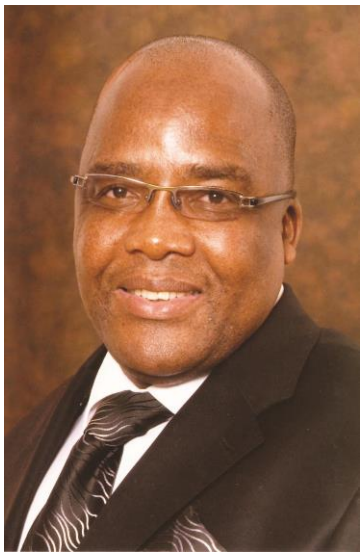
ANNUAL PERFORMANCE PLAN
2014/15 - 2016/17

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Contents



FOREWORD BY THE MINISTER

It is with a humble sense of pride that I endorse the Ministry of Health's Annual Performance Plan for 2014/2015. It documents the policy priorities the Ministry has set regarding its strategic direction for health care in South Africa for the next financial year.

This Annual Performance Plan has been developed in concert with the Government's national strategic policy document: the National Development Plan.

The six overall strategic objectives for *promoting health* in the NDP are as follows:

- Greater intersectoral and interministerial collaboration is central to promotion of health in South Africa;
- Health is not just a medical issue; the social determinants of health need to be addressed, including promoting health behaviours and lifestyles;
- A major goal is to reduce the disease burden to manageable levels;
- Human capacity is key; managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed;
- The national health system as a whole needs to be strengthened by improving governance and eliminating infrastructure backlogs;
- A national health insurance system needs to be implemented in phases, complemented by a reduction in the relative cost of private medical care and supported by better human capacity and systems in the public health sector.

The second of these reinforces our principal focus on primary and preventive health care services and the promotion of health. The fifth point relates to maintaining effective and efficient quality and safe clinical health care and rehabilitation services.

The major public health concerns are non-communicable diseases, emerging and re-emerging communicable diseases, maternal and child health, mental health and pandemics or other disasters affecting the health and well-being of the community. There are other environmental factors that have an impact on health such as climate change and these need appropriate consideration as well. A major focus is to operationalise these programmes at community level.

Serious operational programmes to control communicable diseases will be sustained. The arena of NCDs needs to be tackled by over arching Health Promotion in its entirety with seedling strategies to address diabetes, hypertension, cardiovascular diseases and cancer from within the sphere. Greater emphasis will continue to be on prevention and wellness rather than treatment. Without any serious action, the NCD epidemic is projected to kill over 60 million people annually by 2030 globally. We know that high blood pressure is the leading underlying cause of premature global deaths and a leading cause of disability adjusted life years (DALYs). Globally, 51 percent of deaths due to stroke (cerebrovascular disease) and 45 percent of deaths due to ischemic heart disease are attributable to high systolic blood pressure.

At any given age, the risk of dying from high blood pressure in low- and middle-income countries is more than double that in high-income countries. In the high-income countries, only 7 percent of deaths caused by high blood pressure occur under age 60. The World Health Organisation (WHO)

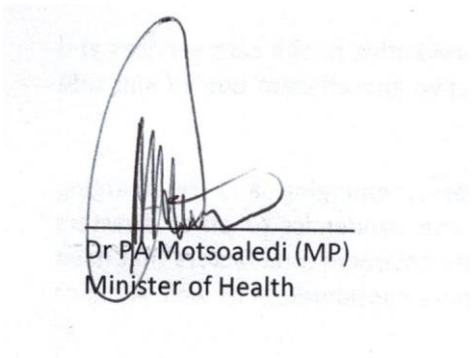
informs us that nearly 80 percent of current deaths due to non-communicable diseases occur in low- and middle-income countries.

There is abundant evidence on a causal relation between salt intake and high blood pressure. We will intensify our resolve to control the amount of salt in packaged and industry prepared food, and through our Health Promotion and Nutrition interventions, influence social behaviour to avoid excessive salt intake.

A focus on human resource development and staff retention will still be maintained and addressed in depth to meet the acute shortage of health professionals in the public sector –as this is vital to ensure sustainability in the delivery of health services to South Africans.

Patient satisfaction and quality of care remains areas of major concern. Increased output from the medical and nursing schools will address some of the work pressure. But we remain convinced that stewardship in the management of health facilities is critical in addressing these challenges.

I therefore invite all of our partners in health; NGO's, development partners, other ministries and the private sector to work closely with the Ministry of Health in achieving the strategic objectives cited in this plan as necessary steps towards the realisation of our country health objectives as enshrined in the National Development Plan.



Dr PA Motsoaledi (MP)
Minister of Health

STATEMENT FROM THE DIRECTOR-GENERAL

As the capstone of an ongoing planning process, this Annual Performance Plan describes broad-based Health Sector priorities that will guide programmes, policies, and initiatives through the next financial year.

This Annual Performance Plan is an important document in achieving the objectives of the health sector as articulated in Strategic Plan 2014-2019 and the National Development Plan through its ongoing health sector reforms. It builds on the experiences of the previous Plans, and provides continuity. Most of the strategies of the previous plan are updated in this plan, and new strategies are added, where appropriate.

In here, we have responded to the policy priorities of responsible, transparent and accountable management of health care resources and the related need to target resources to the most effective health care interventions. These important challenges require high quality data, research, deliberate service development strategies and a willingness to change. At the same time, the Plan has also responded to the community's reasonable expectation that quality of care will be continuously improved.

Equally as important, the Plan has been shaped by the characteristics and challenges of the country-wide communities we serve:
Response to these country-wide factors is evident in the stated priorities and objectives. This includes giving the highest priorities to health service and making major advances in the prevention and management of chronic illness. We want a healthier nation – a long and healthy life for all South Africans.
While the Department has taken responsibility to craft the Plan, the breadth of vision and inspiration for many of the objectives and actions has come from the accumulated experience and wisdom of our staff and clinicians, key stakeholders in the health sector, and consumers of our services.

This is not a plan for Health alone. The breadth of its vision and the expertise and resources required to implement it must involve partnerships with shared goals, mutual benefits and unambiguous responsibilities.

In the pages that follow, we describe the priorities and objectives that will turn our vision into a reality.
In addition, the Plan has been guided by:

- the policies of the our Government;
- the priorities identified in the National Development;
- the State of the Nation Address; and
- the changing health environment.

This strategic plan therefore, contributes to South Africa's efforts to reduce child and maternal mortality and to control communicable and non-communicable diseases, as well as, in its efforts to encourage South Africans to embrace healthy lifestyle. We believe that, the health sector can make an important contribution to the reduction of poverty and hunger in South Africa by ensuring that our nation is healthy. The Government of South Africa is fully committed to achieving the MDGs. Although in recent years, progress has been made in the reduction of child and infant mortality, the maternal and neonatal mortality remain, persistently high. There is still some hard work to be done.

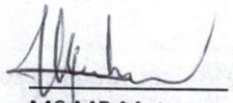
The health sector has to work in partnership with all government institutions that are responsible for services that have impact on health. Partnership with the private sector is also necessary, to increase accessibility and quality of health services. The private sector consists of all non-state actors. We believe that, by joining hands, with all that can provide services to improve the health of the people, is beneficial for the development of the Country.

Our Development Partners provide the health sector with the needed financial, technical and moral support. We will continue to strengthen our partnership with them

Important partners, who are also beneficiaries of the health services, are the communities and families, that have to take ownership of their own health, such as, healthy lifestyles, early treatment and adequate care at home, that can save many lives. All efforts in the health sector should be focused on mobilising them to collaborate for better health, starting from the level of the household.

Last but not least, our health workers, especially those who on a day-to-day basis, are in contact with patients and clients, are our partners and representatives. They represent the face of the health sector, create trust in the communities and deliver quality care, often at odd hours or in remote places. The Department will, therefore ensure that, good performance is achieved and better rewarded, and that, our health workers are motivated to achieve better health outcomes.

I would like to express my profound gratitude to all who contributed to the completion of this plan. The success of this plan relies on the continued commitment of all stakeholders, within the government, non-governmental organisations, partners and users of the services we provide.



MS MP Matsoso
Director General

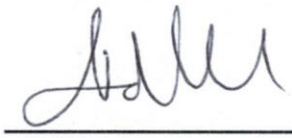
OFFICIAL SIGN OFF

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 is responsible.

Accurately reflects the performance targets which the National Department of Health will endeavor to achieve given the resources made available in the budget for 2014/15 financial year.

MR I VAN DER MERWE
Chief Financial Officer



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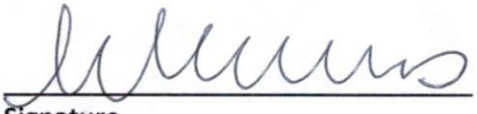
MS M WOLMARANS
Chief Director: Policy Co-ordination and Integrated Planning



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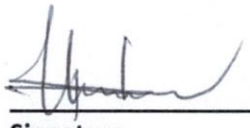
MS MP MATSOSO
Director-General



Signature

Approved by :

DR A MOTSOALEDI
Minister of Health

Signature

PART A
Strategic Overview

1. VISION

A long and healthy life for all South Africans

2. MISSION

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

3. LEGISLATIVE AND OTHER MANDATES

The legislative mandate of the Department of Health is derived from the Constitution, the National Health Act, 61 of 2003, and several pieces of legislation passed by Parliament.

3.1. Constitutional Mandates

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

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

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

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

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

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

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

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

(b) sufficient food and water; and

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

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

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

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

3.2. National Health Act, 61 of 2003

Provides a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objects of the National Health Act (NHA) are to:

- unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
- provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;
- establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourage participation;
- promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and
- create the foundations of the health care system, and must be understood alongside other laws and policies which relate to health.

3.3. Legislation falling under the Minister of Health's portfolio

- **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, and also provides for transparency in the pricing of medicines.

- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 (as amended)**

  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.

- **Hazardous Substances Act, 15 of 1973**

  Provides for the control of hazardous substances, in particular those emitting radiation.

- **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.

- **Pharmacy Act, 53 of 1974 (as amended)**

  Provides for the regulation of the pharmacy profession, including community service by pharmacists

- **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.

- **Dental Technicians Act, 19 of 1979**

  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

- **Allied Health Professions Act, 63 of 1982 (as amended)**

  Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.

- **Human Tissue Act, 65 of 1983**

  Provides for the administration of matters pertaining to human tissue.

- **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.

- **SA Medical Research Council Act, 58 of 1991**

  Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

- **Academic Health Centres Act, 86 of 1993**

  Provides for the establishment, management and operation of academic health centres.

- **Choice on Termination of Pregnancy Act, 92 of 1996 (as amended)**

  Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

- **Sterilisation Act, 44 of 1998**

  Provides a legal framework for sterilisations, including for persons with mental health challenges.

- **Medical Schemes Act, 131 of 1998**

  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

- **Tobacco Products Control Amendment Act, 12 of 1999 (as amended)**

  Provides for the control of tobacco products, the prohibition of smoking in public places and of advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry.

- **National Health Laboratory Service Act, 37 of 2000**

  Provides for a statutory body that offers laboratory services to the public health sector.

- **Council for Medical Schemes Levy Act, 58 of 2000**

  Provides a legal framework for the Council to charge medical schemes certain fees.

- **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 an emphasis on human rights for mentally ill patients.

- **Nursing Act, of 2005**

  Provides for the regulation of the nursing profession.

3.4. Other legislation in terms of which the Department operates

- **Criminal Procedure Act, Act 51 of 1977, Sections 212 4(a) and 212 8(a).**

  Provides for establishing the cause of non-natural deaths.

- **Child Care Act, 74 of 1983**

  Provides for the protection of the rights and well-being of children.

- **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.

- **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, and for death resulting from such injuries or disease.

- **The National Roads Traffic Act, 93 of 1996**

  Provides for the testing and analysis of drunk drivers.

- **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.

- **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.

- **Skills Development Act, 97of 1998**

  Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.

- **Public Finance Management Act, 1 of 1999**

  Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

- **Promotion of Access to Information Act, 2 of 2000**

  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

- **Promotion of Administrative Justice Act, 3 of 2000**

  Amplifies the constitutional provisions pertaining to administrative law by codifying it.

- **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.

- **The Division of Revenue Act, 7 of 2003**

  Provides for the manner in which revenue generated may be disbursed.

- **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.

3.5. Planned policy initiatives

3.5.1. Facilitate Implementation of National Health Insurance (NHI)

South Africa is at the brink of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system in order to realize universal health coverage. The phase implementation of National Health Insurance (NHI) is intended to bring about these changes and is expected to have to ensure integrated financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable and quality health services.

To achieve Universal Health Coverage (UHC), institutional and organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered; and ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups.

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

As part of the initial 5 year preparatory work to improve health systems performance, interventions to improve service delivery and provision are being implemented at all levels of the health system.

The focus areas of these interventions include (i) improving the management of health facilities; (ii) improving throughput from training institutions to address key Human resources for Health requirements; (iii) strengthening infrastructure programme and procurement of equipment; (iv) health information systems and technology; (v) rationalising of laboratory services; (vi) effective and integrated procurement of Health Commodities; (vii) the implementation and compliance of National Quality Standards for Health; (viii) Re-engineering of Primary Health Care; (ix) the contracting of General Practitioners to strategically render health services in identified facilities; (x) restructuring and improving the provision of Occupational Health, Mental Health, Disability and Emergency Medical Services as part of the comprehensive health entitlements that will be covered by the NHI Fund.

3.5.2. Establishment of the Office on Health Standards Compliance

On 29 January 2014 Minister Aaron Motsoaledi inaugurated the board of the newly established Office of Health Standards Compliance, a statutory body created through the amendment of the National Health Act to monitor compliance with norms and standards for healthcare delivery.

The 12-member board consists of healthcare professionals, academics and activists. The establishment of the Office of Health Standards Compliance is another step towards realising universal healthcare coverage and improving the quality of care in SA.

At the base level, the Office of Health Standards Compliance will inspect public hospitals for six basic health standards — cleanliness, infection control, attitude of staff, safety and security of staff and patients, waiting times and drug stock-outs. It will also have an ombudsman, which will make it possible for patients to complain about healthcare institutions.

3.5.3. South Africa Health Products Regulatory Authority (SAHPRA)

The Medicines and Related Substances amendment bill to create the South African Health Products Regulatory Authority (SAHPRA) was submitted to parliament.

The proposal is to bring the medical devices industry, cosmetics and foodstuffs as well as pharmaceuticals under the jurisdiction of the SAHPRA. The SAHPRA will be established as an organ of State within the public service and would thus be able to regulate its own income.

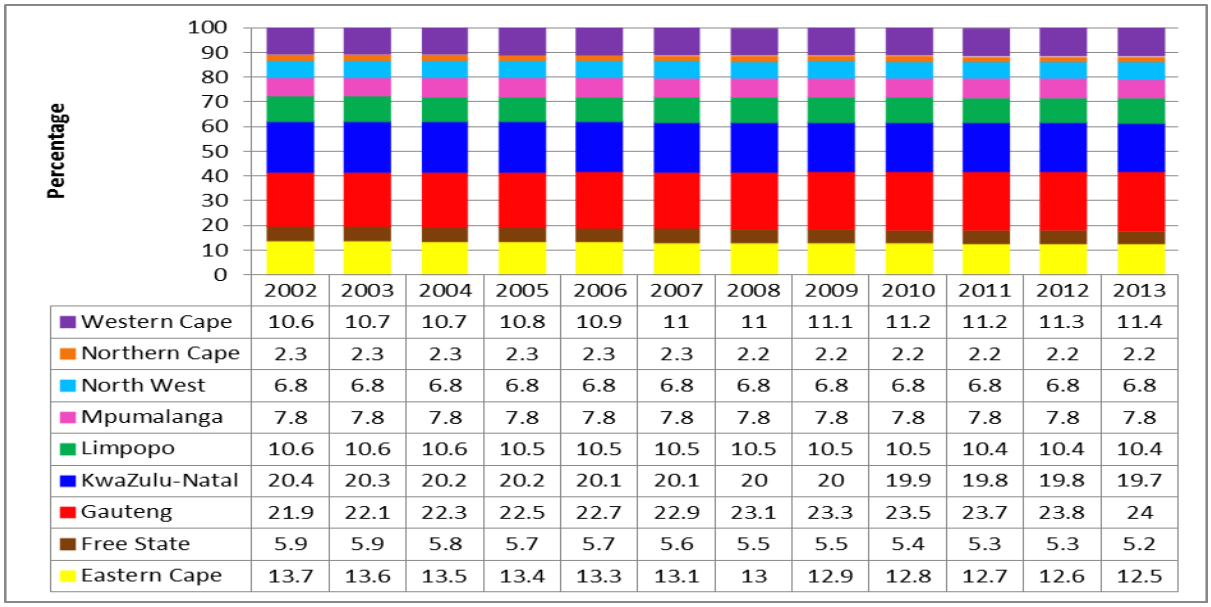
4. SITUATIONAL ANALYSIS

4.1. Demographic Profile

For 2013, Statistics South Africa (StatsSA) estimates the mid-year population as 52, 98 million. Figure 1 displays the percentage distribution of the projected provincial share of the total population according to the 2013 midyear estimates. Gauteng comprises the largest share of

the South African population. Approximately 12.7 million people (24%) live in this province. KwaZulu-Natal is the province with the second largest population, with 10.5 million people (19.7%) living in this province. With a population of approximately 1.16 million people (2.2%), Northern Cape remains the province with the smallest share of the South African population.

