15.
- The TB success rate among all TB patients must improve from 73.9% in 2009 to 85% by 2014/15
- The total number of patients on ART must increase from 1.1 million in 2009 to 2.5 million in 2014/15

Output	Sub-outputs
Output 1: Increasing Life Expectancy	• Rapidly scaling up access to Antiretroviral Therapy (ART) for people living with HIV and AIDS especially identified vulnerable groups. • Strengthening of the National TB Control Programme; • Strengthening immunisation programmes to protect South African children against vaccine preventable diseases • Increasing the early detection of people with chronic conditions (hypertension, diabetes) • Implementing upstream strategies to reduce intentional and non-intentional injuries.
Output 2: Decreasing Maternal and Child mortality	• Enhancing the clinical skills of health workers in Emergency Obstetric Care and Comprehensive Emergency Obstetric Care; • Enforcing the use of clinical guidelines and protocols; • Increasing the national immunisation coverage. • Expanding coverage with IMCI Household Community Component • Provision of PMTCT to eligible pregnant HIV positive women • Increasing access to Highly Active Antiretroviral Therapy (HAART) for eligible HIV positive pregnant women and children • Increasing access to school health services • Polymerase chain reaction (PCR) test is performed on all HIV-exposed babies. • Increasing access to safe Choice on Termination of Pregnancy (CTOP) services Institutionalising the review maternal and perinatal deaths across the health sector

Output	Sub-outputs
Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis	• Implementing health care provider-initiated HIV Counselling and Testing (HCT) in all health facilities. • Rapidly scaling up condom distribution at all health facilities • Increase condom distribution to non-medical sites • Scaling up access to Antiretroviral Treatment • Enhancing the clinical skills of health professionals in TB management • Strengthening community involvement in the TB DOTS Programme
Output 4: Strengthening Health System Effectiveness	• Strengthening Primary Health Care (PHC) approach to service delivery. • Producing a revised Human Resources Plan for Health • Assessing with partners the functionality, efficiency and appropriateness of the organisational structure of each hospital. • Supporting Public Health Facilities to produce and implement Quality Improvement Plans • Improve Health Care Financing and Strengthening Financial Management • Implementation of National Health Insurance • Accelerating Health Infrastructure Improvement. • Ensuring appropriate technologies are procured maintained and supported • Information management

The four outputs carry different weights, and can be stratified into four layers; inputs; output; outcomes and impact.

An increased life expectancy for all South Africans is the highest impact that the country seeks to attain. It lies at the summit of the 4 outputs that the health sector seeks to deliver on.

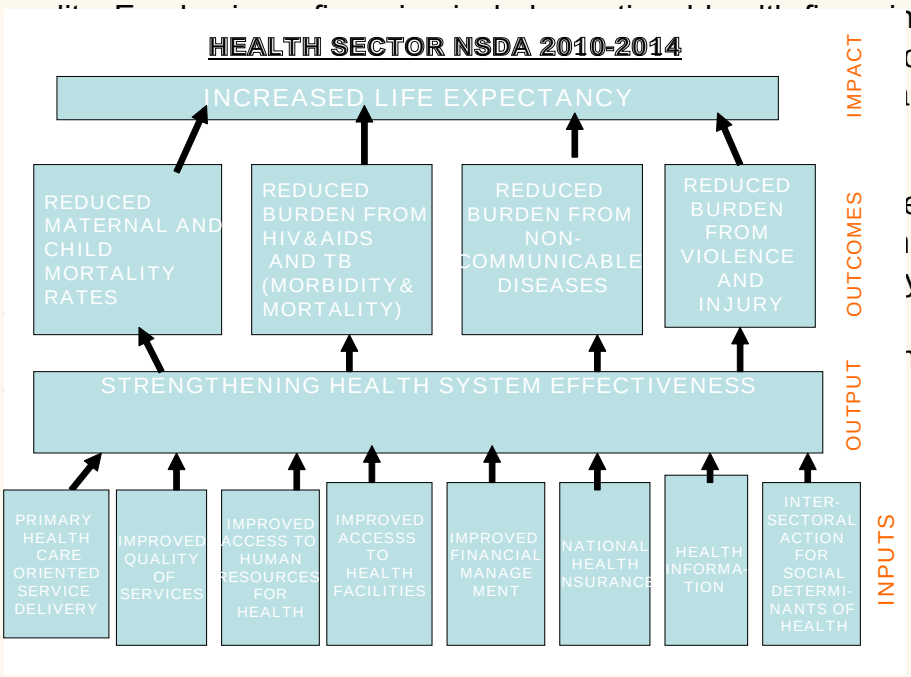
The second layer consists of improving health outcomes such as infant and child mortality rates, and morbidity and mortality from HIV&AIDS and Tuberculosis. This is by virtue of the fact improved health outcomes will contribute to enhancing life expectancy.

Strengthening the effectiveness of the health system is the foundation on which successful interventions to improve health outcomes can be built. International

experience points to the fact that only a strengthened health system, further fortified by effective intersectoral collaboration to address social determinants of health, can improve health outcomes. A weak health system will collapse in the face of major health demands.

WHO defines quintessential six building blocks for a health system namely: (1) service delivery; (2) health workforce; (3) information; (4) medical products, vaccines and technologies; (5) health system financing and (6) leadership and governance.[2]

Service delivery encompasses the packages; delivery models; infrastructure; management; safety & quality and demand for care. Health workforce issues include national workforce policies and investment plans; advocacy; norms, standards and data. Information entails facility and population based information & surveillance systems; global standards, tools. Issues around medical products encompass norms, standards, policies; reliable procurement; equitable access;



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2 Everybody's Business: Strengthening Health Systems to improve health outcomes, World Health Organisation (WHO)'s Framework for Action, WHO, 2007

Organisational Environment

The organisational structure of the National Department of Health was transformed in 2011/12 to be aligned to the four NSDA outputs and to enable it to improve its oversight function across the health system. The revised organisational structure was approved by Department of Public Service and Administration.

The focus of the National Department of Health during the 2012/13 to 2014/15 planning cycle will continue to be results-based management, *"a management strategy focusing on performance and the achievement of outputs, outcomes and impacts".* Each intervention included in this Annual Performance Plan (APP) must contribute logically, systematically and sequentially to the attainment of the objectives outlined in the NSDA 2010 – 2014 and eventually to the desired impact on the lives of the people of South Africa.

The Department of Health introduced an electronic system of performance management and development system and has improved its turnaround times in the assessment of the performance of its personnel.

3. HEALTH LEGISLATION

Legislation governing the functioning of the Department is outlined below, with a brief description of their provisions

3.1 LEGISLATION FALLING UNDER THE MINISTER'S PORTFOLIO

- **Constitution of the Republic of South Africa Act, 108 of 1996**
  Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.

- **National Health Act, 61 of 2003**
  Provides for a transformed national health system for the entire Republic

- **Medical Schemes Act, 131 of 1998**
  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

- **Medicines and Related Substances Act, 101 of 1965**
  Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy. The Act also provides for transparency in the pricing of medicines.

- **Mental Health Care Act, 17 of 2002**
  Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with emphasis on human rights for mentally ill patients.

- **Choice on Termination of Pregnancy Act, 92 of 1996**
  Provides a legal framework for termination of pregnancies based on choice under certain circumstances.

- **Sterilization Act, 44 of 1998**
  Provides a legal framework for sterilizations, also for persons with mental health challenges.

- **SA Medical Research Council Act, 58 of 1991**
  Provides for the establishment of the SA Medical Research Council and its role in relation to health research.

- **Tobacco Products Control Amendment Act, 63 of 2008**
  Provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products as well as sponsoring of events by the tobacco industry.

- **National Health Laboratory Service Act, 37 of 2000**
  Provides for a statutory body that provides laboratory services to the public health sector.

- **Health Professions Act, 56 of 1974 as amended**
  Provides for the regulation of health professions, in particular, medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

- **Pharmacy Act, 53 of 1974 as amended**
  Provides for the regulation of the pharmacy profession, including community service by pharmacists.

- **Nursing Act, of 2005**
  Provides for the regulation of the nursing profession.

- **Allied Health Professions Act, 63 of 1982 as amended**
  Provides for the regulation of health practitioners like chiropractors, homeopaths and others, and for the establishment of a council to regulate these professions.

- **Dental Technicians Act, 19 of 1979**
  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

- **Hazardous Substances Act, 15 of 1973**
  Provides for the control of hazardous substances, in particular those emitting radiation.

- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 as amended**
  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in

particular, setting quality and safety standards for the sale, manufacturing and importation thereof.

- **Occupational Diseases in Mines and Works Act, 78 of 1973**
  Provides for medical examinations on persons suspected of having contracted occupational diseases especially in mines and for compensation in respect of those diseases.

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

- **National Policy for Health Act, 116 of 1990**
  Provides for the determination of national health policy to guide the legislative and operational programmes of the health portfolio.

- **Academic Health Centres Act, 86 of 1993**
  Provides for the establishment, management and operation of academic health centres.
- **Human Tissue Act, 65 of 1983**
  Provides for the administration of matters pertaining to human tissue.

3.2 OTHER LEGISLATION IN TERMS OF WHICH THE DEPARTMENT OPERATES

- **Public Service Act, Proclamation 103 of 1994**
  Provides for the administration of the public in its national and provincial spheres, as well as provides for the powers of ministers to hire and fire.

- **Promotion of Administrative Justice Act, 3 of 2000**
  Amplifies the constitutional provisions pertaining to Administrative law by codifying it.

- **Promotion of Access to Information Act, 2 of 2000**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

- **Labour Relations Act, 66 0f 1996**
  Regulates the rights of workers, employers and trade unions

- **Compensation for Occupational injuries and Diseases Act, 130 of 1993**
  Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their

employment, for death resulting from such injuries or disease.

- **Basic Conditions of Employment Act, 75 of 1997**
  Provides for the minimum conditions of employment that employers must comply with in their workplaces.

- **Occupational Health and Safety Act, 85 of 1993**
  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

- **The Division of Revenue Act, 7 of 2003**
  Provides for the manner in which revenue generated may be disbursed.

- **Skills Development Act, 97of 1998**
  Provides for the measures that employers are required to take improve the levels of skill of employees in workplaces.

- **Preferential Procurement Policy Framework Act, 5 of 2000**
  Provides for the implementation of the policy on preferential procurement pertaining to historically disadvantaged entrepreneurs.

- **Employment Equity Act, 55 of 1998**
  Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

- **State Information Technology Act, 88 of 1998**
  Provides for the creation and administration of an institution responsible for the State's information technology system.

- **Children Act 38 of 2005**
  Provides for the protection of the rights and well being of children.

- **The Competition Act, 89 0f 1998**
  Provides for the regulation of permissible competitive behaviour, regulation of mergers of companies and matters related thereto.

- **The Copyright Act, 98 of 1998**
  Provides for the protection of intellectual property of a literary, artistic musical nature that is reduced to writing.

- **The Patents Act, 57 of 1978**
  Provides for the protection of inventions including the gadgets and chemical processes.

- **The Merchandise Marks Act, 17 of 1941**
  Provides for the covering and marking of merchandise, and incidental matters.

- **Trade Marks Act, 194 of 1993**
  Provides for the registration of, certification and collective trademarks and matters incidental thereto.

- **Designs Act, 195 of 1993**
  Provides for the registration of designs and matters incidental thereto.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**
  Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

- **State Liability Act, 20 of 1957**
  Provides for the circumstances under which the State attracts legal liability.

- **Broad Based Black Economic Empowerment Act, 53 of 2003**
  Provides for the promotion of black economic empowerment in the manner that the State awards contracts for services to be rendered, and incidental matters.

- **Unemployment Insurance Contributions Act, 4 of 2002**
  Provides for the statutory deduction that employers are required to make from the salaries of employees.

- **Public Finance Management Act, 1 of 1999**
  Provides for the administration of State funds by functionaries, their responsibilities and the incidental matters.

- **Protected Disclosures Act, 26 of 2000**
  Provides for the protection of whistle-blowers in the fight against corruption.

- **Control of Access to Public Premises and Vehicles Act, 53 of 1985**
  Provides for the regulation of individuals entering government premises, and incidental matters.

- **Conventional Penalties Act, 15 of 1962**
  Provides for the enforceability of penal provisions in contracts.

- **Intergovernmental Fiscal Relations Act, 97 of 1997**
  Provides for the manner of harmonisation of financial relations between the various spheres of government, and incidental matters.

- **Public Service Commission Act, 46 of 1997**
  Provides for the amplification of the constitutional principles of accountability governance, and incidental matters.

3.3 SECTIONS OF THE NATIONAL HEALTH ACT, 2003 (ACT 61 OF 2003) PROCLAIMED ON 1ST MARCH 2012

SECTIONS	BRIEF DESCRIPTION
11	Deals with the provision of health services for experimental or research purposes.
35	empowers the Minister to classify all health establishments into such categories as may be appropriate
41	Empowers the Minister, in respect of central hospital and the relevant MEC in respect of all other public health establishments to determine the range of services that may be provided therein.
42	Deals with the establishment of clinics and community health centre committees through provincial legislation.
43	Empowers Minister to prescribe minimum standards and requirements for the provision of health services in locations other than health establishments
44	Deals with referral from one public health establishment to another.
45	Directs Minister to prescribe mechanisms to enable a co-ordinated relationship between private and public health establishments in the delivery of health services
46	imposes an obligation to every private health establishment to maintain insurance cover for indemnity
50	Establishes the Forum Statutory Health Professional Councils, a forum on which all the statutory health professional councils must be represented.
51	Empowers Minister to, in consultation with the Minister of Education, establish academic health complexes
54	Empowers Minister to designate any institution other than an institution contemplated in section 63 as an authorised institution which may acquire, use or supply the body of a deceased person
57	Prohibits the reproductive cloning of human beings.
58	Deals with the removal and transplantation of human tissue in hospital or authorised institution
59	Removal, use or transplantation of tissue, and administering of blood and blood products by medical practitioner or dentist
60	Prohibits any person from receiving payment in connection with the importation, acquisition or supply of tissue, blood, blood products or gametes
61	Deals with the allocation and use of human organs
62	Deals with the donation of human bodies and tissue of deceased persons
63	Stipulates that human bodies, tissue, blood, blood products or gametes may be donated to prescribed institution or person

SECTIONS	BRIEF DESCRIPTION
64	Deals with purposes of donation of body, tissue, blood or blood products of deceased persons
65	Deals with the manner of revocation of donation by the donor.
66	Stipulates the circumstances under which post mortem examination of bodies may take place.
67	Deals with the removal of tissue at post mortem examinations and obtaining of tissue by institutions and persons
71	Deals with research on or experimentation with human subjects
93	Deals with repeal of laws, and savings

REGULATIONS PUBLISHED ON 2 MARCH 2012

SECTION OF THE NHA	NAME OF REGULATION
68	Regulations Relating to— *(a)* artificial fertilization of persons; *(b)* the rendering of clinical forensic medicine services; *(c)* the use of human biological material; *(d)* the registration of microbiological laboratories and the acquisition, importation, handling, maintenance and supply of human pathogens; *(e)* blood and blood products; *(f)* the general control of human bodies, tissue, blood, blood products and gametes; *(g)* the import and export of human tissue, blood, blood products, cultured cells, stem cells, embryos, zygotes and gametes; *(h)* tissue banks; and *(i)* stem cell institutions or organisations
35	Regulations relating to categorisation of public hospitals

4. OVERVIEW OF 2012/13 BUDGET AND MTEF ESTIMATES

Budget summary

Budget summary

R thousand	2012/13				2013/14	2014/15
	Total to be appropriated	Current payments	Transfers and subsidies	Payments for capital assets	Total	Total
MTEF allocation						
Administration	357 852	350 944	479	6 429	382 143	397 623
National Health Insurance, Health Planning and Systems Enablement	315 521	162 868	150 462	2 191	526 332	670 166
HIV and AIDS, TB, Maternal and Child Health	9 292 548	340 875	8 950 221	1 452	11 081 238	12 816 303
Primary Health Care Services	87 420	83 997	2 164	1 259	92 925	97 093
Hospitals, Tertiary Health Services and Human Resource Development	16 927 870	135 157	16 778 762	13 951	18 016 512	19 232 174
Health Regulation and Compliance Management	575 807	192 561	379 808	3 438	614 449	645 223
Total expenditure estimates	27 557 018	1 266 402	26 261 896	28 720	30 713 599	33 858 582
Executive authority	Minister of Health					
Accounting officer	Director General of Health					
Website address	www.doh.gov.za					

The Estimates of National Expenditure e-publications for individual votes are available on www.treasury.gov.za.These publications provide more comprehensive

information at the level of service delivery, where appropriate.

Expenditure trends

Expenditure grew from R16.4 billion in 2008/09 to R26 billion in 2011/12 at an average annual rate of 16.5 per cent and is expected to increase over the medium term to R33.9 billion at an average annual rateof 9.2 per cent. The increase in both periods is driven largely by transfers to provinces, with the largest areas of spending comprising conditional grants to provinces in the *HIV/ AIDS, TB, Maternal and Child Health* and *Hospitals, Tertiary Health Services and Human Resource Development* programmes. Increasing fromR117.4million to R670.2million over the medium term at an average annual rate of 78.7 per cent, the *National Health Insurance, Health Planning and Systems Enablement* programme is expected to have the highest percentage growth due to new conditional grant introduced in 2012/13 for the national health insurance scheme.

The2012Budgetincludesnewallocations ofR97.6millionin2012/13,R618.4.million in 2013/14 and R1.9 billion in 2014/15 for the following policy priorities:

- R10 million in each year to purchase equipment and appoint staff to address backlogs at the forensic chemistry laboratories
- R20 million each year for higher accommodation costs of the department's

renovated head office building

- R3 million each year for the Medical Research Council and R10 million each year for the department for annual wage increases
- R100 million, R150 million and R200 million to nursing colleges to plan and coordinate the upgrading, recapitalising and maintaining of nursing colleges following the infrastructure audit
- R834 million for the HIV and AIDS conditional grant for the rapidly growing treatment programme (lower threshold CD4 350) and to strengthen prevention programmes
- R128 million to provide for the first of five large hospital public private partnership projects under the hospital revitalisation grant
- R150 million, R350 million and R500 million to cover the cost of national health insurance pilots
- R189.2 million, R231.2 million and R216.7 million increases for the effects of wage increases in the national tertiary services grant.

Infrastructure spending

The vote contains the hospital revitalisation, health infrastructure and nursing college grants. The hospital revitalisation grant is allocatedR12.9 billion over the medium term. The grant aims to allow provinces to plan, manage, modernise, rationalise and transform health infrastructure, health technology, and monitoring and evaluation of the health facilities in line with national policy objectives. The health infrastructure grant is allocated R5.1 billion over the MTEF period and will focus on maintaining institutions and smaller upgrading projects in primary care institutions and hospitals. The nursing colleges grant is new and is for the upgrade to provincial nursing colleges. This grant isallocatedR450 million over the MTEF period.

PART B:
PROGRAMMES AND SUB PROGRAMMES

5. PROGRAMME 1: ADMINISTRATION

5. 1 Programme Purpose

Purpose: Provide overall management of the department and centralised support services.

There are six sub programmes:

- ***Ministry***
- ***Management***
- ***Financial Management***
- ***Corporate Services***
- ***Office Administration***

5.2 Strategic objective , Performance indicators and Annual targets for 2012/13 to 2014/15

The table below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Administration Programme.