In terms of migrating patterns between provinces, there has been a gradual outflow of population in 5 provinces with 2 provinces that had no change. Gauteng and Western Cape experienced a significant population influx between 2002 and 2013.



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Western Cape	10.6	10.7	10.7	10.8	10.9	11	11	11.1	11.2	11.2	11.3	11.4
Northern Cape	2.3	2.3	2.3	2.3	2.3	2.3	2.2	2.2	2.2	2.2	2.2	2.2
North West	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8
Mpumalanga	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8
Limpopo	10.6	10.6	10.6	10.5	10.5	10.5	10.5	10.5	10.5	10.4	10.4	10.4
KwaZulu-Natal	20.4	20.3	20.2	20.2	20.1	20.1	20	20	19.9	19.8	19.8	19.7
Gauteng	21.9	22.1	22.3	22.5	22.7	22.9	23.1	23.3	23.5	23.7	23.8	24
Free State	5.9	5.9	5.8	5.7	5.7	5.6	5.5	5.5	5.4	5.3	5.3	5.2
Eastern Cape	13.7	13.6	13.5	13.4	13.3	13.1	13	12.9	12.8	12.7	12.6	12.5

Figure 1: South Africa's Mid-year Population Estimates for 2013 (Source: Mid-year population estimates 2013 (StatsSA, May 2013)

The age specific population estimates for South Africans in 2001 and 2011 are compared in the population pyramids for Census 2001 and Census 2011 in the table above and the graphs below. The population increased from 44,909,750 in 2001 to 51,770,750 in 2011. There is a noticeable difference in the age groups younger than 15 years and age groups 20-29 years. In Census 2001, 34.9% (15.6 million) of the population were aged younger than 15 years compared to Census 2011 where 29.2% (15.1 million) of the population were aged younger than 15 years. In Census 2001, 19% (8.5 million) of the population were aged 20-29 years compared to Census 2011 where 20% (10.4 million) of the population were aged 20-29 years.

In 2011 Census approximately fifty-one per cent (approximately 27.16 million) of the population is female and approximately 7.8% (4.15 million) is 60 years or older.

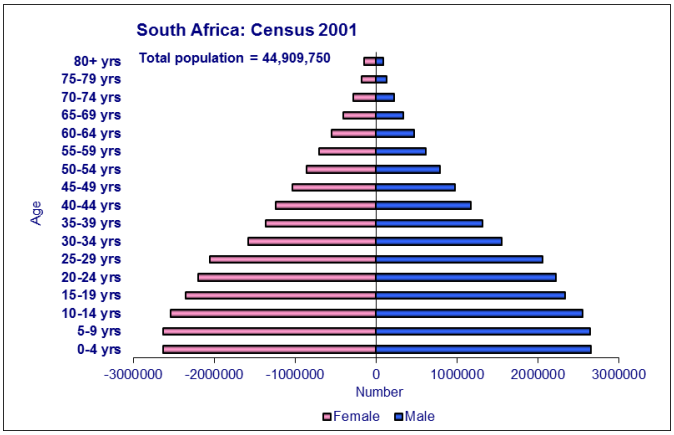


Figure 3: South Africa's Mid-year Population Estimates for 2011 Source: Census 2011 (StatsSA)

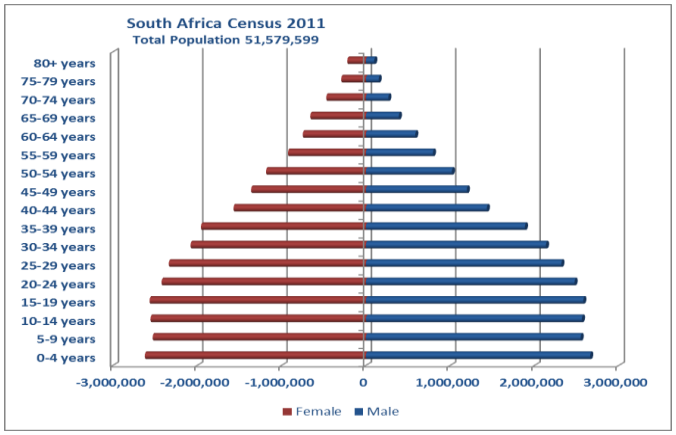


Figure 2: South Africa's Mid-year Population Estimates for 2001 Source: Census 2001 (StatsSA)

4.2. Social Determinants of Health

Progress is being made towards providing basic services that are social determinants of health[1]. These include the following basic services: no-fee paying schools; social grants; RDP housing; provision of basic and free services such are reticulated water; electricity; sanitation and sewerage and free primary health care. Results towards the social determinants include:

a) a decline in the proportion of the population living below the poverty line – based on diverse measures of poverty;
b) provision of basic services to indigent households as follows:

Free water	71,6%
Electricity	59,5%
Sewerage and sanitation	57,9%
Solid waste management	54,1%

c) Improved availability of data has resulted in better targeting with 3,5million households being identified as indigent;
d) Progress has also been made towards achieving universal primary education[2] with
   - Adjusted net enrolment ratios in primary education increased from:
     - 96,5% in 2002 to 98,9% in 2013 for males;
     - 96,8% in 2002 to 99,2% in 2013 for females;
   - Proportion of learners starting Grade 1 who reach last grade of Primary School increased from:
     - 89,2% in 2002 to 93,4% in 2013 for males;
     - 90,1% in 2002 to 96,1% in 2013 for females;
     - Literacy rate of 15 to 24 year olds increased from:
     - 83,3% in 2002 to 90,7% in 2013 for males; and

[1] Development Indicators 2012; South Africa's MDG Country Report 2013
[2] South Africa's MDG Country Report 2013

- 88,4% in 2002 to 94,6% in 2013 for females.

4.3. Epidemiological Profile

South Africa's Millennium Development Goals 2013 Country Report indicates that some key interventions impacted on the epidemiological profile and that social determinants of health needs to be addressed to reach the desired future state of health of South Africans.

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, South Africans also continue to have a significant burden of communicable diseases (mainly HIV, AIDS and TB), in conjunction with chronic diseases.

The life expectancy of South Africans for both males and females has improved between 2009 and 2011 while premature mortality has decreased for both males and females during the same period (see Table 1 below).

Table 1: Life Expectancy and Adult Mortality (Source: MRC, Rapid Mortality Surveillance Report 2011)

Indicator	Baseline	Progress	
	2009	2010	2011
Life expectancy at birth: **Total**	56.5	58.1	60.0
Life expectancy at birth: **Male**	54.0	55.5	57.2
Life expectancy at birth: **Female**	59.0	60.8	62.8
Adult mortality (45q15): **Total**	46%	43%	40%
Adult mortality (45q15): **Male**	52%	49%	46%
Adult mortality (45q15): **Female**	40%	37%	34%

This is also evident in the StatsSA 2013, midyear population estimates, where the average Provincial life expectancy at birth has increased for both males and females in all the provinces and has reached 57.7 years and 61.4 years for males and females respectively in 2013 as illustrated in Table 2 below. Free State province has the lowest life expectancy and Western Cape the highest amongst the nine provinces.

Table 2: Life Expectancy 2001 -2013 Source: Mid-year population estimates 2013 (StatsSA, May 2013)

Province	2001-2006		2006-2011		2011-2016	
	Males	Females	Males	Females	Males	Females
Eastern Cape	47.40	51.60	49.80	55.50	53.70	59.30
Free State	41.90	46.00	45.90	49.80	49.60	52.90
Gauteng	53.70	58.10	57.70	60.80	61.70	63.30
KwaZulu-Natal	45.70	51.00	50.00	55.20	53.40	58.70
Limpopo	51.20	59.00	55.40	60.80	59.00	63.80
Mpumalanga	48.50	53.00	51.80	56.60	55.90	60.10
North West	46.00	49.50	49.90	54.30	55.90	58.90

Northern Cape	49.70	55.90	52.20	57.90	54.90	60.10
Western Cape	56.60	63.70	60.60	66.10	64.20	70.10
ZA	**50.0 (2006)**	**55.20 (2006)**	**50.2 (2011)**	**54.6 (2011)**	**57,7 (2013)**	**61,4 (2013)**

Table 3: Births and deaths for the period 2002–2013 (Source: StatsSA, Statistical Release P0302, Mid-year population estimates 2013)

Year	Number of births	Total number of deaths	Total number of AIDS deaths	Percentage AIDS deaths
2002	1 117 731	636 416	257 394	40,4
2003	1 119 820	674 281	295 237	43,8
2004	1 105 534	703 651	325 405	46,2
2005	1 095 999	722 075	344 657	47,7
2006	1 092 768	701 001	324 192	46,2
2007	1 098 959	657 051	280 098	42,6
2008	1 107 603	618 324	240 309	38,9
2009	1 114 301	591 135	211 903	35,8
2010	1 123 409	580 673	201 174	34,6
2011	1 109 926	579 371	200 259	34,6
2012	1 095 669	572 600	191 620	33,5
2013	1 084 397	559 631	178 373	31,9

Years of Life Lost (YLLs) are an estimate of premature mortality based on the age at death and thus highlight the causes of death that should be targeted for prevention. The four leading single causes of YLLs in South Africa TB, pneumonia, diarrhoea and heart disease. The 3 main causes of death are all linked to HIV and this suggests that HIV-related mortality is by far the leading cause of YLLs in the majority of districts in South Africa.

Table 4: Summary of key health outcomes 2002 to 2013 (Source: Statistics South Africa (2013a); Statistical release P0302. Mid-year population estimates, 2013)

Year	Crude birth rate	Total fertility rate	Life expectancy at birth			Infant mortality rate	Under 5 mortality rate	Crude death rate	Rate of natural increase %
			Male	Female	Total				
2002	24,5	2,71	50.0	55.2	52.7	63.5	92.9	13.9	1.06
2003	24,2	2.68	49.5	54.4	52.1	62.6	91.9	14.6	0.96
2004	23.6	2.61	49.3	53.9	51.7	60.1	89.3	15.0	0.86
2005	23.1	2.56	49.4	53.6	51.6	58.0	85.4	15.2	0.79
2006	22.8	2.53	50.2	54.6	52.5	55.6	80.9	14.6	0.82
2007	22.6	2.53	51.7	56.1	54.0	53.6	76.7	13.5	0,91

Year	Crude birth rate	Total fertility rate	Life expectancy at birth			Infant mortality rate	Under 5 mortality rate	Crude death rate	Rate of natural increase %
			Male	Female	Total				
2008	22.5	2.52	53.3	57.6	55.5	50.8	72.3	12.6	0.99
2009	22.3	2.51	54.6	58.8	56,8	49.1	68.5	11.8	1.05
2010	22.2	2.50	55.5	59.5	57.6	47.1	65.2	11.5	1.07
2011	21.6	2.44	56.1	60.0	58.1	45.1	62.1	11.3	1.03
2012	21.0	2.39	56.8	60.5	58.7	43.5	59.5	11.0	1.00
2013	20.5	2.34	57.7	61.4	59.6	41.7	56.5	10.6	0.99

4.4. HIV/AIDS and TB

South Africa is experiencing serious generalised HIV and TB epidemics. It continues to be home to the world's largest number of people living with HIV, estimated to be 6.4 million in 2012 (Spectrum policy modelling system, Statistics South Africa 2013). The country also ranks third among countries with the highest burden of TB in the world after India and China (WHO 2012). Levels of HIV and TB co-infection are very high, with as many as 60% of patients having HIV-associated TB. There is also increasing incidence of multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB.

The estimated national HIV prevalence among the general adult population (15-49 years old) has remained stable at around 17.3% since 2005. The evolution of HIV prevalence among women presenting for antenatal care has been routinely measured since 1990, and has stabilised at about 29% since 2004.

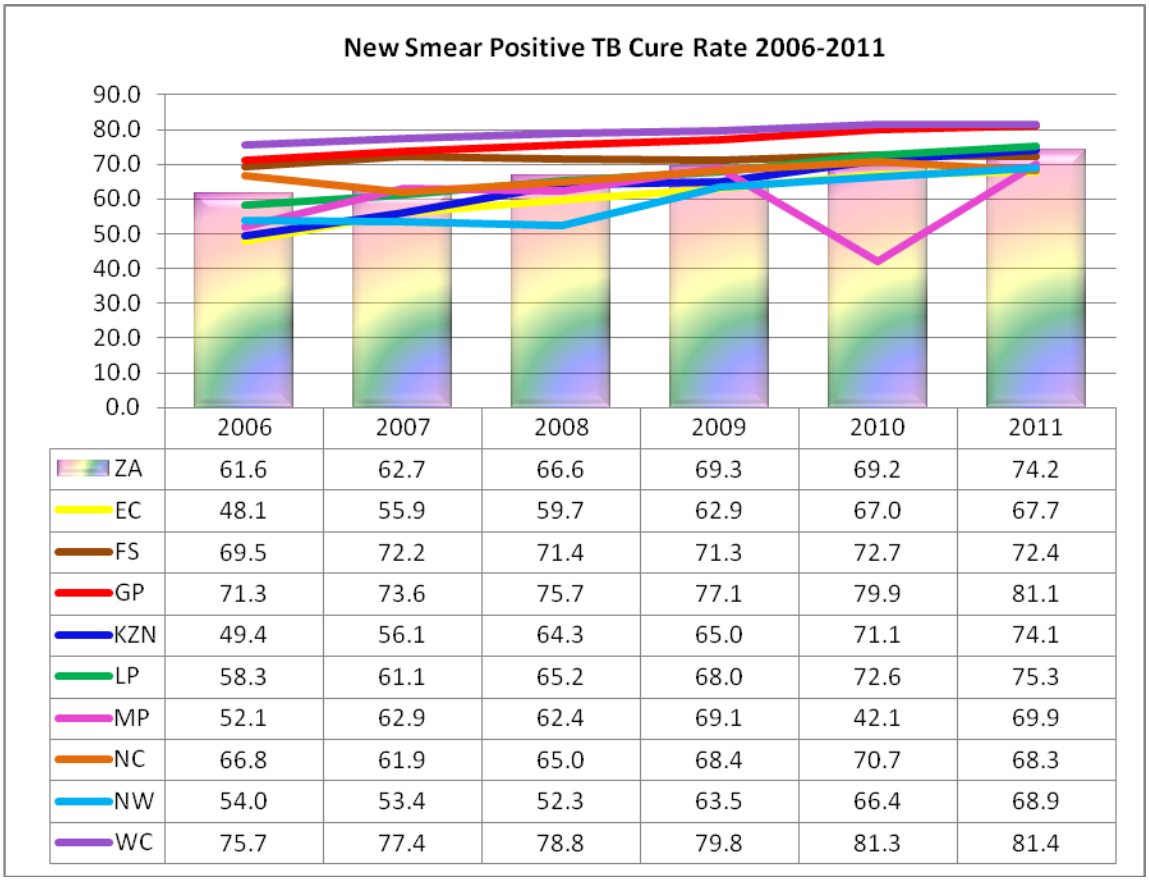
There were more than 389 000 new tuberculosis cases reported in 2011. The 2012 Global WHO TB report indicates that, even though notified cases have been declining since 2009, South Africa still has one of the highest TB incidence rates in the world at 993 cases per 100 000 population. Case detection rates increased between 2007 and 2009 and currently stand at 69% relative to the 70% global target. However, there are still many missed opportunities to identify and treat existing cases to curb transmission at community level.