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To ensure effective **financial manage**-ment and account-ability	Un qualified audit opinion from Auditor General	Qualified Audit Opinion	Unqualified Audit Opinion	Qualified Audit Opinion	Unqualified Audit Opinion	Unqualified Audit Opin-ion	Unqualified Audit Opinion	Unqualified Audit Opinion
	Audit opinion of the Auditor General: Provincial DoHs	1/9 Provincial DoHs with Unqualified Audit Opin-ions	2/9 Provincial DoHs with Unqualified Audit Opin-ions	2/9 Pro-vincial DoHs with Unquali-fied Audit Opinions	5 provincial DOH with unqualified audit out-comes	6 provincial DOH with unqualified audit out-comes	7 provincial DOH with un-qualified audit outcomes	8 provincial DOH with unqualified audit outcomes
	Total number of Provinces with finan-cial improvement plans	-	9	9	9	9	9	9
To ensure that Information Com-munication Tech-nology (ICT) sup-ports the business objectives of the Department.	Master Informa-tion systems plan (MISP) to support the business functions produced	-	-	-	MISP Pro-duced	Approved MISP and Phase I of the MISP implemented	Phase II of the MISP imple-mented	Final Phase of the MISP implemented
	Produce a ICT Busi-ness Continuity Plan which incorporates a Disaster Recovery Plan	-	-	-	ICT Business Continuity Plan inclusive of a disaster recovery plan produced	ICT Busi-ness Con-tinuity Plan tested and distributed	Business Conti-nuity Plan imple-mented	Business Continuity Plan implemented
	Governance body for all ICT services established	-	-	-	Information Technology Committee established	Functional Information Technology Committee for the De-partment	Functional Infor-mation Technolo-gy Committee for the Department	Functional Information Technology Commit-tee for the Depart-ment

5.3 Quarterly targets for 2012/13

The reporting period for all indicators under programme 1, Administration is Annual

5.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

Administration

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R thousand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Ministry1	22 570	22 073	25 920	31 738	32 626	34 258	35 749
Management	30 206	29 499	29 770	42 767	42 008	44 009	46 005
Corporate Services	128 516	134 940	126 184	163 591	152 086	160 119	161 817
Office Accommodation	41 565	46 422	55 245	85 265	89 526	97 514	105 825
Financial Management	21 058	40 474	25 906	42 601	41 606	46 243	48 227
Total	243 915	273 408	263 025	365 962	357 852	382 143	397 623
Change to 2011 Budget estimate				35 570	28 001	33 000	33 002

Economic classification							
Current payments	221 332	268 974	257 354	353 425	350 944	374 346	389 806
Compensation of employees	88 664	103 060	108 132	125 449	131 631	138 213	145 123
Goods and services	132 668	165 914	149 222	227 976	219 313	236 133	244 683
of which:							
Consultants and professional services: Business and advisory services	*2 811*	*2 684*	*3 308*	*8 310*	*5 299*	*5 673*	*5 913*
Inventory: Medical supplies	–	*5*	*1*	*70*	*1*	*1*	*1*
Lease payments	*42 520*	*47 455*	*49 767*	*82 982*	*86 621*	*94 737*	*103 095*
Travel and subsistence	*29 206*	*16 373*	*20 218*	*35 955*	*31 246*	*32 950*	*34 258*
Transfers and subsidies	355	362	550	2 624	479	508	528
Departmental agencies and accounts	278	300	370	424	479	508	528
Public corporations and private enterprises	–	37	–	–	–	–	–
Households	77	25	180	2 200	–	–	–
Payments for capital assets	22 088	4 065	5 114	9 913	6 429	7 289	7 289
Machinery and equipment	22 088	3 927	5 114	9 913	6 429	7 289	7 289
Software and other intangible assets	–	138	–	–	–	–	–
Payments for financial assets	140	7	7	–	–	–	–
Total	243 915	273 408	263 025	365 962	357 852	382 143	397 623

Details of selected transfers and subsidies

Households							
Social benefits							
Current	77	25	180	2 200	–	–	–
Employee social benefit	77	25	180	2 200	–	–	–
Departmental agencies and accounts							
Departmental agencies (non-business entities)							
Current	278	300	370	424	479	508	528
Health and Welfare Service Sector Education and Training Authority	278	300	370	424	479	508	528
Public corporations and private enterprises							
Public corporations							
Other transfers to public corporations							
Current	–	37	–	–	–	–	–
Private entity	–	37	–	–	–	–	–

Expenditure Trends

Expenditure grew from R244 million in 2008/09 to R366 million in 2011/12, at an average annual rate of 14.5 per cent. Over the medium term, expenditure is expected to grow to R 397.6 million, at an average annual rate of 2.8 per cent. The bulk of the increase in both periods goes towards filling critical vacant management and administrative posts, as well as for spending on goods and services related to higher audit fees, communication, property leases, and travel and subsistence.

6. Programme 2: National Health Insurance, Health Planning and Systems Enablement

6.1 Programme Purpose

Purpose: To improve access through development and implementation of policies to achieve universal coverage through integrated health systems planning, improving access to quality health services, reporting, monitoring and evaluation, and research.

There are five sub programmes:

- ***Technical Policy and Planning*** provides advisory and strategic technical assistance on policy and planning and supports policy implementation. A National Health Information Warehouse is being developed in the National DoH, which will support health planning in general, and in preparation for the implementation of National Health Insurance.
- ***Health Information Management and Monitoring and Evaluation*** develops and maintains a national health information system, and commissions and coordinates research. This entails the development and implementation of disease surveillance programmes, coordination of health research and the monitoring and evaluation of strategic health programmes. An integrated system to monitor the implementation of Annual Performance Plans and identify risks at National, Provincial and District level would be implemented in 2012/13.
- ***Sector-wide Procurement*** provides rules and regulations that are set in place to govern the process of acquiring goods and services required by the department to function. Over the medium term, 30 per cent of licensed medicine prescribers will be inspected per year for compliance with the relevant legislation.
- ***Health Financing and National Health Insurance*** undertakes health economics research, develops policy for medical schemes and public-private partnerships, and provides technical oversight for the Council for Medical Schemes. The programme develops and implements policies, legislation and other necessary frameworks for the expansion of health insurance to the broader population; and oversees the coordination of research into alternative healthcare financing mechanisms for achieving universal health coverage.
- ***International Health and Development*** develops and implements bilateral and multilateral agreements to strengthen the health system, including agreements on the recruitment of health workers from other countries; and provides technical capacity to South Africa in fields such as health technology management and surveillance systems, among others.

6.2 Strategic objective , Performance indicators and Annual targets for 2012/13 of 2014/15

The table below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the National Health Insurance, Health Planning and Systems Enablement

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
Facilitate and co-ordinate evidence based planning for all levels of the health care system, aligned to the health sector's 10 point plan and negotiated service delivery agreement.	Revised guidelines for planning developed and implemented	-	-	-	Planning guidelines revised and implemented	1 National APP and 9 Provincial Annual Performance Plans (APPs) developed according to guidelines	1 National APP and 9 Provincial APPs developed according to guidelines	1 National APP and 9 Provincial APPs developed according to guidelines
	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	7 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To develop and implement an integrated monitoring and evaluation system aligned to outcomes contained in the negotiated service delivery agreement.	Integrated monitoring and evaluations system developed and implemented	New indicator	New indicator	New indicator	Integrated monitoring and evaluation system for health developed	Monitoring and evaluation system for Health implemented and maintained	Monitoring and evaluation system for Health implemented and maintained	Monitoring and evaluation system for Health implemented and maintained
Monitor HIV and syphilis prevalence by conducting the annual national HIV survey	Annual National HIV and Syphilis Survey reports published	2007 National HIV and Syphilis prevalence estimates and trends report published	2008 National HIV and Syphilis prevalence estimates and trends report published	2009 Annual National HIV and Syphilis prevalence estimates and trends report published during November 2010	2010 Annual National HIV and Syphilis prevalence estimates and trends report published	2011 Annual National HIV and Syphilis prevalence estimates and trends report published	2012 Annual National HIV and Syphilis prevalence estimates and trends report published	2013 Annual National HIV and Syphilis prevalence estimates and trends report published
To develop and manage eHealth	eHealth strategy developed and implemented	New Indicator	New Indicator	New Indicator	New Indicator	eHealth strategy finalised	Inter operability standaards developed and implemented	National patient based information system developed
Strengthen research and development	National health research priority identified	New indicator	New indicator	New indicator	National health research priority list finalised	National health research priority list published	National health research priority list published	National health research priority list published

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
Prepare for the implementation of the National Health Insurance (NHI)	Policy and legal framework for the Implementation of NHI developed	-	Draft policy document presented to Cabinet Committee. The Cabinet committee requested a revision of the document. Cabinet established an Inter-ministerial Committee (IMC) on NHI.	Revision of the draft policy on NHI taking into consideration requests from Cabinet and guidance from IMC on NHI.	Revised NHI policy document resubmitted to IMC on NHI and Cabinet for approval. Draft policy document published as Green Paper on NHI as part of the public consultation process.	• NHI White paper prepared • Draft NHI legislation prepared for public consultation	NHI Bill tabled in Parliament	Relevant regulations developed
	Phased in implementation of NHI	New Indicator	New Indicator	New Indicator	Methodology for the selection of the NHI Pilot sites developed and funding model developed	NHI pilots in 10 selected districts initiated	Phased implementation of NHI	Phased implementation of NHI
Provide stewardship and leadership for improving health outcomes through working with international development partners, SADC and AU	Number of Cross border initiatives facilitated to manage communicable diseases along SA's border	-	1 Cross border initiatives facilitated	2 Cross border initiatives facilitated	3 Cross border initiatives facilitated	4 Cross border initiatives facilitated	5 Cross border initiatives facilitated	5 Cross border initiatives facilitated

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
Revised guidelines for planning developed and implemented	Annual	1 National APP and 9 Provincial Annual Performance Plans (APPs) developed according to guidelines				
9 Provincial APPs analysed and feedback provided	Annual	9 Provincial APPs analysed and feedback provided				
Integrated monitoring and evaluations system developed and implemented	Annual	Monitoring and evaluation system for Health implemented and maintained				
Annual National HIV and Syphilis Survey reports published	Annual	2011 Annual National HIV and Syphilis prevalence estimates and trends report published				
National health research priority identified	Annual	National health research priority list used for publicly funded health research				
Policy and legal framework for the Implementation of NHI	Annual	NHI White paper prepared Draft NHI legislation prepared for public consultatoin.				
Phased in implementation of NHI	Annual	Initiation of the NHI pilots in 10 selected districts.				
Number of Cross border initiatives facilitated to manage communicable diseases along SA's border	Quarterly	4 Cross border initiatives facilitated	1	2	3	4

6.4. Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

National Health Insurance, Health Planning and Systems Enablement

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R thousand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Technical Policy and Planning	–	–	–	7 825	19 873	23 059	20 308
Health Information Management, Monitoring and Evaluation	27 307	39 114	21 631	37 184	38 640	40 371	36 826
Sector-wide Procurement	12 949	15 201	13 059	19 666	21 238	22 668	23 779
Health Financing and National Health Insurance	17 547	53 395	26 593	42 855	182 144	383 676	530 069
International Health and Development	61 452	34 960	35 933	55 096	53 626	56 558	59 184
Total	119 255	142 670	97 216	162 626	315 521	526 332	670 166
Change to 2011 Budget estimate				2 239	137 962	336 985	474 859
Economic classification							
Current payments	117 313	109 826	93 054	160 291	162 868	173 497	167 307
Compensation of employees	45 182	49 750	50 795	61 495	80 867	87 956	88 645
Goods and services	72 131	60 076	42 259	98 796	82 001	85 541	78 662
of which:							
Consultants and professional services: Business and advisory services	*3 052*	*6 304*	*2 978*	*18 918*	*16 361*	*16 936*	*12 313*
Inventory: Medical supplies	–	–	–	–	–	–	–
Lease payments	*2 504*	*491*	*316*	*1 053*	*984*	*1 001*	*1 021*
Travel and subsistence	*34 722*	*12 624*	*12 132*	*23 814*	*22 137*	*22 410*	*22 768*
Transfers and subsidies	11	30 051	15	440	150 462	350 485	500 509
Provinces and municipalities	–	30 000	–	–	150 000	350 000	500 000
Departmental agencies and accounts	–	–	–	440	462	485	509
Households	11	51	15	–	–	–	–
Payments for capital assets	1 927	2 793	4 112	1 895	2 191	2 350	2 350
Machinery and equipment	1 927	1 895	4 112	1 895	2 191	2 350	2 350
Software and other intangible assets	–	898	–	–	–	–	–
Payments for financial assets	4	–	35	–	–	–	–
Total	119 255	142 670	97 216	162 626	315 521	526 332	670 166

Details of selected transfers and subsidies

Households							
Social benefits							
Current	11	51	15	–	–	–	–
Employee social benefit	11	51	15	–	–	–	–
Departmental agencies and accounts							
Departmental agencies (non-business entities)							
Current	–	–	–	440	462	485	509
National Health Laboratory Services Cancer Register	–	–	–	440	462	485	509

Expenditure Trends

Expenditure increased from R119 million in 2008/09 to R162.6 million in 2011/12 with an average annual rate of 10.9 per cent, and is expected to increase significantly over the medium term to R 670.2 million at an average annual rate of 60.3 per cent. An additional allocation of R1 billion over the MTEF period has been made available through the national health insurance conditional grant to cover the cost of the national health insurance pilot projects and further preparation for the implementation of national health insurance .

7. Programme 3: HIV / AIDS, TB and Maternal and Child Health

7.1 Programme Purpose

Purpose: Develop national policies, coordinates and funds HIV and AIDS and STI, Tuberculosis, Maternal and Child Health, and Women's Health programmes. Develops and oversee implementation of policies, strengthen systems and set norms and standards and monitors programme implementation

There are three sub-programmes:

HIV and AIDS programme develops national policies and supports national HIV and AIDS and sexually transmitted infections programmes, including coordinating the implementation of the HIV and AIDS plan. In the medium term, the aim is to scale up a combination of prevention interventions to reduce new infections.

Tuberculosis subprogramme develops national policies and guidelines and set norms and standards for Tuberculosis. In line with the vision outlined in the new National Strategic Plan for HIV, STIs and TB (2012 to 2016).

Maternal and Child Health*:* develops and monitors policies, guidelines; and sets norms and standards for maternal, woman and child health.

7.2 Strategic objective , Performance Indicators and Annual targets for 2012/13 to 2014/15

The table below summarize the strategic objectives, indicators and three-year targets for the various sub-programmes funded from the HIV&AIDS, TB and Maternal, Child and Women's Health

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To scale up combination of prevention interventions to reduce new infections	Number of Medical Male circumcisions conducted	-	-	140 000	500 000	600 000	800 000	1 000 000
	Number of HIV tests done	-	13 million	15 million	15 million	18 million	20 million	22 million
To improve the quality of life of people living with HIV and AIDS by providing an appropriate package of care, treatment and support services to at least 80 per cent of people living with HIV and AIDS	Number of new patients put on ART per year	781 907	539 819	418 677	625 000	500 000	500 000	550 000

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To reduce infant, child and youth morbidity and mortality	National immunisation coverage rate(children under the age of 1 year)	92.1% (926 168)	97.4% (955 485)	89.4% (882500)	90% (1 066 401)	90% (1 066 401)	90% (1 066 401)	90% (1 066 401)
	Measles immunisation coverage rate (second dose)	78% (797 617)	90% (900 347)	81% (800081)	90% (1 066 041)	90% (1 066 041)	90% (1 066 041)	90% (1 066 041)
	Percentage of quintile 1 schools visited by the school health team to provide integrated school health progam (ISHP) services	New indicator	New indicator	New indicator	New indicator	80% (6454 schools)	90% (7261 schools)	95% (7665 schools)
	Percentage of Grade 1 learners in quintile 1 and 2 schools assessed using the ISHP(write out) learner assessment.	New indicator	New indicator	New Indicator	New indicator	80% (680 000 learners)	90% (765 000 learners)	95% (807 500 learners)
	Percentage of Grade 8 learners in quintile 1 schools assessed using the ISHP learner assessment.	New indicator	New indicator	New Indicator	New indicator	50% (65 100 learners)	40% (104 160 learners)	60% (156 240 learners)

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To reduce maternal mortality	Antenatal care coverage rate	111.8%	109.4%	100%	100%	100%	100%	100%
	Antenatal coverage before 20 weeks	32.9%	34.55	37.5	40%	50%	60%	65%
	Proportion of deliveries taking place in health facilities under the supervision of trained personnel	87.9%	88.5%	86.5%	90%	92%	95%	96%
	Percentage of Mothers and Babies that received post natal care within 6 days after delivery.	-	30%	29.9% of babies were reviewed 6 days postnatal 27% of mothers were reviewed within 6 days postnatal	45%	75%	79%	82%

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To improve access to sexual and reproductive health services	Cervical cancer screening coverage	45.8%	47.7%	52.2%	52%	54%	56%	58%
	Couple year protection rate	31.3%	32%	32%	33%	35%	36%	37%
	Percentage health facilities with contraceptive services	New Indicator	New Indicator	New Indicator	New Indicator	80%	85%	90%
Expand the PMTCT coverage to pregnant women	Percentage of pregnant woman tested for HIV	86.5%	92.7%	100%	100%	98%	98%	98%
	Antenatal client initiated on HAART rate	-	76.9%	79.4%	100%	85%	90%	95%
	Percentage of babies testing PCR positive 6 weeks after birth out of all babies tested	9.2%	10.9%	3.5%	3.5%	3.0%	2.5%	2.0%

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To reduce the burden of Tuberculosis	TB Cure rate	60%	68%	72.5%	75%	80%	85%	90%
	TB treatment defaulter rate	8.5%	7.9%	6.8%	6%	5%	5%	> 5%
Combating TB and HIV by reducing co-infection burden	Percentage of HIV positive patients screened for TB	48%	58%	71%	85%	85%	90%	90%
	Percentage of TB patients tested for HIV	76%	77%	68%	85%	90%	90%	90%
	Percentage of eligible TB/HIV co-infected patients started on Cotrimoxazole Prophylaxis Therapy (CPT)	77%	78%	71%	80%	80%	85%	90%
	Number of HIV positive patients eligible to receive Isoniazid Preventive Therapy (IPT)	15 558	30 047	210 396	60 000	400 000	450 000	500 000

7.3 Quarterly targets for 2012/13

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
Number of Medical Male circumcisions conducted	Quarterly	600 000	125 000	125 000	125 000	125 000
HCT uptake rate	Quarterly	18 million	4.5 million	4.5 million	2.5 million	2.5 million
Number of new patients put on ART per year	Quarterly	500 000	125 000	125 000	125 000	125 000
National immunisation coverage rate(children under the age of 1 year)	Quarterly	90% (1 066 401)	90%	90%	95%	95%
Measles immunisation coverage rate (second dose)	Quarterly	90% (1 066 041)	90%	90%	90%	90%
Percentage of quintile 1 schools visited by the school health team to provide integrated school health progam (ISHP) services	Quarterly	80% (6454 schools)	20%	20%	20%	20%
Percentage of Grade 1 learners in quintile 1 and 2 schools assessed using the ISHP(write out) learner assessment.	Quarterly	80% (680 000 learners)	20%	20%	20%	20%
Percentage of Grade 8 learners in quintile 1 schools assessed using the ISHP learner assessment.	Quarterly	30% (60 100 learners)	7.5%	7.5%	7.5%	7.5%
Antenatal care coverage rate	Quarterly	100%	100%	100%	100%	100%
Antenatal coverage before 20 weeks	Quarterly	50%	46%	47%	48%	50%
Proportion of deliveries taking place in health facilities under the supervision of trained personnel	Annual	92%				
Percentage of Mothers and Babies that received post natal care within 6 days after delivery.	Quarterly	75%	69%	71%	73%	75%
Cervical cancer screening coverage	Quarterly	54%	54%	54%	54%	54%

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
Couple year protection rate	Quarterly	35%	35%	35%	35%	35%
Percentage health facilities with contraceptive services	Quarterly	80%	100 %	100 %	100 %	100 %
Percentage of pregnant woman tested for HIV	Quarterly	100%	100%	100%	100%	100%
Antenatal client initiated on HAART rate	Quarterly	85%	85%	85%	85%	85%
Percentage of babies testing PCR positive 6 weeks after birth out of all babies tested	Quarterly	3.5%	3.5%	3.5%	3.5%	3.5%
TB Cure rate	Annual	80%				
TB treatment defaulter rate	Annual	5%				
Percentage of HIV positive patients screened for TB	Quarterly	85%	85%	85%	85%	85%
Percentage of TB patients tested for HIV	Quarterly	90%	90 %	90 %	90 %	90%
Percentage of eligible TB/HIV co-infected patients started on Cotrimoxazole Prophylaxis Therapy (CPT)	Quarterly	85%	85%	85%	85%	85%
Number of HIV positive patients eligible to receive Isoniazid Preventive Therapy (IPT)	Quarterly	400 000	100 000	100 000	100 000	100 000