The National Department of Health commissioned a Joint Review of the HIV, TB and PMTCT Programmes to be undertaken in 2013. The main purpose was to assess performance of the programmes and provide options for improvement. It was an independent Review carried out by a multi-disciplinary team of reviewers from both inside and outside the country.

The Joint Review found that the country had made impressive strides in the implementation of HIV, TB and PMTCT programmes during the period since the previous reviews were conducted in 2009. Most of the key recommendations from the 2009 TB and HIV reviews appear to have been taken into consideration in on-going programme development and contributed to rapid scale up of key interventions. The impact of these efforts is also beginning to show in declining numbers of new HIV infections, TB infections and low rates of new infections in children. HIV and TB mortality is declining, with a corresponding decline in all natural cause mortality. Maternal mortality, though, appears to be increasing.

There has been rapid scale up of ART services resulting in a four-fold increase in the number of people receiving ART between 2009 and 2012. The HIV Counselling and Testing (HCT) campaign resulted in about 15-20 million tests for HIV and over three million people screened for TB. There is universal coverage of PMTCT services. TB case detection has increased and the number of sites initiating MDR-TB treatment has increased from 11 to 45. The Department of Health (DOH) appears to be on course to meeting its targets as defined in the National Strategic Plan on HIV, STIs and TB (2012-2016).

Tuberculosis remains a significant public health problem in the country. The cure rate for new pulmonary smear-positive TB patients has increased over the last six years from 61.6% in 2006 to 74.2% in 2011. The cure rate in all provinces improved over the last year, except in the Northern Cape where the rate dropped from 70.7% in 2010 to 68.3% in 2011



	2006	2007	2008	2009	2010	2011
ZA	61.6	62.7	66.6	69.3	69.2	74.2
EC	48.1	55.9	59.7	62.9	67.0	67.7
FS	69.5	72.2	71.4	71.3	72.7	72.4
GP	71.3	73.6	75.7	77.1	79.9	81.1
KZN	49.4	56.1	64.3	65.0	71.1	74.1
LP	58.3	61.1	65.2	68.0	72.6	75.3
MP	52.1	62.9	62.4	69.1	42.1	69.9
NC	66.8	61.9	65.0	68.4	70.7	68.3
NW	54.0	53.4	52.3	63.5	66.4	68.9
WC	75.7	77.4	78.8	79.8	81.3	81.4

Figure 4: TB cure rate 2006-2011 (Source DHB 2012/13)

South Africa's TB epidemic is worsened by poor adherence as a result of patients not being initiated on, or lost to treatment. Resultantly, they expand the pool of infection, and also develop resistance to "normal" treatment, requiring much more complex and expensive forms of treatment.

Table 5: TB Indicators

Period	TB case notification	Successful treatment rate	Cure rate	Defaulter Rate
2000	151 239	63	54	13
2001	188 695	61	50	11
2002	224 420	63	50	12
2003	255 422	63	51	11
2004	279 260	66	51	10
2005	302 467	71	58	10
2006	341 165	73	62	9
2007	336 328	71	63	8
2008	340 559	71	69	8
2009	406 082	74	67	8
2010	401 048	79	71	7
2011	389 974	79	73	6,1

The number of patients receiving ART in SA has increased exponentially between 2004 and 2011, with women and users of the public sector gaining greater access to ART.

Table 6: Improved Access to ART (Source: Johnson, LF (2012): Access to Antiretroviral Treatment in South Africa, 2004 – 2011, Southern African Journal of HIV Medicine)

Currently on ART	2004	2005	2006	2007	2008	2009	2010	2011
Total	47 500	110 900	235 000	382 000	588 000	912 000	1 287 000	1 793 000*
By Gender								
Men	17 700	37 500	75 000	120 000	183 000	283 000	396 000	551 000
Women	25 600	63 600	138 000	228 000	354 000	553 000	777 000	1 090 000
Children (<15)	4 200	9 800	22 000	35 000	51 000	76 000	113 000	152 000
By provider								
Public sector	9 600	60 600	163 000	290 000	470 000	748 000	1 073 000	1 525 000
Private sector	34 100	43 800	57 000	68 000	86 000	117 000	154 000	190 000
NGOs	3 900	6 400	15 000	24 000	32 000	47 000	60 000	78 000

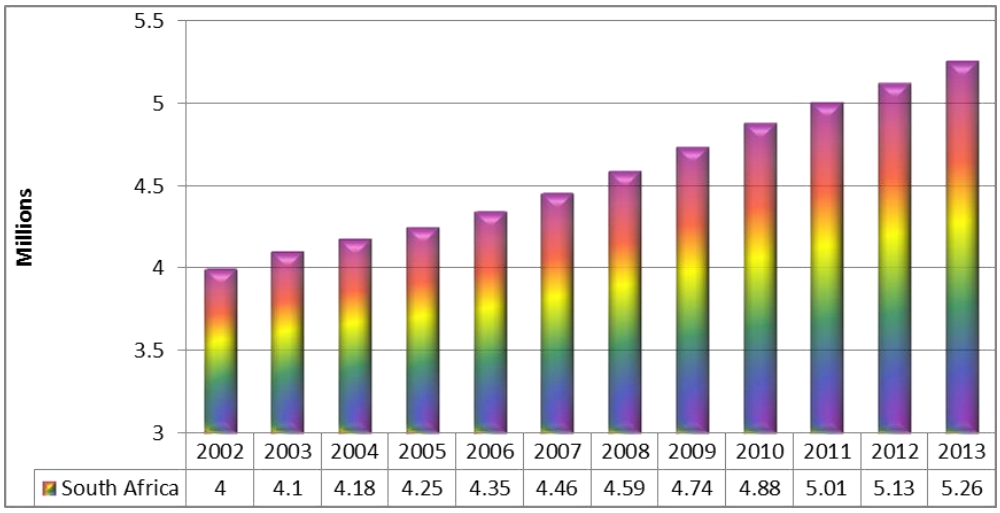


Figure 5: Estimated number of people living with HIV 2002-2013 (Source: Source: StatsSA, Statistical Release P0302, Mid-year population estimates 2013)

The total number of persons living with HIV in South Africa increased from an estimated 4 million in 2002 to 5.26 million by 2013. For 2013 an estimated 10% of the total population is HIV positive. Shisana, et al (2009) estimated the HIV prevalence for 2008 at 10.9%. Approximately 17% of South African women in their reproductive age are HIV positive.

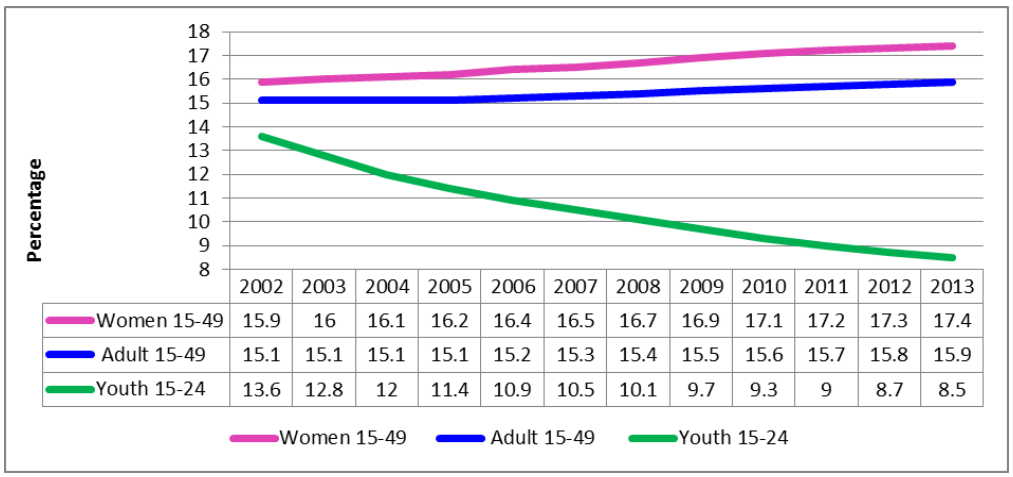


Figure 6: HIV prevalence rate in for women and men 15-49 years as well as Youth 14-24 years in South Africa from 2002 to 2013 (Source: Source: StatsSA, Statistical Release P0302, Mid-year population estimates 2013)

4.5. Maternal and Child Health

The Rapid Mortality Surveillance Report 2011 reflects that:

- The Under-5 mortality rate (U5MR) has decreased from 56 deaths per 1,000 live births in 2009, to 42 deaths per 1,000 live births in 2011. The NSDA target for 2014 was 50 deaths per 1,000 live births.
- The Infant Mortality Rate (IMR) has decreased from 40 deaths per 1,000 live births in 2009, to 30 deaths per 1,000 live births in 2011. The NSDA target for 2014 was 36 deaths per 1,000 live births.
- The Neonatal Mortality Rate (NMR) has remained stable at 14 deaths per 1,000 live births between 2009 and 2011. The NSDA target for 2014 is 12 deaths per 1,000 live births.

Table 7: IMR, U5-MR and MMR progression (Source: Medical Research Council, Rapid Mortality Surveillance Reports, 2011)

Health indicator	Source[1]	Baseline (2009) [1]	NSDA Target (2014) [1]	Progress
Maternal Mortality Ratio	Vital Registration Data Birth estimates from Actuaries Society of South Africa (ASSA) 2008	310 per 100 000 live births (2008)	270 per 100 000 live births	269 [3]
Infant Mortality Rate	Deaths from the national population register. Birth estimates from ASSA 2008	40 per 1000 live births	36 per 1 000 live births	30 per 1 000 live births[2]
Under five Mortality Rate		56 per 1000 live births	50 per 1 000 live births	45 per 1 000 live births[2]
Life expectancy	Deaths from the national population register. Population estimates from ASSA2008	56.5 years 54 years for males 59 years for females	58.5 years 56 years for males 61 years for females	59.6 years[2] 56.9 years for Males[2] 62.4years for females[2]

[1]: *Source: Health Data Advisory and Co-ordination committee report (Published: February 2012)*
[2]: *Source: Rapid Mortality Surveillance Report 2011 (Published: August 2012)*
[3]: *Source : Causes of Death s data from Civil Registration and Vital Statistics System (CRVS*

Institutional Maternal Mortality Ratio (MMR) reflects a downward trend between 2008 and 2012 nationally, and specifically in seven of the Provinces (see Table 8).

Table 8: Institutional Maternal Mortality Ratio (Source: National Committee of Confidential Enquiry into Maternal Deaths)

Province	2008	2009	2010	2011	2012
Eastern Cape	180.4	215.2	197.0	158.26	146.44
Free State	267.0	350.9	263.5	240.0	124.54
Gauteng	136.0	160.2	159.2	121.45	142.52
KZN	183.8	194.2	208.7	186.74	160.33
Limpopo	176.6	160.4	166.7	195.5	185.8
Mpumalanga	179.8	159.4	218.6	190.13	173.76
North West	161.7	279.5	256.1	153.75	127.76
Northern Cape	274.4	251.8	267.4	191.10	149.33
Western Cape	61.8	113.1	88.0	64.81	78.64
South Africa	164.8	188.9	186.2	159.14	146.71

4.6. Violence and Injuries

Violence and injuries forms one of the four components of the quadruple burden of disease that South Africa faces. SA has an injury death rate of 158 per 100 000, which is twice the global average

of 86,9 per 100 000 population and higher than the African average of 139,5 per 100 000[3]. Key drivers of the injury death rates are:

- intentional injuries due to interpersonal violence (46% of all injury deaths);
- road traffic injuries (26%);
- suicide (9%);
- fires (7%);
- drowning (2%),
- falls (2%) and
- poisoning (1%)3.

A need exists to implement a comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate.

4.7. Non-Communicable Diseases (NCDS)

Increased prevalence of NCDs globally and in South Africa, is contributing at least 33% to the burden of diseases. Common risk factors for NCDs include tobacco use; physical inactivity; unhealthy diets, and harmful use of alcohol. South African National Health and Nutrition Examination Survey (SANHANES)-1 published by the HSRC in 2013 reflects that government's tobacco control policy has succeeded in reducing adult smoking by half, from 32% in 1993 to 16,4% in 2012s. However, SANHANES-1 also reflects that:

- 29% of adults were exposed to 'environmental tobacco smoke' i.e. non-smokers who inhaled other people's cigarette smoke;
- high prevalence of pre-hypertension as well as hypertension amongst survey participants; and
- Low levels of physical activity or aerobic fitness amongst the population aged 18-40 years, with 45,2% of females and 27,9% of males found to be unfit.

5. STRATEGIC FRAMEWORK 2014-2019

5.1. Strategic Approach

Despite efforts to transform the health system into an integrated, comprehensive national health system, and significant investment and expenditure, the South African health sector has largely been beset by key challenges inclusive of:

(a) a complex, quadruple burden of diseases;
(b) serious concerns about the quality of public health care;
(c) an ineffective and inefficient health system; and
(d) spiralling private health care costs.

Both the National Development Plan (NDP) 2030 and the World Health Organization (WHO) converge around the fact that a well-functioning and effective health system is important bedrock for the attainment of the health outcomes envisaged in the NDP 2030. The trajectory for the 2030 vision, therefore, commences with strengthening of the health system, to ensure

[3] National DoH and Health Policy Initiative, 2012

that it is efficient and responsive, and offers financial risk protection. The critical focus areas proposed by the NDP 2030 are consistent with the WHO perspective.

The implementation of the strategic priorities for steering the health sector towards Vision 2030, would continue to be managed by the Implementation Forum for Outcome 2: "A long and healthy life for all South Africans", which is the National Health Council (NHC). This Implementation Forum consists of the Minister of Health and the 9 Provincial Members of the Executive Council (MECs) for Health. The Technical Advisory Committee of the NHC (TAC-NHC) functions as the Technical Implementation Forum. The TAC-NHC consists of the Director-General of the National Department of Health (DoH) and the Provincial Heads of Department (HoDs) of Health in the 9 Provinces.

5.2. National Development Plan 2030 vision

The National Development Plan (NDP) sets out nine (9) long-term health goals for South Africa. Five of these goals relate to improving the health and well-being of the population, and the other four deals with aspects of health systems strengthening.