HIV and AIDS, TB, Maternal and Child Health

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R thousand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
HIV and AIDS	3 359 780	4 851 645	6 415 939	7 960 151	9 233 905	11 020 123	12 752 864
Tuberculosis	11 113	16 378	15 822	17 954	25 710	26 495	27 257
Maternal and Child Health	23 549	55 428	51 236	51 737	32 933	34 620	36 182
Total	3 394 442	4 923 451	6 482 997	8 029 842	9 292 548	11 081 238	12 816 303
Change to 2011 Budget estimate				3 314	(84 523)	(106 988)	962 691
Economic classification							
Current payments	350 883	345 721	284 112	355 819	340 875	348 036	396 134
Compensation of employees	39 114	43 510	48 821	57 693	58 789	61 735	64 941
Goods and services	311 769	302 211	235 291	298 126	282 086	286 301	331 193
of which:							
Consultants and professional services: Business and advisory services	*103 757*	*4 890*	*6 122*	*30 317*	*33 831*	*25 151*	*33 511*
Inventory: Medical supplies	*103 283*	*181 211*	–	*172 000*	*135 000*	*140 000*	*148 400*
Lease payments	*368*	*254*	*279*	*463*	*572*	*605*	*630*
Travel and subsistence	*27 132*	*17 659*	*17 342*	*22 146*	*18 972*	*20 702*	*21 929*
Transfers and subsidies	3 042 958	4 576 751	6 197 781	7 672 773	8 950 221	10 731 528	12 418 495
Provinces and municipalities	2 885 423	4 376 105	6 051 757	7 492 962	8 762 848	10 533 886	12 211 322
Higher education institutions	733	500	2 000	6 124	3 000	3 000	3 000
Non-profit institutions	156 624	198 143	143 757	173 687	184 373	194 642	204 173
Households	178	2 003	267	–	–	–	–
Payments for capital assets	598	973	917	1 250	1 452	1 674	1 674
Machinery and equipment	598	973	917	1 250	1 452	1 674	1 674
Payments for financial assets	3	6	187	–	–	–	–
Total	3 394 442	4 923 451	6 482 997	8 029 842	9 292 548	11 081 238	12 816 303

Details of selected transfers and subsidies

Households							
Social benefits							
Current	78	3	267	–	–	–	–
Employee social benefit	78	3	267	–	–	–	–
Higher education institutions							
Current	733	500	2 000	6 124	3 000	3 000	3 000
University of Limpopo	500	500	2 000	562	2 000	2 000	2 000
University of Cape Town	233	–	–	562	1 000	1 000	1 000
University of Witwatersrand	–	–	–	5 000	–	–	–
Non-profit institutions							
Current	156 624	198 143	143 757	173 687	184 373	194 642	204 173
Lifeline	16 000	–	16 243	16 478	17 627	18 308	19 023
Lovelife	55 000	–	38 690	62 023	66 124	70 430	73 951
Soul City	14 000	–	16 960	12 977	13 876	14 820	15 561
HIV and AIDS Non-governmental organisations	58 141	193 842	57 765	69 038	72 490	76 115	79 921
Medical Research Council - South African AIDS Vaccine Initiative	10 000	–	11 660	12 359	12 977	13 626	14 307
Tuberculosis Non-govermental organisations	3 483	3 665	2 439	–	–	–	–
Maternal, Child and Women's Health Non-governmental organisations	–	636	–	812	1 279	1 343	1 410
Households							
Other transfers to households							
Current	100	2 000	–	–	–	–	–
Donation	100	2 000	–	–	–	–	–

Expenditure trends

Expenditure has grown from R3.4 billion in 2008/09 to R8 billion in 2011/12, at an average annual rate of 33.2 per cent, mostly due to transfers to provinces for the HIV and AIDS conditional grant, which has increased as a result of the expanded CD4 count threshold and the subsequent higher numbers of new patients on antiretroviral treatment. Allocations to provinces are made on the basis of burden of disease and progress on antiretroviral treatment uptake.

Over the medium term, expenditure is expected to increase to R12.8 billion, at an average annual rate of 16.9 per cent. Growth in this period is partly to accommodate the change in the antiretroviral treatment threshold to CD4 count of 350 in 2011/12 and expanding the medical male circumcision and condom distribution programmes. The spending focus over the MTEF period will be on strengthening HIV and AIDS prevention programmes.

8. Programme 4: Primary Health Care Services (PHC)

8.1 Programme Purpose

Purpose: Develops and oversees implementation of legislation, policies, systems and norms and standards for a uniform District Health System, environmental health, communicable and non communicable diseases, health promotion and nutrition.

There are 4 sub-programs:

District Services and Environmental Health promotes coordinates and institutionalises the district health system; integrates the implementation of programmes, including the Primary Health Care approach and environmental health and community based services; and ensures that there are norms and standards for the district health system.

Communicable Diseases develops policies and supports provinces to ensure the control of infectious diseases, and supports the National Institute of Communicable Diseases.

Non-Communicable Diseases establishes policies, legislation and guidelines; and assists provinces in implementing and monitoring chronic diseases, disability, the elderly people, eye care, oral health, mental health and substance abuse and injury prevention.

Health Promotion and Nutrition formulates, supports and monitors policies, guidelines, and norms and standards for health promotion and nutrition.

8.2 Strategic objective , Performance indicators and Annual targets for 2012/13 to 2014/15

The tables below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Primary Health Care Services (PHC) Programme.

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To strengthen the integrated delivery of PHC through the implementation of the PHC re-engineering strategy	PHC Utilisation rate	2.4 visits	2.5 visits	2.4 visits	2.6 visits	2.8 visits	3 visits	3.2 visits
	No of ward based PHC outreach teams established	New indicator	New indicator	New indicator	54	500	1000	2000
	Fixed PHC facilities with monthly supervisory visits	70%	70%	68.4%	75%	80%	85%	90%
	No of districts implementing the district specialist teams	New Indicator	New Indicator	New Indicator	New Indicator	10	20	20
To support the implementation of a functional District Health system in line with the National Health Act	DHS policy revised and approve	New Indicator	New Indicator	New Indicator	New Indicator	Draft DHS policy	Approved DHS policy and monitor implementation	Monitor implementation of the
	No of DHP's analysed and feedback provided	52	46	46	46	52	52	52
	Framework for addressing Social Determinants of Health	New indicator	New indicator	New indicator	New indicator	Draft Framework for addressing social determinants of Health developed	Framework for the Social Determinants of Health approved	Monitoring the implementation of the Framework for addressing the Social Determinants of Health
Improve nutritional status of people living with HIV & AIDS and TB	Proportion of PHC facilities implementing nutritional intervention for PLHIV & AIDS and TB	New Indicator	New Indicator	79%	80%	85%	90%	100%
Reduction of vitamin A **deficiency in under 5** year olds	Vitamin A supplementation coverage among children 12-59 months	32.4%	36.6%	33%	40%	42%	50%	55%
Improve initiation and support for exclusive breastfeeding	Proportion of health facilities in which deliveries are done that are MBFI accredited	-	-	-	-	55% (300 facilities)	65% (354 facilities)	80% (436 facilities)
To strengthen the implementation of Health Promotion Initiatives	Integrated Health Promotion Strategy Developed and Implemented	-	-		Integrated Health Promotion Strategy Developed	Implementation of integrated Health Promotion Strategy	Monitor & support implementation	Monitor & support implementation

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To strengthen the quality of Environmental Health Services	Norms and Standards for Environmental Health Services	New Indicator	New Indicator	New Indicator	Draft Norms and Standards for Environmental Health Policy Developed	Norms and Standards for Environmental Health Services policy finalised	Monitor the implementation Norms and Standards for Environmental Health Services	Monitor the implementation of Norms and Standards for Environmental Health Services
	No of Ports of entry designated in terms of IHR	-	7	9	12	24	36	43
	No of provinces that comply with NEMA	-	1	9	9	9	9	9
To eliminate Malaria by 2018 by reducing g the local transmission of malaria cases to 0 per 1000 population at risk, through the implementation of the malaria elimination strategy	Malaria incidence per 1000 population at risk	1.13	0.49 – confirmed local cases 0.70 – aggregate of local cases and cases of unknown origin	0.66 confirmed local cases	0.43 confirmed local cases 0.62 - aggregate of local cases and cases of unknown origin	0.40- confirmed local cases 0.58 - aggregate of local cases and cases of unknown origin	0.37 - confirmed local cases 0.54 - aggregate of local cases and cases of unknown origin	0.34 confirmed local cases 0.45 aggregate of local cases and cases of unknown origin
To prevent and manage non-communicable diseases by implementing the chronic care model.	No of districts implementing the Chronic Care model	New indicators	New indicators	New indicators	3 Districts implementing the Chronic care model	3 Districts implementing the Chronic care mode	8 Districts implementing the Chronic care model	10 Districts implementing the Chronic care model
Introduce legislation and regulations to reduce NCDs	Legislation on alcohol advertising. Regulations on salt content in processed foods	New indicators	New indicators	New indicators	Drafts of legislation and regulations	Legislation on alcohol advertising passed Regulations on salt in food enacted	Legislation and regulations monitored for compliance	Legislation and regulations monitored for compliance
Strengthen the health system to increase cataract surgery rates	Increased cataract surgery rates	333 per million population	387.6 per million population	549.7 per million population	600 per million population	Cataract surgery rates of 1 500 per million population reached in 3 provinces	Cataract surgery rates of 1 500 per million population reached in 6 provinces	Cataract surgery rates of 1 500 per million population reached in all provinces

8.3 Quarterly targets for 2012/13

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
PHC Utilisation rate	Quarterly	2.8 visits	2.7	2.75	2.78	2.8
No of ward based PHC outreach teams established	Quarterly	500	125	125	125	125
Fixed PHC facilities with monthly supervisory visits	Quarterly	80%	80%	80%	80%	80%
No of districts implementing the district specialist teams	Annual	10				
DHS policy revised and approve	Annual	Draft DHS policy				
No of DHP's analysed and feedback provided	Annual	52				
Framework for addressing Social Determinants of Health	Annual	Draft Framework for addressing social determinants of Health developed				
Proportion of PHC facilities implementing nutritional intervention for PLHIV & AIDS and TB	Annual	85%				
Vitamin A supplementation coverage among children 12-59 months	Annual	42%				
Proportion of health facilities in which deliveries are done that are MBFI accredited	Annual	55% (300 facilities)				
Integrated Health Promotion Strategy Developed and Implemented	Annual	Implementation of integrated Health Promotion Strategy				
Norms and Standards for Environmental Health Services	Annual	Norms and Standards for Environmental Health Services policy finalised				
No of Ports of entry designated in terms of IHR	Annual	24				
No of provinces that comply with NEMA	Annual	9				

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
Malaria incidence per 1000 population at risk	Annual	0.40- confirmed local cases 0.58 - aggregate of local cases and cases of unknown origin				
No of districts implementing the Chronic Care model	Annual	3 Districts implementing the Chronic care mode				
Legislation on alcohol advertising.	Annual	Legislation on alcohol advertising passed Regulations on salt in food enacted				
Regulations on salt content in processed foods	Annual	Regulations on salt in food, enacted				
Increased cataract surgery rates	Annual	Cataract surgery rates of 1 500 per million population reached in 3 provinces				

8.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

Primary Health Care Services

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R thousand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
District Services and Environmental Health	11 679	11 605	28 868	23 558	22 423	24 151	25 063
Communicable Diseases	8 072	204 172	13 985	14 506	17 091	18 346	19 246
Non-Communicable Diseases	23 976	18 325	25 686	29 950	27 234	28 597	29 888
Health Promotion and Nutrition	26 632	11 288	10 232	16 496	20 672	21 831	22 896
Total	70 359	245 390	78 771	84 510	87 420	92 925	97 093
Change to 2011 Budget estimate				(2 379)	11 391	12 392	11 208
Economic classification							
Current payments	68 558	192 969	72 000	80 670	83 997	89 303	93 331
Compensation of employees	27 402	31 255	32 871	39 519	41 848	44 740	47 127
Goods and services	41 156	161 714	39 129	41 151	42 149	44 563	46 204
of which:							
Consultants and professional services: Business and advisory services	*1 396*	*3 052*	*21 380*	*8 609*	*7 054*	*7 437*	*7 459*
Inventory: Medical supplies	*519*	*144 302*	*2 106*	*70*	–	–	–
Lease payments	*346*	*243*	*284*	*544*	*444*	*463*	*477*
Travel and subsistence	*13 852*	*6 635*	*6 351*	*11 070*	*16 860*	*17 465*	*18 007*
Transfers and subsidies	1 170	51 916	6 339	2 642	2 164	2 298	2 438
Provinces and municipalities	–	50 000	–	–	–	–	–
Departmental agencies and accounts	–	–	4 600	–	–	–	–
Non-profit institutions	959	1 881	1 709	2 642	2 164	2 298	2 438
Households	211	35	30	–	–	–	–
Payments for capital assets	630	493	432	1 198	1 259	1 324	1 324
Machinery and equipment	630	493	432	1 198	1 259	1 324	1 324
Payments for financial assets	1	12	–	–	–	–	–
Total	70 359	245 390	78 771	84 510	87 420	92 925	97 093

Details of selected transfers and subsidies

Households							
Social benefits							
Current	109	35	30	_	_	_	_
Employee social benefit	9	35	30	_	_	_	_
Donation	100	–	–	_	_	_	_
Departmental agencies and accounts							
Departmental agencies (non-business entities)							
Current	–	–	4 600	_	_	_	_

Humans Sciences Research Council	–	–	4 600	_	_	_	_
Non-profit institutions							
Current	959	1 881	1 709	2 642	2 164	2 298	2 438
South African Federation for Mental Health	234	–	261	277	290	305	320
South African Council for the Blind	525	552	585	620	651	684	718
South African Community Epidemiology Netwotk on Drug Use	200	508	366	388	408	428	450
Mental health non-governmental organisations	–	246	147	157	165	173	182
Health promotion non-governmental organisations	–	575	350	1 099	650	708	768
Environmental health non-governmental organisations	–	–	–	101	–	–	–
Households							
Other transfers to households							
Current	102	–	–	–	–	–	–
Donation	102	–	–	–	–	–	–

Expenditure trends

Expenditure increased from R70.4 million in 2008/09 to R84.5 million in 2011/12, at an average annula rate of 6.3 per cent, and is expected to increase to R97.1 million over the medium term, at an average annual rate of 4.7 percent. The increase of R 50 million is spending in 2009/10 was for the cholera outbreak and R144 million for a mass influenza vaccination campaign.

9. Programme 5: Hospital, Tertiary Health Services and Human Resource Development

9.1 Programme Purpose:

Purpose: Develops policies, delivery models and clinical protocols for hospitals and emergency medical services. Ensures that Academic Medical Centres and health workforce programmes are aligned.

There are six sub-programmes

Health Facilities Infrastructure Management focuses on the coordination and funding of health infrastructure to enable provinces to plan, manage, modernise, rationalise and transform infrastructure, health technology, hospital management and improvement of the quality of care in line with national policy objectives.

Tertiary Health Care Planning and Policy focuses on developing credible, long term provision of tertiary and high quality specialised services in a modernised and reconfigured manner; and identifies tertiary and regional hospitals that should serve as centres of excellence for disseminating quality improvements. The sub programme is responsible for the management of the National Tertiary Services grant. The purpose of the grant is to provide strategic funding to enable provinces to plan, modernize, rationalize and transform the tertiary hospital services platform in line with national policy objectives including access and equity.

Hospital Management deals with national policy on hospital and emergency medical services by focusing on developing an effective referral system to ensure clear delineation of responsibility by level of care, clear guidelines for referral and improved communication, and development of specific detailed hospital plans.

Human Resources for Health *is* responsible for medium to long term human resources planning in the national health system. This entails implementing the national human resources for health plan; facilitating capacity development for sustainable health workforce planning; and developing and implementing human resources information systems for planning and monitoring purposes.

Nursing Services is responsible for developing policy framework to oversee the development of the required nursing skill and capacity in the system.

9.2 Strategic objective , Performance indicators and Annual targets for 2012/13 to 2014/15

The tables below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Hospitals, Tertiary Health Services and Human Resource Development

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
Accelerate the delivery of health infrastructure	National Infrastructure plan developed in collaboration with Provincial Infra Structure Units	New Indicator	New Indicator	New Indicator	All provinces manage to submit U-AMPs. These plans show the provincial project list over the MTEF and one National Infrastructure Plan over the MTEF is drawn from this plans.	Updated National Infrastructure Plan developed	Updated National Infrastructure Plan developed	Updated National Infrastructure Plan developed
	Monitor Revitalisation and maintenance of Hospitals, CHCs and Clinics	New Indicator	New Indicator	New Indicator	Revitalisation and maintenance hospitals, CHCs and Clinics funded through HRG and HIG monitored	Revitalisation and maintenance hospitals, CHCs and Clinics funded through HRG and HIG monitored	Revitalisation and maintenance hospitals, CHCs and Clinics funded through HRG and HIG monitored	Revitalisation and maintenance hospitals, CHCs and Clinics funded through HRG and HIG monitored
	Implementation of Five PPP Tertiary Flagship Projects	New Indicator	New Indicator	New Indicator	Transactional Advisors have been appointed for all five PPPs.Currently conducting needs analysis for the feasibility studies	Complete feasibility studies for three projects and issue RFQs and RFP.	Procure and sign agreements for at least two projects and begin construction. Complete feasibility studies for remaining projects and issue RFQs and RFP for the projects	Procure, sign agreements and begin construction for all outstanding projects. All projects under construction

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
Accelerate the delivery of health infrastructure	Revitalisation of Nursing College and schools	New Indicator	New Indicator	New Indicator	A service provider to develop the master plan and Feasibility Study appointed	Maintenance of existing prioritised nursing college and schools through the new Nursing College/ School Grant. Developed and conclude the master plan plus feasibility study for the Nursing college and schools	Implementation of master plan and feasibility study for the Nursing college/ school grant	Continued Implementation of master plan and feasibility study for the Nursing college/ school grant.
	Sustainable set of universally adopted national norms and standards, guidelines and benchmarks for all levels of health care facilities	New Indicator	New Indicator	New Indicator	The NDOH through CSIR has developed first draft of infrastructure Norms and Standard. Costing model.	Health infra structure norms and standards for all levels finalised and approved	Monitor the implementation of Health infra structure norms and standards for all levels	Monitor the implementation of Health infra structure norms and standards for all levels -
	Infra Structure Project management information system (PMIS) established	New Indicator	New Indicator	New Indicator	Infrastructure PMIS designed, developed and piloted	Implementation, configuration and maintenance of the Infrastructure PMIS	Implementation, configuration and maintenance of the Infrastructure PMIS	Implementation, configuration and maintenance of the Infrastructure PMIS

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To ensure appropriate health technology are available and efficiently managed.	Health Technology Strategy developed and approved	New Indicator	New Indicator	Draft Health technology strategy developed	Health technology strategy revised for finalisation	Implementation of Health technology strategy commenced	Implementation of Health technology strategy continued	Implementation of Health technology strategy continued
	Essential Equipment lists for the different levels of care developed	New Indicator	New Indicator	New Indicator	Essential equipment list finalised for all levels of healthcare facilities	Revise EELs based on feedback	Monitor the implementation of EEL's	Monitor the implementation of EEL's
	Optimisation of Health Technology maintenance	New Indicator	New Indicator	New Indicator	Standards for the use and maintenance of Health Technology drafted	Standards for use and maintenance of Health Technology finalised	Standards for use and maintenance of Health Technology implemented	Standards for use and maintenance of Health Technology implemented
Improve Health Workforce planning management and development	Develop norms and standards for health workforce	New Indicator	New Indicator	New Indicator	Develop norms and standards for Human Resource for Health for Primary Health Care and Secondary Health Care	Human Resource for Health norms and standards implementation monitoring and gap analysis.	Human Resource for Health norms and standards implementation monitoring and gap analysis.	Human Resource for Health norms and standards implementation monitoring and gap analysis.
	Community health worker policy finalised	Continue with the process and started a major project of reviewing the 2004 Policy Framework document and the development of a new draft policy document	Draft policy document completed but was put on hold as a new process started in the CHW environment. A task team for CHW was formed with new objectives	-	Phase II: Integration into the Health System of CHW's. Review remuneration package and develop new remuneration packages and job descriptions for CHW. Start process of Monitoring and evaluation	Standardized training programmes in place. Work with FET and HWSETA to implement. Monitor and evaluate training.	Provincial visits for M&E of CHW Programme. Review and recommend changes through research and audits	Provincial visits for M&E of CHW Programme. Review and recommend changes through research and audits