By 2030, South Africa should have:

1. Raised the life expectancy of South Africans to at least 70 years;
2. Progressively improve TB prevention and cure
3. Reduce maternal, infant and child mortality
4. Significantly reduce prevalence of non-communicable diseases
5. Reduce injury, accidents and violence by 50 percent from 2010 levels
6. Complete Health system reforms
7. Primary healthcare teams provide care to families and communities
8. Universal health care coverage
9. Fill posts with skilled, committed and competent individuals

5.3. Priorities to achieve Vision 2030

The NDP 2030 states explicitly that there are no quick fixes for achieving the nine goals outlined above. The NDP also identifies a set of nine (9) priorities that highlight the key interventions required to achieve a more effective health system, which will contribute to the achievement of the desired outcomes. The priorities are as follows:

a. Address the social determinants that affect health and diseases
b. Strengthen the health system
c. Improve health information systems
d. Prevent and reduce the disease burden and promote health
e. Financing universal healthcare coverage
f. Improve human resources in the health sector
g. Review management positions and appointments and strengthen accountability mechanisms
h. Improve quality by using evidence
i. Meaningful public-private partnerships

5.4. Alignment between NDP Goals, Priorities and NDoH Strategic Goals

NDP Goals 2030	NDP Priorities 2030	NDoH Strategic Goals 2014- 2019
Average male and female life expectancy at birth increased to 70 years	a. Address the social determinants that affect health and diseases	Prevent disease and reduce its burden, and promote health;
Tuberculosis (TB) prevention and cure progressively improved;		
Maternal, infant and child mortality reduced	d. Prevent and reduce the disease burden and promote health	
Prevalence of Non-Communicable Diseases reduced		
Injury, accidents and violence reduced by 50% from 2010 levels		
Health systems reforms completed	b. Strengthen the health system	Improve health facility planning by implementing norms and standards;
		Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms;
	c. Improve health information systems	Develop an efficient health management information system for improved decision making;
	h. Improve quality by using evidence	Improve the quality of care by setting and monitoring national norms and standards, improving systems for user feedback, increasing safety in health care, and by improving clinical governance
Primary health care teams deployed to provide care to families and communities		Re-engineer primary healthcare by: increasing the number of ward based outreach teams, contracting general practitioners, and district specialist teams; and expanding school health services;
Universal health coverage achieved	e. Financing universal healthcare coverage	Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation;
Posts filled with skilled, committed and competent individuals	f. Improve human resources in the health sector	Improve human resources for health by ensuring adequate training and accountability measures.
	g. Review management positions and appointments and strengthen accountability mechanisms	

5.5. STRATEGIC GOALS OF THE DEPARTMENT

The Department's five year strategic goals are to:

- Prevent disease and reduce its burden, and promote health;
- Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation;
- Re-engineer primary healthcare by: increasing the number of ward based outreach teams, contracting general practitioners, and district specialist teams; and expanding school health services;
- Improve health facility planning by implementing norms and standards;
- Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms;
- Develop an efficient health management information system for improved decision making;
- Improve the quality of care by setting and monitoring national norms and standards, improving system for user feedback, increasing safety in health care, and by improving clinical governance;
- Improve human resources for health by ensuring adequate training and accountability measures.
-

6. ORGANISATIONAL ENVIRONMENT

The organisational structure of the National Department of Health was recently approved by the Department of Public Service and Administration and its implementation commenced in April 2012. The transformation of the organisational structure was aimed at ensuring an alignment with strategic priorities of the health sector and to improve the department's oversight function across the health system.

The organisational structure has been reviewed to maximise achievement on the departmental's strategic priorities. The success of the implementation thereof is highly dependent on the alignment with the allocated available budget. Through the years the development of the organisational structure was done in isolation from the budget process, and this practise has provided challenges in actioning some of the key outputs. The current approved organisational structure is taking into consideration the change of organisational culture, improvement of productivity, development of leadership capability and repositioning of NDoH as an employer of choice whereby only candidates who meet the profile of the desired NDoH cadre of employees will be considered for appointment.

7. OVERVIEW OF 2014/15 BUDGET AND MTEF ESTIMATES

Expenditure estimates

Programme	Audited outcome			Adjusted appropri-ation	Revised estimate	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R million	2010/11	2011/12	2012/13	2013/14		2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Administration	263.0	317.6	380.2	405.7	405.7	15.5%	1.3%	399.7	426.4	449.7	3.5%	1.2%
National Health Insurance, Health Planning and Systems Enablement	97.2	164.1	294.7	491.8	288.8	43.8%	0.8%	621.3	620.0	650.1	31.1%	1.6%
HIV and AIDS, Tuberculosis, Maternal and Child Health	6 471.3	7 916.0	9 169.0	11 042.0	11 045.0	19.5%	32.6%	13 049.9	14 728.6	16 299.5	13.9%	39.3%
Primary Health Care Services	82.3	97.3	111.0	102.6	102.6	7.6%	0.4%	93.5	98.1	103.7	0.3%	0.3%
Hospitals, Tertiary Health Services and Human Resource Development	15 065.7	16 700.1	17 395.9	17 722.4	17 522.4	5.2%	62.8%	18 925.8	19 693.3	20 761.0	5.8%	54.9%
Health Regulation and Compliance Management	540.7	517.8	548.2	763.7	763.7	12.2%	2.2%	865.3	1 064.8	1 123.7	13.7%	2.7%
Total	**22 520.3**	**25 712.8**	**27 898.9**	**30 528.2**	**30 128.2**	**10.2%**	**100.0%**	**33 955.5**	**36 631.3**	**39 387.7**	**9.3%**	**100.0%**
Change to 2013 Budget estimate				(178.5)	(578.5)			31.1	(53.9)	(249.5)		
Economic classification												
Current payments	**898.0**	**1 083.4**	**1 190.1**	**1 628.0**	**1 428.0**	**16.7%**	**4.3%**	**2 014.1**	**2 107.7**	**2 017.9**	**12.2%**	**5.4%**
Compensation of employees	353.7	409.7	482.3	538.4	540.5	15.2%	1.7%	597.2	637.3	674.7	7.7%	1.7%
Goods and services	544.4	673.7	707.8	1 089.6	887.5	17.7%	2.6%	1 416.9	1 470.4	1 343.2	14.8%	3.7%
of which:												
Administration fees	*0.2*	*0.5*	*0.8*	*2.0*	*2.0*	*105.7%*	*0.0%*	*1.0*	*1.0*	*0.4*	*-44.3%*	*0.0%*
Advertising	*49.2*	*33.8*	*12.2*	*23.4*	*23.4*	*-21.9%*	*0.1%*	*58.5*	*39.4*	*26.1*	*3.7%*	*0.1%*
Assets less than the capitalisation threshold	*1.4*	*3.3*	*3.5*	*17.0*	*17.0*	*127.8%*	*0.0%*	*18.2*	*21.0*	*10.9*	*-13.7%*	*0.0%*
Audit costs: External	*16.1*	*22.2*	*23.8*	*29.5*	*29.5*	*22.3%*	*0.1%*	*30.7*	*32.7*	*31.1*	*1.8%*	*0.1%*
Bursaries: Employees	*1.1*	*1.6*	*0.9*	*1.6*	*1.6*	*14.9%*	*0.0%*	*1.5*	*1.6*	*1.3*	*-6.8%*	*0.0%*
Catering: Departmental activities	*3.7*	*3.0*	*3.0*	*8.4*	*8.4*	*31.1%*	*0.0%*	*7.8*	*8.2*	*4.8*	*-17.0%*	*0.0%*
Communication	*17.7*	*17.4*	*15.3*	*28.1*	*28.1*	*16.8%*	*0.1%*	*23.8*	*25.1*	*32.5*	*5.0%*	*0.1%*
Computer services	*15.0*	*56.0*	*9.3*	*26.1*	*26.1*	*20.3%*	*0.1%*	*23.6*	*24.3*	*16.4*	*-14.3%*	*0.1%*
Consultants and professional services: Business and advisory services	*66.7*	*110.6*	*185.8*	*148.2*	*148.2*	*30.5%*	*0.5%*	*126.5*	*128.8*	*136.6*	*-2.7%*	*0.4%*
Consultants and professional services: Laboratory services	*–*	*–*	*0.0*	*0.1*	*0.1*	*–*	*0.0%*	*0.1*	*0.1*	*0.4*	*70.8%*	*0.0%*
Consultants and professional services: Scientific and technological services	*–*	*0.0*	*–*	*–*	*–*	*–*	*0.0%*	*30.0*	*–*	*–*	*–*	*0.0%*

Consultants and professional services: Legal costs	*0.7*	*10.2*	*14.6*	*1.1*	*1.1*	*15.5%*	*0.0%*	*1.1*	*1.2*	*1.0*	*-3.6%*	*0.0%*
Contractors	*22.0*	*6.6*	*9.8*	*313.8*	*113.8*	*73.0%*	*0.1%*	*416.0*	*434.4*	*467.4*	*60.1%*	*1.0%*
Agency and support / outsourced services	*8.0*	*9.0*	*20.1*	*15.2*	*15.2*	*23.7%*	*0.0%*	*14.0*	*21.3*	*31.5*	*27.6%*	*0.1%*
Entertainment	*0.2*	*0.1*	*0.1*	*0.8*	*0.8*	*51.2%*	*0.0%*	*0.9*	*0.9*	*0.1*	*-56.5%*	*0.0%*
Inventory: Fuel, oil and gas	*0.3*	*0.1*	*0.9*	*0.5*	*0.5*	*25.7%*	*0.0%*	*0.5*	*0.6*	*1.0*	*25.0%*	*0.0%*
Inventory: Learner and teacher support material	*0.0*	*–*	*–*	*0.2*	*0.2*	*348.1%*	*0.0%*	*0.2*	*0.2*	*–*	*-100.0%*	*0.0%*
Inventory: Materials and supplies	*0.2*	*0.1*	*0.1*	*0.5*	*0.5*	*40.2%*	*0.0%*	*0.5*	*0.6*	*0.5*	*0.6%*	*0.0%*
Inventory: Medical supplies	*119.5*	*124.2*	*112.4*	*140.8*	*140.8*	*5.6%*	*0.5%*	*149.2*	*189.3*	*218.7*	*15.8%*	*0.5%*
Inventory: Medicine	*30.0*	*20.0*	*32.1*	*1.1*	*1.1*	*-66.7%*	*0.1%*	*201.2*	*201.2*	*2.9*	*38.6%*	*0.3%*
Medsas inventory interface	*1.0*	*–*	*–*	*1.6*	*1.6*	*17.9%*	*0.0%*	*–*	*–*	*–*	*-100.0%*	*0.0%*
Inventory: Other supplies	*4.9*	*6.3*	*6.9*	*11.5*	*11.5*	*32.5%*	*0.0%*	*12.6*	*15.8*	*14.1*	*7.1%*	*0.0%*
Consumable supplies	*0.4*	*0.2*	*0.3*	*0.7*	*0.7*	*17.9%*	*0.0%*	*–*	*–*	*–*	*-100.0%*	*0.0%*
Consumable: Stationery, printing and office supplies	*18.3*	*24.2*	*16.8*	*46.1*	*46.1*	*36.1%*	*0.1%*	*41.3*	*47.0*	*29.2*	*-14.1%*	*0.1%*
Operating leases	*51.7*	*92.5*	*85.7*	*103.0*	*103.0*	*25.8%*	*0.3%*	*111.7*	*116.9*	*113.2*	*3.2%*	*0.3%*

Economic classification												
	Audited outcome			**Adjusted appropri-ation**	**Revised estimate**	**Average growth rate (%)**	**Expen-diture/ total: Average (%)**	**Medium-term expenditure estimate**			**Average growth rate (%)**	**Expen-diture/ total: Average (%)**
R million	**2010/11**	**2011/12**	**2012/13**	**2013/14**		**2010/11 - 2013/14**		**2014/15**	**2015/16**	**2016/17**	**2013/14 - 2016/17**	
Property payments	*–*	*3.7*	*9.6*	*5.5*	*5.5*		*0.0%*	*5.6*	*7.8*	*12.1*	*30.2%*	*0.0%*
Transport provided: Departmental activity	*2.2*	*3.1*	*3.2*	*4.0*	*4.0*	*21.3%*	*0.0%*	*0.7*	*0.7*	*0.8*	*-41.7%*	*0.0%*
Travel and subsistence	*71.8*	*76.5*	*94.0*	*106.2*	*103.3*	*12.9%*	*0.3%*	*74.3*	*81.0*	*128.3*	*7.5%*	*0.3%*
Training and development	*4.8*	*5.8*	*5.5*	*3.2*	*6.9*	*13.1%*	*0.0%*	*5.5*	*5.7*	*6.4*	*-2.6%*	*0.0%*
Operating payments	*27.1*	*27.7*	*33.9*	*26.9*	*23.9*	*-4.2%*	*0.1%*	*36.7*	*38.5*	*45.3*	*23.8%*	*0.1%*
Venues and facilities	*10.3*	*14.9*	*7.2*	*22.7*	*22.7*	*30.2%*	*0.1%*	*23.4*	*25.3*	*10.0*	*-23.8%*	*0.1%*
Transfers and subsidies	**21 604.0**	**24 598.8**	**26 682.7**	**28 433.8**	**28 433.8**	**9.6%**	**95.4%**	**30 916.4**	**33 462.3**	**36 213.4**	**8.4%**	**92.1%**
Provinces and municipalities	21 042.0	24 034.8	26 071.7	27 686.4	27 686.4	9.6%	93.0%	30 111.3	32 484.4	35 183.9	8.3%	89.6%
Departmental agencies and accounts	420.7	379.4	392.7	540.7	540.7	8.7%	1.6%	596.0	770.2	811.0	14.5%	1.9%
Higher education institutions	2.0	12.8	21.0	7.0	7.0	51.8%	0.0%	3.0	3.1	3.3	-22.1%	0.0%
Non-profit institutions	138.7	166.9	196.2	199.8	199.8	12.9%	0.7%	206.1	204.6	215.1	2.5%	0.6%
Households	0.6	5.0	1.1	–	–	-100.0%	0.0%	–	–	–	–	–
Payments for capital assets	**17.8**	**28.7**	**20.4**	**466.4**	**266.4**	**146.5%**	**0.3%**	**1 025.0**	**1 061.3**	**1 156.4**	**63.1%**	**2.5%**
Buildings and other fixed structures	–	–	–	440.0	240.0		0.2%	979.9	1 021.2	1 115.2	66.9%	2.4%
Machinery and equipment	17.6	28.6	20.4	26.3	26.4	14.5%	0.1%	45.2	40.1	41.2	16.0%	0.1%
Software and other intangible assets	0.2	0.1	–	–	–	-100.0%	0.0%	–	–	–	–	–
Payments for financial assets	**0.6**	**1.8**	**5.7**	**–**	**–**	**-100.0%**	**0.0%**	**–**	**–**	**–**	**–**	–
Total	**22 520.3**	**25 712.8**	**27 898.9**	**30 528.2**	**30 128.2**	**10.2%**	**100.0%**	**33 955.5**	**36 631.3**	**39 387.7**	**9.3%**	**100.0%**

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment														Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate								Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17			2013/14 - 2016/17	
Health			Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost		
Salary level	**1 500**	**50**	**1 378**	**482.3**	**0.3**	**1 500**	**540.5**	**0.4**	**1 535**	**597.2**	**0.4**	**1 535**	**637.3**	**0.4**	**1 535**	**674.7**	**0.4**	**0.8%**	**100.0%**
1 – 6	546	28	532	86.5	0.2	547	88.1	0.2	551	98.0	0.2	551	103.3	0.2	551	107.9	0.2	0.2%	36.0%
7 – 10	584	7	528	166.1	0.3	585	177.8	0.3	638	230.8	0.4	638	243.7	0.4	638	257.5	0.4	2.9%	40.9%
11 – 12	234	7	195	108.6	0.6	234	128.7	0.5	209	120.5	0.6	209	133.3	0.6	209	140.5	0.7	-3.7%	14.1%
13 – 16	134	8	121	107.5	0.9	132	139.1	1.1	135	117.6	0.9	135	126.1	0.9	135	133.3	1.0	0.8%	8.8%
Other[3]	2	–	2	13.6	6.8	2	6.9	3.4	2	30.4	15.2	2	30.8	15.4	2	35.5	17.8	–	0.1%

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

2. Rand million.

3. Includes periodic payments to board members who do not form part of the establishment.

Expenditure trends

The spending focus over the medium term will continue to be on increasing life expectancy and reducing the burden of disease by revitalising hospitals, providing specialised tertiary services, and preventing and treating HIV and AIDS. Thus, the bulk of the department's budget over the medium term is allocated to transfers of: the health facility revitalisation, national tertiary services, and health professions training and development grants in the *Hospitals, Tertiary Health Services and Human Resource Development* programme; and the comprehensive HIV and AIDS conditional grant in the *HIV and AIDS, TB, Maternal and Child Health* programme. Spending on the HIV and AIDS conditional grant is set to increase over the medium term to allow the department to put 500 000 new patients on antiretroviral treatment each year. The 2014 Budget provides a further Cabinet approved additional allocation of R1 billion in 2016/17 for the department to continue to provide the public greater access to antiretroviral treatment, which explains the significant increase projected in spending in the *HIV and AIDS, TB, Maternal and Child Health* programme in that year. In addition, the programme receives a Cabinet approved additional allocation of R200 million in both 2014/15 and 2015/16 through a newly formed component of the national health grant to provide for the rollout of the human papilloma virus vaccine, which protects women and girls against cervical cancer. Once the rollout of the vaccine is under way, it will be funded through the provincial equitable share in 2016/17.