9.3 Quarterly targets for 2012/13

The reporting period for all indicators under programme 5 is Annual

9.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

Hospitals, Tertiary Health Services and Human Resource Development

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R thousand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Health Facilities Infrastructure Management	3 701 848	4 198 814	5 191 544	6 057 426	5 854 383	6 080 964	6 619 813
Tertiary Health Care Planning and Policy	6 767 231	7 146 140	7 990 670	8 705 251	8 950 467	9 695 572	10 247 397
Hospital Management	7 481	7 980	6 517	12 257	12 616	13 247	13 840
Human Resources for Health	1 702 465	1 790 503	1 880 530	2 018 720	2 108 854	2 224 629	2 348 774
Nursing Services	–	–	–	–	1 550	2 100	2 350
Total	12 179 025	13 143 437	15 069 261	16 793 654	16 927 870	18 016 512	19 232 174
Change to 2011 Budget estimate				192 137	(150 405)	287 980	423 354
Economic **classification**							
Current payments	61 554	72 153	74 011	224 556	135 157	136 341	135 071
Compensation of employees	36 039	41 417	41 978	58 151	67 257	70 645	72 800
Goods and services	25 515	30 736	32 033	166 405	67 900	65 696	62 271
of which:							
Consultants and professional services: Business and advisory services	*273*	*10 573*	*14 504*	*130 404*	*25 086*	*21 733*	*15 626*
Inventory: Medical supplies	*39*	*11*	*10*	*46*	*50*	*100*	*150*
Lease payments	*487*	*696*	*506*	*1 465*	*1 748*	*1 854*	*1 960*
Travel and subsistence	*6 748*	*4 648*	*4 587*	*10 368*	*7 959*	*7 730*	*7 819*
Transfers and subsidies	12 103 237	13 067 743	14 990 221	16 549 820	16 778 762	17 865 790	19 082 722
Provinces and municipalities	12 103 235	13 067 645	14 990 204	16 541 820	16 778 762	17 865 790	19 082 722
Higher education institutions	–	–	–	8 000	–	–	–
Households	2	98	17	–	–	–	–
Payments for capital assets	14 233	3 538	4 880	19 278	13 951	14 381	14 381
Machinery and equipment	14 233	3 258	4 880	19 278	13 951	14 381	14 381
Software and other intangible assets	–	280	–	–	–	–	–
Payments for **financial assets**	1	3	149	–	–	–	–
Total	12 179 025	13 143 437	15 069 261	16 793 654	16 927 870	18 016 512	19 232 174

Details of selected transfers and subsidies							
Households							
Social benefits							
Current	1	98	–	–	–	–	–
Employee social benefit	1	98	–	–	–	–	–
Provinces and municipalities							
Provinces							
Provincial Revenue Funds							
Current	8407 619	8876 104	9820 349	10616 568	11054 186	11960 723	12690 023
Health professions training and development grant	1679 061	1759 799	1865 387	1977 310	2076 176	2190 366	2321 788
National tertiary services grant	6134 084	6614 442	7398 000	8048 878	8878 010	9620 357	10168 235
Nursing colleges grant	–	–	–	–	100 000	150 000	200 000
Forensic pathology services grant	594 474	501 863	556 962	590 380	–	–	–
Capital	3695 616	4191 541	5169 855	5925 252	5724 576	5905 067	6392 699
Hospital revitalisation grant	2735 633	2989 139	3568 103	4220 790	4103 595	4183 933	4556 297
Health infrastructure grant	959 983	1202 402	1601 752	1704 462	1620 981	1721 134	1836 402
Higher education institutions							
Current	–	–	–	8 000	–	–	–
University of Witwatersrand	–	–	–	8 000	–	–	–
Households							
Other transfers to households							
Current	1	–	17	–	–	–	–
Employee social benefit	1	–	17	–	–	–	–

Expenditure trends

Expenditure increased from R 12.1 billion in 2008/09 to R16.7 billion in 2011/12, at an annual rate of 11.3 per cent. The growth was mainly in transfers and subsidies to the infrastructure grant to provinces. Over the medium term, spending is expected to increase to R19.2 billion, at an average annual rate of 4.6 per cent. Provinces reported under spending of R400 million fro the financial year to December 2011. The marginal growth in the programme in 2012/13 arises mainly from the phasing out of the forensic pathology conditional grant into provincial funding streams. R 450 million is allocated over the medium term for the upgrading of nursing colleges. The spending over the MTEF period will focus on health infrastructure planning across the provinces and strengthening tertiary services.

10 Programme 6: Health Regulation and Compliance Management

10.1 Programme Purpose:

Purpose: Regulates procurement of medicines and pharmaceutical supplies, including food control; trade in health products and health technology. Promotes accountability and compliance by regulatory bodies for effective governance and quality of health care.

There are six sub-programmes:

Food Control regulates foodstuffs and non-medical health products to ensure food safety by developing and implementing food control policies, norms and standards, and regulations.

Public Entities Management provides policy frameworks for health public entities with regard to planning, budgeting procedures, financial reporting and oversight, ownership, governance, remuneration and accountability.

Office of Standards Compliance deals with quality assurance, compliance with national standards and patient complaints; and radiation control.

Compensation Commissioner for Occupation Diseases and Occupational Health is responsible for the payment of benefits to active and ex-miners who have been certified to be suffering from lung related diseases as a result of the risk work they have performed in the mines or classified works. The focus over the medium term revolves around reengineering business processes around revenue to ensure sustainability, the reduction of the turnaround period in settling claims, amendments to the Occupational Diseases in Mines and Works Act (1973), and to improve governance, internal controls and relationships with the key stakeholders.

Pharmaceutical Trade and Product Regulation regulates the procurement of medicines and pharmaceutical supplies, and provides oversight of trade in health products to ensure access to safe and affordable medicines.

10.2 Strategic obejctives, Performance indicators and Annual targets for 2012/13 to 2014/15

The tables below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Health Regulation and Compliance Management

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
Improve the registration of medicines and reduce the time to market through reducing the backlog on medicine registrations by building in house capacity, training and aggressive recruitment of evaluators , clinical trial management and performing inspections on an ongoing basis.	Registration timelines of 12 months for NCE and 6 months for generics	-	Registration time lines of 36 months for NCE and 24 months for generics	Registration time lines of 32 months for NCE and 30 months for generics	Registration time lines of 30 months for NCE and 18months for generics	Registration time lines of 28months for NCE and 15months for generics	Registration time lines of 24 months for NCE and 12 months for generics	Registration time-lines of 24 months for NCEs and 12 months for generics
To improve oversight over the registration of Pharmaceutical and related products	Establish the Pharmaceutical and related product regulation and management authority	New Indicator	Ministerial task team appointed to assist with the establishment of the Pharmaceutical and related product regulations and management authority		Legislation finalised for the establishment of a new Regulatory Authority	Finalisation of amendments of legislation and publication of regulations thereto. Preparation of MCC to SAHPRA	Migration of the MCC to SAHPRA	Consolidation of regulations for all commodities regulated under SAHPRA
Improve the quality of health services	Establishment of an independent Office of Health Standards Compliance as a national quality certification body	New Indicator	New Indicator		National Health Amendment Bill promulgated. OHSC established	Functional Office of Health Standards Compliance	Functional Office of Health Standards Compliance	Functional Office of Health Standards Compliance
	% of complaints resolved within 25 days	-	25%	60%	60%	75%	80%	80%
	% of hospitals conducting a patient satisfaction survey at least once per year	-	-		60% of public sector hospitals	90% of 400 public sector hospitals	100% of 400 public sector hospitals	100% of 400 public sector hospitals
	No of health facilities assessed for compliance with the 6 priorities of the core standards	-	-	-	3 900 facilities assessed	20% (800) facilities assessed	40% (1600) facilities assessed	60% (2400) facilities) assessed

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To improve access to Benefit Medical Examination (BME) services for mineworkers	No of service provides offering BME	-	-	-	190	220	240	260
	No of mineworkers who undergo BME			15 000	16 500	18 000	20 000	22 000
Strengthening food control risk management measures related to development/ publication/ implementation of relevant national legislation, based on international standards adopted by the FAO/WHO Codex Alimentarius, where applicable	Nutrient profiling model available and implemented to evaluate health claims and determine foodstuffs with an unhealthy nutrient profile for listing in 2nd phase of labelling regulations	-	-	-	Nutrient profiling model available and tested in respect of the evaluation of health claims and to determine foodstuffs with an unhealthy nutrient profile	Nutrient profiling model finalized and development of 2nd Phase of labelling regulations commenced which will include measures related to the approval of health claims and listing of foodstuffs with an unhealthy nutrient profile	Nutrient profiling Model utilized for evaluation of health claims for approval and list of foodstuffs with an unhealthy nutrient profile drafted	Nutrient profiling Model utilized for evaluation of health claims for approval and list of foodstuffs with an unhealthy nutrient profile drafted
	5 sets of regulations drafted, published for comments and/ or final regulations published	10 sets of regulations drafted, published for comments and/or final regulations published	4 sets of regulations drafted, published for comments and/ or final regulations published	7 sets of regulations drafted, published for comments and/or final regulations published	5 sets of regulations drafted, published for comments and/or final regulations published	5 sets of regulations drafted, published for comments and/ or final regulations published	5 sets of regulations drafted, published for comments and/ or final regulations published	5 sets of regulations drafted, published for comments and/ or final regulations published

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
		2008/09	2009/10	2010/11		2012/13	2013/14	2014/15
To strengthen and facilitate good corporate and management governance of public entities and statutory health professional councils	Public health entities governance and management framework	New Indicator	New Indicator	New Indicator	Public health entities governance and management framework developed	Public health entities governance and management framework implemented and reports provided bi-annually	Public health entities governance and management framework implemented and reports provided bi-annually	Public health entities governance and management framework implemented and reports provided bi-annually
Monitor compliance and implementation of policies and legislative prescripts relevant to public entities	Public entities' quarterly compliance report	New Indicator	New Indicator	New Indicator	Public entities' quarterly compliance report guided by performance guidelines	Public entities' quarterly compliance report guided by performance guidelines	Public entities' quarterly compliance report guided by performance guidelines	Public entities' quarterly compliance report guided by performance guidelines
Establish a forum of statutory health professional council in terms of Section 50 of the National Health Act, 2003	Functional Forum of Statutory Health Professional Councils	New Indicator	New Indicator	New Indicator	Forum of Statutory Health Professional Councils (FSHPC) established	Bi-annual submission of functionality reports of the FSHPC	Bi-annual submission of functionality reports of the FSHPC	Bi-annual submission of functionality reports of the FSHPC
To strengthen Laboratory Services	Strategy for the reform of Laboratory Services	New Indicator	New Indicator	New Indicator	New Indicator	Strategy for the reform of laboratory services (Forensic Laboratories and NHLS) developed	Monitor the implentation of the stategy	Monitor the implementation of the strategy

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
Registration timelines of 12 months for NCE and 6 months for generics	Annual	Registration time lines of 28months for NCE and 15months for generics				
Establish the Pharmaceutical and related product regulation and management authority	Annual	Migration of the MCC to SAHPRA				
Establishment of an independent Office of Health Standards Compliance as a national quality certification body	Annual	Functional Office of Health Standards Compliance				
% of complaints resolved within 25 days	Annual	75%				
% of hospitals conducting a patient satisfaction survey at least once per year	Annual	90% of 400 public sector hospitals				
No of health facilities assessed for compliance with the 6 priorities of the core standards	Annual	20% (800) facilities assessed				
No of service providers offering BME	Quarterly	220	220	220	220	220
No of mine workers who undergo BME	Quarterly	18 000	450	450	450	450
Nutrient profiling model available and implemented to evaluate health claims and determine foodstuffs with an unhealthy nutrient profile for listing in 2nd phase of labelling regulations	Quarterly	Nutrient profiling model finalized and development of 2nd Phase of labelling regulations commenced which will include measures related to the approval of health claims and listing of foodstuffs with an unhealthy nutrient profile	Project of NWU to develop the model and supporting software completed and Nutrient profiling model available for application	Drafting of labelling regulations (2nd phase) commenced	Draft regulations as internal document available and circulated for further inputs	Draft regulations submitted to Legal Services for further processing and publication in the *Government Gazette* for publication

Performance indicator	Reporting period	Annual target 2012/13	Quarterly targets			
			1st	2nd	3rd	4th
5 sets of regulations drafted, published for comments and/or final regulations published	Quarterly	5 sets of regulations drafted, published for comments and/or final regulations published	1 set of regulations drafted, published for comments and/ or final regulations published	1 set of regulations drafted, published for comments and/ or final regulations published	1 set of regulations drafted, published for comments and/or final regulations published	2 sets of regulations drafted, published for comments and/or final regulations published
Public health entities governance and management framework	Bi-annual	Public health entities governance and management framework implemented and reports provided bi-annually		Public health entities governance and management report		Public health entities governance and management report
Public entities' quarterly compliance report	Quarterly	Public entities' quarterly compliance report guided by performance guidelines	Quarterly Compliance reports for public entities	Quarterly Compliance reports for public entities	Quarterly Compliance reports for public entities	Quarterly Compliance reports for public entities
Functional Forum of Statutory Health Professional Councils	Bi-annual	Bi-annual submission of functionality reports of the FSHPC		Report of FSHPC		Report of FSHPC
Strategy for the Laboratory Services	Annual	Strategy for the reform of Laboratory Services (Forensic Laboratories and NHLS developed)				

10.4 Reconciling Performance targets with the Budget and MTEF

Expenditure Estimates

Health Regulation and Compliance Management

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R thousand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Food Control	6 426	5 443	5 751	6 839	7 131	7 532	7 926
Pharmaceutical Trade and Product Regulation	50 232	55 179	67 681	79 537	83 124	89 448	93 670
Public Entities Management	315 909	334 628	406 340	364 913	380 220	410 168	431 440
Office of Standards Compliance	17 586	16 293	18 723	41 223	62 261	54 518	56 974
Compensation Commissioner for Occupational Diseases and Occupational Health	27 304	28 713	30 567	38 865	43 071	52 783	55 213
Total	417 457	440 256	529 062	531 377	575 807	614 449	645 223
Change to 2011 Budget estimate				5 536	3 774	13 508	8 543
Economic classification							
Current payments	97 175	100 051	117 729	162 956	192 561	201 555	211 222
Compensation of employees	56 107	64 031	71 059	84 995	98 408	103 543	109 019
Goods and services	41 068	36 020	46 670	77 961	94 153	98 012	102 203
of which:							
Consultants and professional services: Business and advisory services	*13 396*	*11 639*	*20 895*	*18 255*	*30 557*	*25 296*	*27 163*
Inventory: Medical supplies	*23*	*13*	*524*	*486*	*504*	*735*	*761*
Lease payments	*572*	*525*	*598*	*1 250*	*1 402*	*1 592*	*1 659*
Travel and subsistence	*16 058*	*11 824*	*13 444*	*26 640*	*27 972*	*30 350*	*31 155*
Transfers and subsidies	318 349	339 019	409 069	366 440	379 808	409 286	430 393
Departmental agencies and accounts	315 638	335 550	404 038	360 343	371 556	399 034	419 526
Non-profit institutions	2 626	2 757	4 922	6 097	8 252	10 252	10 867
Households	85	712	109	–	–	–	–
Payments for capital assets	1 885	1 184	2 121	1 981	3 438	3 608	3 608
Machinery and equipment	1 885	1 184	2 121	1 981	3 438	3 608	3 608
Payments for financial assets	48	2	143	–	–	–	–
Total	417 457	440 256	529 062	531 377	575 807	614 449	645 223

Details of selected transfers and subsidies

Households							
Social benefits							
Current	85	712	109	_	_	_	_
Employee social benefit	85	712	109	_	_	_	_
Departmental agencies and accounts							
Departmental agencies (non-business entities)							
Current	313 283	331 871	401 418	357 566	368 640	395 972	416 311
National Health Laboratory Services	70 623	76 475	120 309	82 167	84 640	88 873	93 317
South African Medical Research Council	236 509	251 531	281 109	271 205	279 690	302 574	318 243
Council for Medical Schemes	6 151	3 865	–	4 194	4 310	4 525	4 751
Non-profit institutions							
Current	2 626	2 757	4 922	6 097	8 252	10 252	10 867
Health Systems Trust	2 626	2 757	4 922	6 097	8 252	10 252	10 867
Departmental agencies and accounts							
Social security funds							
Current	2 355	3 679	2 620	2 777	2 916	3 062	3 215
Compensation Fund	2 355	3 679	2 620	2 777	2 916	3 062	3 215

Expenditure trends

Expenditure increased from R417.5 million in 2008/09 to R531.4 million in 2011/12, at an average annual rate of 8.3per cent, and is expected to increase over the medium term to R645.2 million, at an average annual rate of 6.7 per cent. The increase is partly due to the transfers to public entities. The largest spending increase over the MTEF period is in the Office of Standard compliance sub-programme to create an independent agency for quality assurance and accreditation of health facilities. There is also strong growth over the MTEF in Pharmaceutical Trade and Product regulation programme to reduce large backlogs in medicine registration and establish the South African Health Product Regulatory Authority.

PART C:
LINKS TO OTHER PLANS

11. CONDITIONAL GRANTS

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2012/13
Health Profession's Training & Development Grant	To support provinces to fund operational costs associated with training of health professionals; development and recruitment of medical specialists in under-served provinces; and support and strengthen undergraduate and post graduate teaching and training processes in health facilities	• Under graduate Students-	• 38149
		• Registrars-	• 1599
		• Expanded specialists and teaching infrastructure in target provinces	• 125 specialists
National Tertiary Services Grant	• To compensate tertiary facilties for the additional costs associated with the rendering of tertiary service provision and spill-over effects	• Inpatient separations • Day patient separations • In-patient days • Out-patient first attendance • Outpatient follow-up attendance	• There are no set targets for this grant as it funds recurrent activities with respect to the provision of tertiary services

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2012/13
Comprehensive HIV and AIDS Grant	• To enable the health sector to develop an effective response to HIV and AIDS including the universal access to HIV counselling & testing (HCT) • To support the implementation of the National Operational Plan for Comprehensive HIV and AIDS treatment and care • To subsidize in-part funding for antiretroviral treatment programme.	Number of individuals counselled and tested	18 million
		Number of MMC conducted	600 000
		Number of new patients initiated on ART	500 000

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2012/13
Hospital Revitalisation	• To provide funding to enable provinces to plan, modernise, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals; and to transform hospital management and improve quality of care in line with national policy objectives.	• Number of Hospitals receive funding from Hospital Revitalisation Grant	Compliance with the target set on approved 2012/13 Project Implementation Plans for: • 33 hospitals to be under construction • 22 hospitals to be on planning
		• Number of PPP Flagship Projects accepted	All five tertiary hospitals should complete the Feasibility study • Chris Hani Baragwanath Hospital • George Mukhari Hospital • Limpopo Academic Hospital • King Edward VIII Hospital • Nelson Mandela Academic Hospital

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2012/13
National Health Insurance	To implement the National Health Insurance (NHI) pilots in selected districts and central hospitals across the country as part of the phased implementation of NHI	A framework that: • Enhances managerial autonomy, delegation of functions and accountability in districts and health facilities • Provides for a scalable model, including the required institutional arrangements, for a district health authority (DHA) as the contracting agency. • Tests the linkage between health service management and administration and how it relates to the functions and responsibilities of DHAs • Provides models for contracting private providers that include innovative arrangements for harnessing private sector resources at a primary health care level • Provides for a rational referral system based on a re-engineered primary health care platform with a particular focus in rural and previously disadvantaged areas • Provides a model for revenue collection and management model for identified central hospitals	Frameworks and models for identified areas of NHI developed in 10 pilot districts

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2012/13
Nursing Colleges and Schools Grant	To supplement provincial funding of health infrastructure to accelerate the provisions of health facilities including office furniture and related equipment and also to ensure proper maintenance of provincial infrastructure for Nursing Colleges and Schools	Number of Nursing Colleges and schools, planned, designed, constructed, maintained and operationalized	As defined per provincial business plans

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