Together with a Cabinet approved additional allocation of R30 million in 2014/15 for a national survey on health demographics, the national health insurance component of the national health grant is set to increase spending in the *National Health Insurance, Health Planning and Systems Enablement* programme significantly over the MTEF period. This component of the grant provides for an expansion of the scheme's pilot programme in 10 districts, including contracting general medical practitioners, which explains the significant increase expected in spending on contractors over the medium term.

The *Hospitals, Tertiary Health Services and Human Resource Development* programme receives Cabinet approved additional allocations of R70 million over the MTEF period for capital assets for the forensic chemistry laboratories and for commissioning the new laboratory in Durban. The health facilities revitalisation component of the national health grant is set to continue increasing this programme's expenditure over the medium term as the department continues to revitalise hospitals, which is the reason for the increase in spending on payments for capital assets. However, allocations are reduced as a result of Cabinet approved reductions of R200 million, R254.8 million and R249.5 million over the medium term due to slow spending. These allocations will be reviewed as capacity improves. The programme receives a further R2 million through the health facilities revitalisation grant, which is transferred to provinces, to repair health infrastructure damaged by disasters. An additional R274 000 in 2013/14 was also allocated for this purpose. Spending in the *Health Regulation and Compliance Management* programme is projected to increase significantly over the medium term to strengthen the Medical Research Council's research programmes and to allow the Office of Standards Compliance, which is currently a subprogramme in the department, to employ additional staff to establish itself and build its inspectorate function. This is set to increase the department's establishment from 1 500 in 2013/14 to 1 535 in 2014/15. From 2014/15, the Office of Standards Compliance is set to become a standalone public entity.

Infrastructure spending

The department's infrastructure spending is funded through two conditional grants: the provincially delivered health facilities revitalisation grant and the nationally delivered health facility revitalisation component of the national health grant. The total spending on conditional grants for infrastructure projects was R5.5 billion in 2012/13 and unaudited figures put expenditure in 2013/14 at R5.5 billion. R19.1 billion is budgeted for infrastructure projects over the MTEF period.

Mega projects

There are currently 7 mega projects being implemented by national or provincial departments, funded by conditional grants. Each project has a total estimated cost of more than R1 billion. R919.7 million was spent on these projects in 2012/13 and constituted 16.6 per cent of overall infrastructure expenditure. King George V Hospital in KwaZulu-Natal is scheduled for completion in 2013/14, while Natalspruit Hospital in Gauteng was completed in 2013/14 and is to be commissioned early in 2014/15. R2.8 billion has been allocated over the medium term for the remaining 5 mega projects.

Large projects

There are currently 50 large infrastructure projects being implemented by the national or provincial departments funded by the conditional grants. Each project has a total estimated cost of more than R250 million, but less than R1 billion. In 2012/13, the provincial departments spent R2.5 billion on large projects, or 44.9 per cent of overall infrastructure expenditure. In 2013/14, the projects to build hospitals in Zola in Gauteng, Ladybrand in Free State, and Upington in Northern Cape were completed and are currently being commissioned. Over the MTEF period, R9 billion has been allocated for the remaining large health infrastructure projects.

Small projects

R2.1 billion spent by the provincial departments of health on small projects, such as the construction and upgrading of clinics, community health centres and nursing colleges, makes up the remaining 38 per cent of overall expenditure in 2012/13. Over the medium term, the small projects will involve the installation of mobile doctors' consulting rooms in the national health insurance pilot districts, as well as minor maintenance of health facilities carried out by students at further education and training colleges. R7.3 billion will be invested in small projects over the medium term.

Part B

Updated population estimates were received from StatsSA during 2014. All Population based indicators use prior set of population estimates because the updated population estimates received from StatsSA during 2014 have not been imported into the information systems. Baselines and targets will be subject to change after the updated population estimates have been implemented in all information systems.

PROGRAMME 1: ADMINISTRATION

1.1 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR 2014/15 TO 2016/17

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

Strategic Objective Statement	**Performance Indicator**	**Audited/Actual performance**			**Estimated performance**	**Medium-term targets**			**Strategic Plan Target**
		2010/11	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2018/19**
Ensure effective financial management and accountability by improving audit outcomes	Audit opinion from Auditor General	Unqualified audit opinion	Qualified audit opinions	Unqualified audit opinion	Unqualified audit opinions	Unqualified Audit opinion	Unqualified Audit opinion	Clean Audit opinion for	Clean Audit Opinion for the NDOH
	Audit opinion from Auditor for Provincial Departments of Health		2 Unqualified audit opinion	1 Unqualified audit opinions	2 Unqualified audit opinions	3 Unqualified audit opinions	4 Unqualified audit opinions	5 Unqualified audit opinions	7 Unqualified audit opinions
Develop and implement the ICT Governance framework by focusing on the business continuity plan (BCP) inclusive of a disaster recovery plan (DRP)	Develop and Implement Business Continuity Plan inclusive of a disaster recovery plan	None	Tested various backup / DRP solutions Procured a backup Solution	Draft DRP developed	Draft Disaster Recovery Plan available	BCP and DRP Finalized and Approved Implementation plan for BCP and DRP developed	Implement Phase 1 of the BCP and DRP	Implement Phase 2 of the BCP and DRP	Full implementation of Business Continuity Plan and disaster recovery plan

Strategic Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Provide support for effective communication by developing an integrated communication strategy and implementation plan	Develop an integrated communication strategy and implementation plan	New Indicator	New Indicator	New Indicator	Fragmented communication programme	Draft Implementation Plans for Communication Strategy	Implementing and monitoring	Implementing monitoring and evaluation	Integrated Communication strategy and implementation plan developed and implemented
Ensure efficient and responsive Human Resource Services through the implementation of efficient recruitment processes and responsive Human Resource support programmes	Average Turnaround times for recruitment processes	New Indicator	New Indicator	New Indicator	6 months	Average recruitment process turnaround time will be 5 months	Average recruitment process turnaround time will be 4 months	Average recruitment process turnaround time will be 4 months	3 months
	Develop and Implement Employee wellness programme that comply with Public Service Regulations (PSR) and Employee Health and Wellness Strategic Framework	New Indicator	New Indicator	New Indicator	Inadequate compliance with Employee Health Wellness regulations	All 4 EHW Pillars for improved employee well being and productivity implemented	Employee absenteeism reduced and heightened level of awareness by employees	A visible improvement in the quality of work life and employee performance	Employee Health and Wellness Programme that adhere to Part VI of the PSR and EHWSF

Strategic Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Provide leadership in the health sector by integrating all health sector plans and providing support for developing plans identified plans	Develop and implement a framework for Integrated Health Service Plans at all levels of the Health sector	New Indicator	New Indicator	New Indicator	New Indicator	Draft Framework for integrated health service plans developed	Identified service plans aligned to planning framework	Identified service plans aligned to planning framework	Framework for Integrated Health Service Plans at all levels of the Health care sector developed and implemented
	Review Provincial Annual Performance Plans (APPs)	9 Provincial APPs reviewed and feedback provided	9 Provincial APPs reviewed and feedback provided	9 Provincial APPs reviewed and feedback provided	9 Provincial APPs reviewed and feedback provided	9 Provincial APPs reviewed and feedback provided	9 Provincial APPs reviewed and feedback provided	9 Provincial APPs reviewed and feedback provided	

1.2 QUARTERLY TARGETS FOR 2014/15

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Audit opinion from Auditor General	Annual	Unqualified Audit opinion for 2013/14 financial year				
Audit opinion for Provincial Departments of Health	Annual	3 Unqualified audit opinions for 2013/14 financial year				
Develop and Implement Business Continuity Plan inclusive of a disaster recovery plan	Quarterly	BCP and DRP Finalized and Approved Implementation plan for BCP and DRP developed	Consultation on the draft BCP and DRP	Consultation on the draft BCP and DRP	BCP and DRP Finalized and Approved	Implementation plan for BCP and DRP developed
Develop an integrated communication strategy and implementation plan	Quarterly	Draft Implementation Plans for Communication Strategy	Internal & External Consultation completed	Draft strategy developed	Approved Integrated Communication Strategy & Implementation Plans	Implementation Commenced
Average Turnaround times for recruitments processes	Bi-Annually	Average recruitment turnaround time will be 5 months		Average recruitment turnaround time will be 5 months		Average recruitment turnaround time will be 5 months
Develop and Implement Employee wellness programme that comply with Public Service Regulations (PSR) and Employee Health and Wellness Strategic Framework (EHWSF)	Quarterly	All EHW 4 Pillars policies will be implemented	Implementation of Wellness Management Pillar	Implementation of Health and Productivity Pillar	Implementation of HIVand AIDS andTB Management Pillar	Implementation of Safety, Health , Risk and Quality Management

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Develop and implement a framework for Integrated Health Service Plans at all levels of the Health sector	Annual	Draft Framework for integrated provincial plans developed				
Review Provincial Annual Performance Plans (APPs)	Annual	9 Provincial APPs reviewed and feedback provided				

1.3 RECONCILING PERFORMANCE TARGETS WITH THE BUDGETS AND THE MTEF

Expenditure estimates

Administration

Subprogramme	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Ministry	25 920	27 280	25 547	35 375	10.9%	8.4%	31 046	32 476	34 380	-0.9%	7.9%
Management	29 770	20 721	20 291	27 421	-2.7%	7.2%	26 458	27 772	29 544	2.5%	6.6%
Corporate Services	126 185	145 313	158 081	191 226	14.9%	45.4%	184 647	201 432	212 456	3.6%	47.0%
Office Accommodation	55 245	92 081	92 978	97 514	20.9%	24.7%	105 825	110 693	116 560	6.1%	25.6%
Financial Management	25 906	32 165	83 305	54 191	27.9%	14.3%	51 745	54 073	56 797	1.6%	12.9%
Total	**263 026**	**317 560**	**380 202**	**405 727**	**15.5%**	**100.0%**	**399 721**	**426 446**	**449 737**	**3.5%**	**100.0%**
Change to 2013 Budget estimate				(5 238)			(20 054)	(20 995)	(20 463)		

Administration

Economic classification	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Current payments	**257 251**	**306 077**	**369 443**	**398 623**	**15.7%**	**97.4%**	**392 430**	**420 209**	**443 162**	**3.6%**	**98.4%**
Compensation of employees	108 132	112 246	137 406	167 078	15.6%	38.4%	161 600	170 475	180 019	2.5%	40.4%
Goods and services	149 119	193 831	232 037	231 545	15.8%	59.0%	230 830	249 734	263 143	4.4%	58.0%
of which:											
Administration fees	*101*	*82*	*187*	*177*	*20.6%*	*–*	*188*	*197*	*188*	*2.0%*	*–*
Advertising	*4 697*	*5 840*	*2 493*	*6 255*	*10.0%*	*1.4%*	*6 876*	*12 148*	*5 078*	*-6.7%*	*1.8%*
Assets less than the capitalisation threshold	*395*	*989*	*971*	*1 993*	*71.5%*	*0.3%*	*2 071*	*2 168*	*1 109*	*-17.7%*	*0.4%*
Audit costs: External	*14 690*	*19 501*	*22 763*	*25 578*	*20.3%*	*6.0%*	*26 321*	*28 000*	*28 039*	*3.1%*	*6.4%*
Bursaries: Employees	*956*	*1 474*	*797*	*1 366*	*12.6%*	*0.3%*	*1 420*	*1 485*	*877*	*-13.7%*	*0.3%*
Catering: Departmental activities	*1 033*	*558*	*798*	*939*	*-3.1%*	*0.2%*	*976*	*1 018*	*881*	*-2.1%*	*0.2%*
Communication	*13 341*	*13 677*	*10 467*	*18 782*	*12.1%*	*4.1%*	*14 234*	*14 889*	*21 439*	*4.5%*	*4.1%*
Computer services	*8 052*	*6 525*	*6 332*	*10 872*	*10.5%*	*2.3%*	*11 294*	*11 817*	*12 965*	*6.0%*	*2.8%*
Consultants and professional services: Legal costs	*616*	*10 109*	*14 592*	*841*	*10.9%*	*1.9%*	*875*	*915*	*970*	*4.9%*	*0.2%*
Agency and support / outsourced services	*1 853*	*2 319*	*2 628*	*2 419*	*9.3%*	*0.7%*	*2 517*	*2 632*	*2 891*	*6.1%*	*0.6%*
Entertainment	*178*	*63*	*45*	*275*	*15.6%*	*–*	*287*	*300*	*49*	*-43.7%*	*0.1%*
Inventory: Food and food supplies	*–*	*–*	*12*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Fuel, oil and gas	*30*	*6*	*489*	*99*	*48.9%*	*–*	*103*	*108*	*536*	*75.6%*	*0.1%*
Inventory: Materials and supplies	*76*	*38*	*6*	*179*	*33.0%*	*–*	*186*	*194*	*–*	*-100.0%*	*–*
Inventory: Other supplies	*527*	*971*	*287*	*775*	*13.7%*	*0.2%*	*806*	*844*	*312*	*-26.2%*	*0.2%*
Consumable: Stationery, printing and office supplies	*7 269*	*7 025*	*7 702*	*10 691*	*13.7%*	*2.4%*	*11 118*	*11 629*	*13 541*	*8.2%*	*2.8%*
Operating leases	*49 767*	*89 548*	*82 800*	*94 737*	*23.9%*	*23.2%*	*103 095*	*107 837*	*106 330*	*3.9%*	*24.5%*
Property payments	*–*	*3 732*	*9 554*	*5 501*	*–*	*1.4%*	*5 563*	*5 819*	*9 610*	*20.4%*	*1.6%*
Travel and subsistence	*20 218*	*18 290*	*21 499*	*25 404*	*7.9%*	*6.3%*	*15 693*	*16 213*	*25 198*	*-0.3%*	*4.9%*
Training and development	*2 449*	*2 850*	*2 376*	*3 113*	*8.3%*	*0.8%*	*5 437*	*5 687*	*2 639*	*-5.4%*	*1.0%*
Operating payments	*2 268*	*2 562*	*2 397*	*4 808*	*28.5%*	*0.9%*	*5 056*	*5 342*	*4 042*	*-5.6%*	*1.1%*
Venues and facilities	*1 328*	*1 470*	*684*	*1 265*	*-1.6%*	*0.3%*	*1 315*	*1 376*	*761*	*-15.6%*	*0.3%*
Transfers and subsidies	**551**	**4 609**	**615**	**1 326**	**34.0%**	**0.5%**	**1 397**	**1 481**	**1 566**	**5.7%**	**0.3%**
Departmental agencies and accounts	370	424	479	1 326	53.0%	0.2%	1 397	1 481	1 566	5.7%	0.3%
Households	181	4 185	136	–	-100.0%	0.3%	–	–	–	–	–
Payments for capital assets	**5 217**	**6 566**	**5 456**	**5 778**	**3.5%**	**1.7%**	**5 894**	**4 756**	**5 009**	**-4.6%**	**1.3%**
Machinery and equipment	5 114	6 505	5 456	5 778	4.2%	1.7%	5 894	4 756	5 009	-4.6%	1.3%
Software and other intangible assets	103.0	61.0	–	–	-100.0%	–	–	–	–	–	–
Payments for financial assets	**7.0**	**308.0**	**4 688.0**	**–**	**-100.0%**	**0.4%**	**–**	**–**	**–**	**–**	**–**
Total	**263 026.0**	**317 560.0**	**380 202.0**	**405 727.0**	**15.5%**	**100.0%**	**399 721.0**	**426 446.0**	**449 737.0**	**3.5%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**1.2%**	**1.2%**	**1.4%**	**1.3%**			**1.2%**	**1.2%**	**1.1%**		

Details of transfers and subsidies											
Households											
Social benefits											
Current	**181**	**4 185**	**136**	**–**	**-100.0%**	**0.3%**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	181	4 185	136	–	-100.0%	0.3%	–	–	–	–	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**370**	**424**	**479**	**1 326**	**53.0%**	**0.2%**	**1 397**	**1 481**	**1 566**	**5.7%**	**0.3%**
Health and Welfare Sector Education and Training Authority	370	424	479	1 259	50.4%	0.2%	1 326	1 406	1 487	5.7%	0.3%
Public Service Sector Education and Training Authority	–	–	–	67	–	–	71	75	79	5.6%	–

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment													Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate							Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17		2013/14 - 2016/17
Administration			**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**		
Salary level	**530**	**10**	**498**	**137.4**	**0.3**	**530**	**167.1**	**0.3**	**488**	**161.6**	**0.3**	**488**	**170.5**	**0.3**	**488**	**180.0**	**0.4**	**-2.7%**	**100.0%**
1 – 6	270	6	267	39.4	0.1	270	41.8	0.2	246	41.7	0.2	246	44.0	0.2	246	46.3	0.2	-3.1%	50.6%
7 – 10	161	1	140	41.6	0.3	161	51.9	0.3	146	49.4	0.3	146	52.0	0.4	146	55.3	0.4	-3.2%	30.0%
11 – 12	49	1	50	25.0	0.5	51	29.6	0.6	54	32.4	0.6	54	34.1	0.6	54	36.3	0.7	1.9%	10.7%
13 – 16	48	2	39	27.7	0.7	46	40.1	0.9	40	34.2	0.9	40	36.3	0.9	40	37.8	0.9	-4.6%	8.3%
Other	2	–	2	3.7	1.8	2	3.7	1.8	2	3.9	1.9	2	4.1	2.1	2	4.3	2.2	–	0.4%

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

2. Rand million.

Expenditure trends

The spending focus over the medium term will continue to be on providing for the department's accommodation and corporate services needs. This is why operating leases and compensation of employees are the programme's largest spending items across the seven-year period. Filled posts over the medium term are expected to decrease to 488 in 2014/15, where they are set to remain over the medium term, which is why expenditure on compensation of employees is set to grow only marginally over the period. The decrease is mainly due to the shifting of programme managers from this programme to their respective line function programmes. At the end of November 2013, there were 24 vacant posts due to natural attrition.

Audit costs have increased sharply, from R14.7 million in 2010/11 to R25.6 million in 2013/14, due to the introduction of a mid-year audit of performance information. Office accommodation costs rose significantly in 2011/12 due to the payments to the Department of Public Works for the upgrade to the Civitas building, which the department has since occupied.

Spending in the *Financial Management* subprogramme over the medium term aims to support effective management and accountability in the department and assist all nine provincial health departments to improve audit opinions. Spending in the *Management* subprogramme in 2014/15 is set to decrease slightly due to the shifting of the staff and office costs of the deputy director generals to their respective programme budgets.

PROGRAMME 2: NATIONAL HEALTH INSURANCE, HEALTH PLANNING AND SYSTEMS ENABLEMENT

2.1 PROGRAMME PURPOSE

Improve access to quality health services through the development and implementation of policies to achieve universal coverage, health financing reform, integrated health systems planning, reporting, monitoring and evaluation and research.

Subprogrammes

- *Programme Management* will provide leadership to this programme in order to improve access to quality health services through the development and implementation of policies to achieve universal coverage, health financing reform, integrated health systems planning, reporting, monitoring and evaluation, and research. This subprogramme contains three filled posts.

- *Technical Policy and Planning* provides advisory and strategic technical assistance on policy and planning, and supports policy implementation. In 2012/13, the department expanded the development of the national health information repository and data-warehouse. The purpose of the repository is to create a national health information centre wherein information from different repositories will be stored and updated on a regular basis. Data and information from the repository were used to produce health profiles for all nine provinces and 52 districts. The system was further expanded in 2013/14 with a focus on the use of the repository through scenario-planning models. This subprogramme houses technical assistants, who are not on the fixed establishment of the department. .
- *Health Information Management, Monitoring and Evaluation* develops and maintains a national health information system, commissions and coordinates research, implements the national disease notification surveillance system and monitors and evaluates strategic health programmes. In 2012/13,a concerted effort was made to strengthen research and development. The department commenced with the implementation of recommendations from the National Health Research Summit by funding 13 PhD scholarships and an independent audit of 33 research ethics committees was commissioned on behalf of the National Health Research Ethics Council. In 2013/14, the Centre for Scientific and Industrial Research was commissioned to produce a normative standards framework for health information systems in South Africa and the result was approved by the National Health Council. In addition, HIV prevalence trends at national, provincial and district level continued to be monitored through the implementation of the annual antenatal sentinel HIV and herpes simplex prevalence surveys. This subprogramme has 48 filled posts.

- *Sector-wide Procurement* is responsible for the selection of essential medicines and equipment, development of standard treatment guidelines, administration of health tenders, and the licensing

of persons and premises that deliver pharmaceutical services. Substantial progress has been made on medicine procurement, with almost all medicine tenders now awarded nationally, with significant cost savings on many tenders, including through the large national antiretroviral tender. In 2012/13, initiatives were introduced to reform procurement systems for essential medicines. These included tender reforms, development of systems for direct delivery and the award of tenders for service providers of chronic medicine prescriptions. A key achievement in 2012/13 was the successful award of medicine tenders, which resulted in significant savings of R2.1 billion. This subprogramme has 43 filled posts.

- *Health Financing and National Health Insurance* develops and implements policies, legislation and frameworks for the achievement of universal health coverage through the phased implementation of National Health Insurance; commissions health financing research including into alternative healthcare financing mechanisms for achieving universal health coverage; develops policy for the medical schemes industry and provide technical oversight over the Council for Medical Schemes; and provides technical and implementation oversight for the two national health insurance conditional grants. The cluster also comprises the Directorate for Pharmaceutical Economic Evaluation, which implements the single exit price regulations, including policy development and implementation initiatives in terms of dispensing and logistical fees. Over the medium term, the initiatives implemented through the pilot districts will be expanded to improve access and quality health care. In 2012/13 and 2013/14,a draft white paper for the National Health Insurance and a draft National Health Insurance bill were developed. The Minister of Health conducted roadshows involving a range of stakeholders in each of the National Health Insurance districts. The White Paper on the National Health Insurance will be tabled in Parliament, legislation further developed and regulations developed and implemented in the coming years. This subprogramme has 23 filled posts.

- *International Health and Development* develops and implements bilateral and multilateral agreements with strategic partners such as the Southern African Development Community (SADC), the African Union (AU), United Nations (UN) agencies, as well as other developing countries and economic groupings of countries such as India-Brazil-South Africa and Brazil-Russia-India-China-South Africa (BRICS), to strengthen the health system; manages processes of technical capacity and financial assistance to South Africa; strengthens cooperation in areas of mutual interest globally; coordinates international development support; and profiles and lobbies for South Africa's policy position internationally. In 2012/13, the implementation of the Cuban medical brigade was facilitated to provide health services and training in Sierra Leone under the South Africa-Cuba-Sierra Leone trilateral project. With respect to the management of cross-border tuberculosis, the SADC heads of government signed the declaration on tuberculosis in the mining sector. This subprogramme has 37 filled posts.

2.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR 2014/15 TO 2016/17

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Achieve Universal Health Coverage through the phased implementation of the National Health Insurance(NHI)	Legislation for NHI	New Indicator	New Indicator	New Indicator	None	Draft NHI Bill gazetted for public consultation	Draft NHI Bill submitted for Parliamen-tary processes	National Health Insurance Act promulgated and gazetted	NHI Bill finalized and promulgate d into law.
	Piloting of NHI in selected districts across the country.	New Indicator	Develop-ment of methodo-logy for the selection of the initial NHI pilot districts	10 NHI pilot districts selected and funded through the NHI-CG	10 NHI pilot districts across the country.	10 NHI pilot districts across the country.	20 NHI pilot districts across the country.	26 NHI pilot districts across the country.	NHI pilots expanded for implementa tion in 50% of the 52 health districts.
	Establishment of the National Health Insurance Fund	New Indicator	New Indicator	New Indicator	Conceptual document of the NHI Fund as per the Draft White Paper on NHI	**Phase 1 of the implementati on of NHI initiated through:** Creation of a Project	Develop-ment and simulation of reformed provider payment mechanisms	Simulation and refinement of provider payment mechanisms	Functional NHI Fund purchasing services on behalf of the population from accredited

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
						Management team established and various activities for the "shadow process" of the NHI Fund initiated Funding Modality for the National Health Insurance Fund including budget reallocation for the district primary health care (PHC) personal health services developed	(i.e. risk-adjusted per capita for PHC and refined budgets for hospitals); develop-ment of a DRG tool for hospitals; contracting arrange-ments for providers; Develop-ment of Risk Engine; Develop-ment of Population Registration Strategies; Develop-ment of ICT Architecture for the NHI Fund and for Monitoring and Evaluation	(i.e. risk-adjusted per capita for PHC and refined global budgets for hospitals); development of a DRG tool for hospitals; contracting arrangement s for providers; simulation and refinement of Risk Engine; Simulation of Population Registration; Simulation of ICT Architecture functionali-ties	and contracted providers established.

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Regulate health care in the private sector by establishing National Pricing Commission and legislating methodologies for calculating fees.	Establish National Pricing Commission to regulate health care in the private sector	New Indicator	New Indicator	New Indicator	New Indicator	Draft National Pricing Commission Bill gazetted for public consultation	Draft National Pricing Commission Bill submitted for Parliamen-tary processes	National Pricing Commission Act promulgated and gazetted	Functional National Pricing Commission to regulate health care in the private sector established by 2017
	Revise and legislate methodology for the determination of the dispensing fee.	New Indicator	New Indicator	New Indicator	Previous cycle fee for both the dispensing fee for pharmacists & persons licensed in terms of 22 C 1 a.	Systematic survey for the dispensing fee completed for 2015/16 cycle	Review of the 2015/16 dispensing fee in determining the 2016/17 maximum dispensing fee	Review of the 2015/16 dispensing fee in determining the 2017/2018 maximum dispensing fee	
	Revise and legislate methodology for the determination of the logistics fee.	New Indicator	New Indicator	New Indicator	Currently unregulated logistics fee.	Revise the instruction document on how to calculate the Logistics Fee for 2015/16	Review the instruction document on how to calculate the Logistics Fee for 2016/17	Review the instruction document on how to calculate the Logistics Fee for 2017/18	
	Publish revised SEP adjustment methodology	New Indicator	New Indicator	New Indicator	The previous cycle SEP as calculated by previous	Implementati on of the gazette 2014/15	Implementat ion of the gazette 2015/16	Implementati on of the gazette 2016/17	New methodo-logy implemen-

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
					annual announcement.	Annual Price Adjustment	Annual Price Adjustment	Annual Price Adjustment	ted for the adjustment of prices for generics and originator drugs.
Improve Management and control of pharmaceutical services	Percentage of the PHC Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	New Indicator	New Indicator	New Indicator	Review 50% Primary Healthcare EML/STG	Review 100% Primary Healthcare EML/STG & publish 2014 edition	Review 20% Primary Healthcare EML/STG	Review 50% Primary Healthcare EML/STG	
	Percentage of the Hospital Level Paediatric Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	New Indicator	New Indicator	New Indicator	Review 100% Hospital Level Paediatric EML/STG & publish 2013 edition	Review 20% Hospital Level Paediatric EML/STG	Review 50% Hospital Level Paediatric EML/STG	Review 100% of Hospital Level Paediatric EML/STG & publish 2016 edition	
	Percentage of the Hospital Level Adult Essential Medicines List (EML) and	New Indicator	New Indicator	New Indicator	Review 20% of Hospital Level Adult EML/STG	Review 50% of Hospital Level Adult EML/STG	Review 100% of Hospital Level Adult EML/STG & publish 2015 edition	Review 20% Hospital Level Adult EML/STG	

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
	Standard treatment Guidelines (STGs) reviewed								
	Number of medicines review reports approved by the NELMC for inclusion in the tertiary EML	New Indicator	New Indicator	New Indicator	Complete 12 medicine reviews for Tertiary Level & update list	Complete 12 medicine reviews for Tertiary Level & update list	Complete 12 medicine reviews for Tertiary Level & update list	Complete 12 medicine reviews for Tertiary Level & update list	
Central chronic medicine dispensing and distribution	Number of Districts implementing centralised chronic medicine dispensing & distribution	New Indicator	New Indicator	New Indicator	Start implementation in 10 NHI districts	Implemented in all 10 NHI pilot districts	Increase implementation to 20 districts	Increase implementation to 30 districts	
Strengthen revenue collection by incentivizing central hospitals to increase their revenue collection	Develop and implement a Revenue Retention model	New Indicator	New Indicator	New Indicator	None	Draft hybrid revenue retention model developed	Final revenue retention model developed	Revenue retention model in central hospitals implemen-ted.	A revenue retention model for Central Hospitals developed and implemente d by 2016
Develop Business and Enterprise architecture for	Develop a complete System design for a National	New Indicator	New Indicator	New Indicator	Normative Standards for eHealth developed	Business architecture for a National	System and Technology architecture for a	Data architecture for a National	System design for a National Integrated

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
eHealth	Integrated Patient based information system				and approved	Integrated Patient Based Information System developed	National Integrated Patient Based Information System developed	Integrated Patient Based Information System developed	Patient based information system completed
Establish a National Health Research Observatory	Functional Health Research Observatory	New Indicator	New Indicator	New Indicator	Draft Concept paper for the establishment of the National Health Research Observatory and Report from HST on best practice health research observatory	Concept paper for the establishment of the National Health Observatory approved	Costed Implementation plan for the establishment of the national health observatory developed and approved	First phase implemented	National Health Research Observatory established by 2019
Develop and implement an integrated monitoring and evaluation plan aligned to health outcomes and outputs	Develop and implement Integrated monitoring and evaluation plan	New Indicator	New Indicator	Draft components of the monitoring and evaluation systems are implemen-ted and	Draft Monitoring and evaluation plan	Monitoring and evaluation plan for health developed	Monitoring and evaluation plan for health reviewed and implemen-ted	Monitoring and evaluation plan for health reviewed and implemen-ted	Integrated monitoring and evaluation plan developed and implemen-ted

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
contained in the Health Sector Strategy				maintained. This includes the NSDA M&E plan					
Establish a coordinated disease surveillance system for Notifiable Medical conditions (NMC)	Develop and implement a strategy and plan for the integration of disease surveillance systems for NMC	New Indicator	New Indicator	New Indicator	Manual disease notification system	Draft strategy for the integration of disease surveillance systems for NMC developed	Strategy for the integration of disease surveillance systems for NMC approved and implementation plans developed	First Phase implemen-taion commenced	Strategy and plan to coordinate and integrate disease surveillance systems for NMC developed and implemen-ted
Monitor HIV prevalence	Annual National HIV Antenatal Prevalence Survey	2009 National HIV and Syphilis prevalence estimates and trends report published	2010 Annual National HIV and Syphilis prevalence estimates and trends report published during November 2010	2011 Annual National HIV and Syphilis Prevalence Report was finalised and launched in November 2011	2012 National Antenatal Sentinal HIV and Herpes Simplex Type 2 prevalence in South Africa	2013 National Antenatal Sentinal HIV and Herpes Simplex Type 2 prevalence in South Africa	2014 National Antenatal Sentinal HIV and Herpes Simplex Type 2 prevalence in South Africa	2015 National Antenatal Sentinal HIV and Herpes Simplex Type 2 prevalence in South Africa	

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Domestication of international treaties and Implementation of multilateral cooperation on areas of mutual and measurable benefit	Implement International treaties and multilateral frameworks	New Indicator	New Indicator	New Indicator	New Indicator	International treaties and multilateral frameworks implemented	International treaties and multilateral frameworks implemen-ted	International treaties and multilateral frameworks implemen-ted	International treaties and multilateral frameworks implemen-ted
Implementation of bilateral cooperation on areas of mutual and measurable benefit	Number of Bilateral projects implemented	New Indicator	New Indicator	New Indicator	New indicator	Two strategic bilateral projects implemented	Five strategic bilateral projects implemen-ted	Seven strategic bilateral projects implemen-ted	Eight strategic bilateral projects implemen-ted

2.3 QUARTERLY TARGETS FOR 2014/15

The reporting period for Most indicators under Programme 2 are annual, however where possible quarterly targets are provided for annual indicators

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Legislation for NHI	Annual	Draft National Health Insurance Bill gazetted for public consultation				
Piloting of NHI in selected districts across the country.	Quarterly	10 NHI pilot districts across the country.	1. Annual performance evaluation report for 2013/14 2. Approved business plans for all 10 pilot districts 3. Monitoring and evaluation performance meetings and site visits for quarter 1 conducted for all 10 NHI pilot sites 4. Consolidated quarter 1 performance report for 2014/15 prepared.	1. Monitoring and evaluation performance meetings and site visits for quarter 2 conducted for all 10 NHI pilot sites 2. Consolidated quarter 2 performance report for 2014/15 prepared.	1. Monitoring and evaluation performance meetings and site visits for quarter 2 conducted for all 10 NHI pilot sites 2. Consolidated quarter 3 performance report for 2014/15 prepared.	1. Monitoring and evaluation performance meetings and site visits for quarter 2 conducted for all 10 NHI pilot sites 2. Consolidated quarter 4 performance report for 2014/15 prepared.

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Establishment of the National Health Insurance Fund	Annual	Creation of a Project Management team and initiation of various activities for the "shadow process" of the NHI Fund. Creation of the Funding Modality for the National Health Insurance Fund including budget reallocation for the district primary health care (PHC) personal health services.	None	Funding modality for the creation of the NHI Fund Project Team determined and mobilised	Project Team created and appointed	Initiate development and implementation of activities for the "shadow process" of the NHI Fund.
Establish National Pricing Commission to regulate health care in the private sector	Annual	Draft National Pricing Commission to regulate health care in the private sector gazetted				
Revise and legislate methodology for the determination of the dispensing fee.	Quarterly	Systematic survey for the dispensing fee completed for 2014/15 cycle	Develop a data collection tool for the dispensing fee survey	Collection and capturing of data from dispensing practitioners across the country	Data analysis on the data from dispensing practitioners across the country	Draft report based on the systematic survey for the dispensing fee completed for 2014/15 cycle
Revise and legislate methodology for the determination of the logistics fee.	Annual	Revise the instruction document on how to calculate the logistics fee				Incorporation of the new calculation of the Logistics Fee in the SEP instruction document and pricing regulations
Publish revised SEP adjustment methodology	Quarterly	Implementation of the gazette 2015/16 Annual Price Adjustment	Implementation of the 2014/2015 Annual Price Adjustment as published on 31 January 2014	Publication of the draft 2015/2016 Annual SEP Adjustment gazette, calling for comments from stakeholders	Review and analysis of comments and data collected for the final 2015/2016 Annual Price Adjustment.	Publication of the final gazette on the 2015/2016 Annual Price Adjustment

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Percentage of the PHC Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	Quarterly	Review 100% Primary Healthcare EML/STG & publish 2014 edition	Review 60% of PHC EML/STG	Review 75% PHC EML/STG	Review 90% PHC EML/STG	Review 100% PHC EML/STG
Percentage of the Hospital Level Paediatric Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	Quarterly	Review 20% Hospital Level Paediatric EML/STG	Review 5% of Hospital Level Paediatric EML/STG	Review 10% Hospital Level Paediatric EML/STG	Review 15% Hospital Level Paediatric EML/STG	Review20% Hospital Level Paediatric EML/STG
Percentage of the Hospital Level Adult Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	Quarterly	Review 50% of Hospital Level Adult EML/STG	Review 25% of Hospital Level Adult EML/STG	Review 35% of Hospital Level Adult EML/STG	Review 45% of Hospital Level Adult EML/STG	Review 50% of Hospital Level Adult EML/STG
Number of medicines review reports approved by the NELMC for inclusion in the tertiary EML	Quarterly	Complete 12 medicine reviews for Tertiary Level & update list	Complete 3 medicine reviews	Complete 3 medicine reviews	Complete 3 medicine reviews	Complete 3 medicine reviews
Number of Districts implementing centralised chronic medicine dispensing & distribution	Quarterly	Implemented in all 10 NHI pilot districts	20% of facilities in 10 NHI districts	40% of facilities in 10 NHI districts	60% of facilities in 10 NHI districts	75% of facilities in 10 NHI districts
Develop and implement a Revenue Retention model	Quarterly	Draft hybrid revenue retention model developed	Make a proposal on the hybrid model : Analyze and present the findings of the two existing models of the WC and FS	Comparative analysis of the two retention models	Present the findings to the CFOF and NT/ PT	Present at the NHC TAC meeting

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Develop a complete System design for a National Integrated Patient based information system	Annual	Business architecture for a National Integrated Patient Based Information System developed				
Establish a National Health Research Observatory	Annual	Concept paper for the establishment of the National Health Observatory approved				
Develop and implement Integrated monitoring and evaluation plan	Annual	Monitoring and evaluation plan for health developed				
Develop and implement a strategy and plan for the integration of disease surveillance systems	Annual	Draft strategy for the integration of disease surveillance systems for NMC developed				
Annual National HIV Antenatal Prevalence Survey	Annual	2013 National Antenatal Sentinal HIV and Herpes Simplex Type 2 prevalence in South Africa				
Implement International treaties and multilateral frameworks	Annual	International treaties and multilateral frameworks implemented				
Number of Bilateral projects implemented	Annual	Two strategic bilateral projects implemented				

2.4. RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Expenditure estimates

National Health Insurance, Health Planning and Systems Enablement

Subprogramme	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Programme Management	–	2 994	1 393	2 961	–	0.7%	2 989	3 146	3 326	4.0%	0.5%
Technical Policy and Planning	–	2 552	12 399	3 947	–	1.8%	2 084	2 184	2 305	-16.4%	0.4%
Health Information Management, Monitoring and Evaluation	21 631	51 918	41 721	44 934	27.6%	15.3%	53 725	24 848	26 572	-16.1%	6.3%
Sector-wide Procurement	13 059	15 569	19 838	21 697	18.4%	6.7%	22 987	24 113	25 392	5.4%	4.0%
Health Financing and National Health Insurance	26 593	39 807	166 377	370 329	140.6%	57.6%	487 210	511 182	535 035	13.0%	79.9%
International Health and Development	35 933	51 246	52 951	47 958	10.1%	18.0%	52 257	54 540	57 430	6.2%	8.9%
Total	**97 216**	**164 086**	**294 679**	**491 826**	**71.7%**	**100.0%**	**621 252**	**620 013**	**650 060**	**9.7%**	**100.0%**
Change to 2013 Budget estimate				(67)			(7 854)	(42 935)	(42 982)		
Economic classification											
Current payments	**92 972**	**155 578**	**128 951**	**438 451**	**67.7%**	**77.9%**	**543 830**	**538 511**	**564 504**	**8.8%**	**87.5%**
Compensation of employees	50 795	57 212	74 740	70 337	11.5%	24.2%	67 193	70 821	74 645	2.0%	11.9%
Goods and services	42 177	98 366	54 211	368 114	105.9%	53.7%	476 637	467 690	489 859	10.0%	75.6%
of which:											
Administration fees	*1*	*280*	*464*	*235*	*517.1%*	*0.1%*	*243*	*253*	*133*	*-17.3%*	*–*
Advertising	*329*	*1 726*	*787*	*1 361*	*60.5%*	*0.4%*	*1 244*	*1 300*	*1 215*	*-3.7%*	*0.2%*
Assets less than the capitalisation threshold	*24*	*94*	*347*	*813*	*223.6%*	*0.1%*	*970*	*1 015*	*469*	*-16.8%*	*0.1%*
Bursaries: Employees	*127*	*104*	*102*	*208*	*17.9%*	*0.1%*	*–*	*–*	*–*	*-100.0%*	*–*
Catering: Departmental activities	*252*	*377*	*559*	*660*	*37.8%*	*0.2%*	*679*	*710*	*556*	*-5.6%*	*0.1%*
Communication	*881*	*362*	*1 058*	*1 387*	*16.3%*	*0.4%*	*888*	*928*	*1 118*	*-6.9%*	*0.2%*
Computer services	*5 254*	*48 396*	*203*	*5 914*	*4.0%*	*5.7%*	*2 119*	*2 739*	*66*	*-77.7%*	*0.5%*
Consultants and professional services: Business and advisory services	*461*	*1 146*	*1 121*	*15 529*	*223.0%*	*1.7%*	*6 953*	*5 694*	*1 390*	*-55.3%*	*1.2%*
Consultants and professional services: Scientific and technological services	*–*	*1*	*–*	*–*	*–*	*–*	*30 000*	*–*	*–*	*–*	*1.3%*
Consultants and professional services: Legal costs	*52*	*23*	*13*	*–*	*-100.0%*	*–*	*–*	*–*	*–*	*–*	*–*
Contractors	*3 354*	*429*	*68*	*294 638*	*344.5%*	*28.5%*	*395 847*	*414 689*	*438 299*	*14.2%*	*64.8%*
Agency and support / outsourced services	*2 205*	*2 076*	*2 781*	*2 441*	*3.4%*	*0.9%*	*793*	*1 421*	*273*	*-51.8%*	*0.2%*
Entertainment	*9*	*7*	*15*	*167*	*164.7%*	*–*	*184*	*193*	*17*	*-53.3%*	*–*
Inventory: Farming supplies	*–*	*–*	*4*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Food and food supplies	*–*	*–*	*7*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Fuel, oil and gas	*1*	*3*	*7*	*2*	*26.0%*	*–*	*2*	*2*	*–*	*-100.0%*	*–*

Inventory: Learner and teacher support material	*2*	*–*	*–*	*3*	*14.5%*	*–*	*–*	*–*	*–*	*-100.0%*	*–*
Inventory: Materials and supplies	*3*	*–*	*–*	*53*	*160.4%*	*–*	*58*	*60*	*–*	*-100.0%*	*–*
Inventory: Medicine	*–*	*–*	*2*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Medsas inventory interface	*957*	*–*	*–*	*1 567*	*17.9%*	*0.2%*	*–*	*–*	*–*	*-100.0%*	*0.1%*
Inventory: Other supplies	*17*	*–*	*5*	*103*	*82.3%*	*–*	*1 737*	*1 817*	*44*	*-24.7%*	*0.2%*
Consumable supplies	*429*	*234*	*329*	*703*	*17.9%*	*0.2%*	*–*	*–*	*–*	*-100.0%*	*–*
Consumable: Stationery, printing and office supplies	*1 522*	*1 375*	*3 054*	*5 904*	*57.1%*	*1.1%*	*4 669*	*4 415*	*4 026*	*-12.0%*	*0.8%*
Operating leases	*238*	*241*	*303*	*873*	*54.2%*	*0.2%*	*1 021*	*1 068*	*502*	*-16.8%*	*0.1%*
Transport provided: Departmental activity	*2 214*	*3 093*	*3 227*	*3 952*	*21.3%*	*1.2%*	*700*	*734*	*784*	*-41.7%*	*0.3%*
Travel and subsistence	*9 918*	*14 875*	*17 078*	*14 986*	*14.8%*	*5.4%*	*9 917*	*11 207*	*16 731*	*3.7%*	*2.2%*

National Health Insurance, Health Planning and Systems Enablement

Economic classification											
	Audited outcome			**Adjusted appropri-ation**	**Average growth rate (%)**	**Expen-diture/ total: Average (%)**	**Medium-term expenditure estimate**			**Average growth rate (%)**	**Expen-diture/ total: Average (%)**
R thousand	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2010/11 - 2013/14**		**2014/15**	**2015/16**	**2016/17**	**2013/14 - 2016/17**	
Training and development	*2*	*1 804*	*3 135*	*3*	*14.5%*	*0.5%*	*–*	*–*	*1 436*	*682.2%*	*0.1%*
Operating payments	*13 151*	*14 869*	*17 882*	*10 614*	*-6.9%*	*5.4%*	*12 414*	*12 961*	*20 907*	*25.4%*	*2.4%*
Venues and facilities	*774*	*6 851*	*1 660*	*5 998*	*97.9%*	*1.5%*	*6 199*	*6 484*	*1 893*	*-31.9%*	*0.9%*
Transfers and subsidies	**15**	**7 831**	**164 381**	**50 953**	**1403.2%**	**21.3%**	**75 000**	**78 967**	**82 887**	**17.6%**	**12.1%**
Provinces and municipalities	–	–	150 000	50 953	–	19.2%	70 000	73 967	77 887	15.2%	11.4%
Departmental agencies and accounts	–	5 400	9 503	–	–	1.4%	–	–	–	–	–
Non-profit institutions	–	2 400	4 600	–	–	0.7%	5 000	5 000	5 000	–	0.6%
Households	15	31	278	–	-100.0%	–	–	–	–	–	–
Payments for capital assets	**4 150**	**674**	**1 165**	**2 422**	**-16.4%**	**0.8%**	**2 422**	**2 535**	**2 669**	**3.3%**	**0.4%**
Machinery and equipment	4 109	617	1 165	2 422	-16.2%	0.8%	2 422	2 535	2 669	3.3%	0.4%
Software and other intangible assets	*41.0*	*57.0*	–	–	*-100.0%*	–	–	–	–	–	–
Payments for financial assets	**79.0**	**3.0**	**182.0**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Total	**97 216.0**	**164 086.0**	**294 679.0**	**491 826.0**	**71.7%**	**100.0%**	**621 252.0**	**620 013.0**	**650 060.0**	**9.7%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**0.4%**	**0.6%**	**1.1%**	**1.6%**			**1.8%**	**1.7%**	**1.7%**		

Details of transfers and subsidies

Non-profit institutions											
Current	**–**	**2 400**	**4 600**	**–**	**–**	**0.7%**	**5 000**	**5 000**	**5 000**	**–**	**0.6%**
Health, information, evaluation and research non-profit institutions	–	2 400	–	–	–	0.2%	–	–	–	–	–
Non-profit institutions	–	–	4 600	–	–	0.4%	–	–	–	–	–
Health information systems programme	–	–	–	–	–	–	5 000	5 000	5 000	–	0.6%
Households											
Social benefits											
Current	**15**	**31**	**271**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**

Employee social benefits	15	31	271	–	-100.0%	–	–	–	–	–	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**–**	**5 400**	**9 503**	**–**	**–**	**1.4%**	**–**	**–**	**–**	**–**	**–**
Council for Scientific and Industrial Research	–	–	4 041	–	–	0.4%	–	–	–	–	–
South African Medical Research Council	–	–	5 000	–	–	0.5%	–	–	–	–	–
Human Sciences Research Council	–	5 400	–	–	–	0.5%	–	–	–	–	–
National Health Laboratory Services Cancer Register	–	–	462	–	–	–	–	–	–	–	–
Households											
Other transfers to households											
Current	**–**	**–**	**7**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	–	–	7	–	–	–	–	–	–	–	–
Provinces and municipalities											
Provinces											
Provincial Revenue Funds											
Current	**–**	**–**	**150 000**	**50 953**	**–**	**19.2%**	**70 000**	**73 967**	**77 887**	**15.2%**	**11.4%**
National health insurance grant	–	–	150 000	50 953	–	19.2%	70 000	73 967	77 887	15.2%	11.4%

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment													Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate							Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17	2013/14 - 2016/17	
National Health Insurance, Health Planning and Systems Enablement			**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**		
Salary level	**161**	**3**	**160**	**74.7**	**0.5**	**161**	**70.3**	**0.4**	**155**	**67.2**	**0.4**	**155**	**70.8**	**0.5**	**155**	**74.6**	**0.5**	**-1.3%**	**100.0%**
1 – 6	39	–	39	7.2	0.2	39	6.9	0.2	42	8.1	0.2	42	8.5	0.2	42	9.0	0.2	2.5%	26.4%
7 – 10	66	–	68	22.4	0.3	66	21.7	0.3	63	22.9	0.4	63	24.1	0.4	63	25.4	0.4	-1.5%	40.7%
11 – 12	33	1	31	21.2	0.7	33	19.6	0.6	28	17.4	0.6	28	18.3	0.7	28	19.3	0.7	-5.3%	18.7%
13 – 16	23	2	22	24.0	1.1	23	22.1	1.0	22	18.8	0.9	22	19.8	0.9	22	20.9	1.0	-1.5%	14.2%

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

Expenditure trends

The spending focus over the medium term will be on working towards attaining universal health care coverage by overseeing 10 national health insurance pilot projects, and conducting health economics research, particularly on the rollout of national health care and alternative health care financing mechanisms. These activities will be carried out through the *Health Financing and National Health Insurance* subprogramme, in which expenditure grew significantly in 2012/13 and 2013/14. The pilot projects began in 2012/13 and were funded through transfer payments. However, in 2013/14, the national health conditional grant was established to provide funding for the pilot projects and funds were shifted accordingly, from spending on transfers to spending on contractors to provide for general medical practitioners contracted to the projects.

The significant increase projected in expenditure in the *Health Information Management Monitoring and Evaluation* subprogramme in 2014/15 is due to a once-off allocation of R30 million for the South African demographic health survey. Used to collect population based health data, the survey is normally carried out every five years but has not been conducted since 2003/04.

Spending in the *International Health and Development* subprogramme increased from 2010/11 to fund a new health attaché position in Cuba, provide for more students sent to Cuba for medical training, and cover an increase in annual membership fees to the World Health Organisation. Spending in the *Sector-wide Procurement* subprogramme is set to increase at a slower rate over the medium term as the payment of members of the Traditional Healers Council, who were appointed at the end of 2012/13, has been reallocated from 2014/15 to the *Hospital, Tertiary Health Services and Human Resource Development* programme.

The number of posts in this programme is expected to decrease slightly, from 161 to 155 in 2014/15, where it is set to remain over the medium term. This is why expenditure on compensation of employees is expected to decrease in 2014/15 and increase slightly thereafter. There were 5 vacant posts at the end of November 2013 due to natural attrition.

PROGRAMME 3: HIV / AIDS, TB AND MATERNAL AND CHILD HEALTH

3.1 PROGRAMME PURPOSE

The overall purpose of programme 3 is to decrease the burden of disease related to the HIV and TB epidemics; to minimise maternal and child mortality and morbidity; and to optimise good health for children, adolescents and women. This is done through the three overarching strategies of setting policies, guidelines, norms, standards and targets; supporting the implementation of these; and monitoring and evaluating the outcomes and impact of this implementation.

The management of the programme have to ensure that all efforts by all stakeholders are harnessed to support the overall purpose. This includes ensuring that the efforts and resources of Development Partners, funders, academic and research organisations, non-governmental and civil society organisations and civil society at large all contribute in a coherent, integrated fashion.

***HIV and AIDS*:** The Chief Directorate: HIV and AIDS is responsible is responsible for policy formulation, coordination, and monitoring and evaluation of HIV and sexually transmitted diseases services. This entails coordinating the implementation of the National Strategic Plan on HIV, STIs and TB, 2012-2016. Management and oversight of the large conditional grant from the National Treasury for implementation by the provinces is an important function of the sub-programme. Another important purpose is the coordination and direction of donor funding for HIV, especially Pepfar, and Global Fund, in the health sector.

Key successes have been the reduction of mother-to-child HIV transmission, which has resulted in lower child mortality rates; increasing antiretroviral treatment coverage, which resulted in lower adult mortality rates; increasing the number of medical male circumcisions; and maintaining HIV testing at high levels. Key challenges include improving preventive programmes and decreasing the numbers of new infections; scaling up the numbers of people on antiretroviral treatment and retaining those on treatment over time.

***Tuberculosis**:* The Chief Directorate Tuberculosis develops national policies and guidelines, and sets norms and standards for TB and monitors the implementation of these in line with the 20 year vision outlined in the National Strategic Plan on HIV, STIs and TB, 2012-2016. Recent successes include the improved success rates for routine TB cases; and scale-up of GeneXpert technology for improved diagnosis. Key challenges include improving overall data management and monitoring of the programme; improved management of MDR-TB and preventing new cases of TB as well as implementing high quality services with universal coverage to inmates in correctional services centres, miners, their families and members of informal settlements neighbouring mines (peri-mining communities). The cluster has received a large Global Fund grant which will used to respond to these challenges.

Women, Maternal and Reproductive Health: The Chief Directorate: Women, Maternal and Reproductive Health develops and monitors policies and guidelines, sets norms and standards for maternal and women's health and monitors the implementation of these. Over the medium term, key initiatives will be implemented as indicated in the maternal and child health strategic plan. In addition efforts to reduce maternal mortality will be based on the recommendations from the ministerial committees on maternal mortality and the South African campaign on the reduction of maternal mortality in Africa (CARMMA) strategy. Interventions will include the following: deploying obstetric ambulances, strengthening family planning services, establishing maternity waiting homes, establishing Kangaroo Mother Care facilities, taking essential steps in managing obstetric emergency (ESMOE) training for doctors and midwives, intensifying midwifery education and training, and strengthening infant feeding practices.

Child, Youth and School Health: The Chief Directorate: Child, Youth and School Health is responsible for policy formulation, coordination, and monitoring and evaluation of child, youth and school health services. Each province also has a unit which is responsible for fulfilling this role, and for facilitating implementation at the provincial level.

Most MNCWH and nutrition services are provided by the provincial Departments of Health, who are thus central role-players in efforts to improve coverage and quality of MNCWH & Nutrition services. At district level, services are provided by a range of health and community workers, and other workers. Many stakeholders outside of the health sector also have key roles to play in promoting improved child and youth health and nutrition – these include other government departments (such as Social Development, Rural Development, Basic Education, Water Affairs and Forestry, Agriculture and Home Affairs), local government, academic and research institutions, professional councils and associations, civil society, private health providers and development partners, including United Nations and other international and aid agencies.

3.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR 2013/14 TO 2015/16

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

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
To implement MNCWH&N Strategic Plan 2012-2016 and the CARMMA strategy to reduce the maternal mortality ratio to under 100 per 100 000 live births	Antenatal 1st visit before 20 weeks rate	37.5%	40.2%	44%	50.6%	65%	70%	75%	
	Mother postnatal visit within 6 days rate	27%	56.9%	65.1%	74.8%	80%	85%	90%	
	Maternal mortality in facility ratio (annualised)	New Indicator	New Indicator	New Indicator	127.9	100	80	60	
To implement MNCWH&N Strategic Plan 2012-2016 and the CARMMA strategy to reduce the neonatal mortality rate to under 6 per 1000 live births	Inpatient Neonatal death rate (annualized)	New Indicator	New Indicator	New Indicator	11.6 per 1000 Live Births	10 per 1000 Live Births	9 per 1000 Live Births	8 per 1000 Live Births	
To improve access to sexual and reproductive health services by expanding the availability of contraceptives	Couple year protection rate	32%	32.5%	37.8%	36%	55%	65%	75%	Couple year protection rate 80%
	Cervical cancer screening coverage	52.2%	55%	55.4%	55%	60%	64%	68%	70% coverage
	HPV 1st dose coverage	New Indicator	New Indicator	New Indicator	New Indicator	80%	85%	88%	90%

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Expand the PMTCT coverage to pregnant women by ensuring all HIV positive Antenatal clients are placed on ARVs and reducing the positivity rate to below 1%	Antenatal client initiated on ART rate	79.4%	80.4%	81.6%	90%	93%	96%	98%	100%
	Infant 1st PCR test positive around 6 weeks rate	3.5%	4%	2.5%	2.5%	2%	1.5%	1%	1%
To reduce under-five mortality rate to less than 23 per 1,000 live births by promoting early childhood development	Child under 5 years diarrhoea case fatality rate	New Indicator	New Indicator	New Indicator	4.2%	3.5%	3.0%	2.5%	2%
	Child under 5 years severe acute malnutrition case fatality rate	New Indicator	New Indicator	New Indicator	9%	8%	7%	6%	5%
	Confirmed measles case incidence per million total population	New Indicator	New Indicator	New Indicator	<5/ 1,000,000	4/1,000,000	3/1,000,000	2/1,000,000	1/1,000,000
	Immunisation coverage under 1 year (Annualised)	89.4%	95.2 %	94%	94%	95%	96%	97%	98%
	DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	New Indicator	New Indicator	New Indicator	8%	7%	6%	5%	5%
	Measles 2nd dose coverage	81%	85.3%	82.7	81.8%	85%	90%	93%	95%
To improve health and educational outcomes amongst school-aged children by rolling out ISHP services	School Grade 1 screening coverage (annualised)	New Indicator	New Indicator	New Indicator	7%	30%	40%	50%	60%
	School Grade 8 screening coverage (annualised)	New Indicator	New Indicator	New Indicator	4%	25%	35%	45%	50%

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Improve the effectiveness and efficiency of the routine TB control programme to increase the identification of TB patients; to ensure that these take and complete their treatment	TB new client treatment success rate	New Indicator	New Indicator	New Indicator	79%	82%	83%	84%	85%
	TB (new pulmonary) defaulter rate	6.8%	6.8%	6.1%	6%	6%	5.5%	5%	5%
	Number of trained TB tracing coordinators available	New Indicator	New Indicator	New Indicator	0	25	35	45	52 trained tracing coordinators available
	TB death rate	New Indicator	New Indicator	New Indicator	6%	6%	5%	4%	< 3%
To improve the functioning of the MDR-TB control programme including earlier initiation and decentralised treatment	Number of professional nurses trained to initiate MDR-TB treatment	New Indicator	New Indicator	New Indicator	5	25	35	45	400 Professional Nurses trained to initiate MDR-TB treatment
	Number of hospitals assessed according to MDR Treatment criteria	New Indicator	New Indicator	New Indicator	New Indicator	50 hospitals	75 hospitals	100 hospitals	255 hospitals assessed
	TB MDR confirmed treatment initiation rate	New Indicator	New Indicator	New Indicator	56%	60%	65%	70%	80%
	TB MDR treatment success rate	New Indicator	New Indicator	New Indicator	42%	50%	60%	65%	65%

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Ensure that all correctional services facilities have appropriate services and that inmates all have access to TB and HIV diagnosis and treatment services and care	Number of Correctional Services Management areas with risk assessments undertaken	New Indicator	New Indicator	New Indicator	0	20	30	40	48 Correctional Services Management areas
	Percentage of correctional services centres conducting routine TB screening	New Indicator	New Indicator	New Indicator	23%	50%	65%	80%	95%
To scale up combination of prevention interventions to reduce new infections including HCT, male medical circumcision and condom distribution	HIV testing coverage (15-49 Years - Annualized)	10 million (Total Population)	9,909,276 (Total Population)	8,978,177	9 million	10 million annually	10 million annually	10 million annually	10 million annually (cumulative 50 million)
	Number of medical male circumcisions conducted	140,000	347,973	422,262	600,000	1, 000 000 per annum	1, 000 000 per annum	1, 000 000 per annum	1, 000 000 per annum (cumulative 5,000 000)
Increase the numbers of HIV positive people who are managed so that they do not contract opportunistic infections especially TB and who receive antiretroviral therapy when needed.	Total clients remaining on ART (TROA) at the end of the month	New Indicator	New Indicator	New Indicator	2.4 million	3.0 million	3.6 million	4.2 million	5,1 million
	TB/HIV co-infected client initiated on ART rate	New Indicator	New Indicator	New Indicator	54.1%	64%	70%	76%	95%

3.3 QUARTERLY TARGETS FOR 2014/15

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Antenatal 1st visit before 20 weeks rate	Quarterly	65%	55%	60%	63%	65%
Mother postnatal visit within 6 days rate	Quarterly	80%	76%	77%	78%	80%
Inpatient Neonatal death rate (annualized)	Quarterly	10 per 1000 Live Births	11 per 1000 Live Births	10.7 per 1000 Live Births	10.3 per 1000 Live Births	10 per 1000 Live Births
Couple year protection rate	Quarterly	55%	55%	55%	55%	55%
Cervical cancer screening coverage	Quarterly	60%	60%	60%	60%	60%
HPV 1st dose coverage	Annually	80%				
Antenatal client initiated on ART rate	Quarterly	93%	93%	93%	93%	93%
Infant 1st PCR test positive within 2 months rate	Quarterly	2%	2%	2%	2%	2%
Child under 5 years diarrhoea case fatality rate	Quarterly	3.5%	3.5%	3.5%	3.5%	3.5%
Child under 5 years severe acute malnutrition case fatality rate	Quarterly	8%	8%	8%	8%	8%
Confirmed measles case incidence per million total population	Quarterly	4/1,000,000	4/1,000,000	4/1,000,000	4/1,000,000	4/1,000,000

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
Immunisation coverage under 1 year (Annualised)	Quarterly	95%	95%	95%	95%	95%
DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	Quarterly	7%	7%	7%	7%	7%
Measles 2nd dose coverage	Quarterly	85%	85%	85%	85%	85%
School Grade 1 screening coverage (annualised)	Quarterly	30%	30%	30%	30%	30%
School Grade 8 screening coverage (annualised)	Quarterly	25%	25%	25%	25%	25%
TB new client treatment success rate	Quarterly	82%	82%	82%	82%	82%
TB (new pulmonary) defaulter rate	Quarterly	6%	6%	6%	6%	6%
Number of trained TB tracing coordinators	Quarterly	25	5	6	7	7
TB Death Rate	Quarterly	6%	6%	6%	6%	6%
Number of professional nurses trained to initiate MDR-TB treatment	Quarterly	25	5	5	7	8

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
Number of hospitals assessed for TB Infection control measures	Quarterly	38	5	10	10	13
TB MDR confirmed treatment initiation rate	Quarterly	56%	57%	58%	59%	60%
TB MDR treatment success rate	Quarterly	42%	44%	46%	48%	50%
Number of Correctional Services Management areas with risk assessments undertaken	Quarterly	20	5	5	5	5
Percentage of correctional services centres conducting routine TB screening	Quarterly	50%	30%	35%	42%	50%
HIV testing coverage (15-49 Years - Annulised)	Quarterly	10 million annually	2.5 million	2.5 million	2.5 million	2.5 million
Total clients remaining on ART (TROA) at the end of the month	Quarterly	3 million	2,550,000	2,700,000	2,850,000	3,000,000
TB/HIV co-infected client initiated on ART rate	Quarterly	64%	57.%	60%	62%	64%

3.4 RECONCILING PERFORMANCE TARGETS WITH THE BUDGETS AND THE MTEF

Expenditure estimates

HIV and AIDS, Tuberculosis, Maternal and Child Health

Subprogramme	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Programme Management	–	1 051	3 497	3 018	–	–	3 609	3 788	3 992	9.8%	–
HIV and AIDS	6 404 279	7 852 898	9 127 936	10 979 180	19.7%	99.3%	12 784 418	14 459 842	16 226 906	13.9%	98.8%
Tuberculosis	15 822	16 592	13 426	25 811	17.7%	0.2%	26 442	27 719	29 199	4.2%	0.2%
Women's Maternal and Reproductive Health	11 826	15 521	10 724	16 981	12.8%	0.2%	17 058	17 891	19 077	4.0%	0.1%
Child, Youth and School Health	39 410	29 893	13 388	16 984	-24.5%	0.3%	218 396	219 337	20 375	6.3%	0.9%
Total	**6 471 337**	**7 915 955**	**9 168 971**	**11 041 974**	**19.5%**	**100.0%**	**13 049 923**	**14 728 577**	**16 299 549**	**13.9%**	**100.0%**
Change to 2013 Budget estimate				12 840			181 453	181 149	(2 997)		

HIV and AIDS, Tuberculosis, Maternal and Child Health

Economic classification	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Current payments	**284 112**	**258 215**	**219 485**	**305 394**	**2.4%**	**3.1%**	**533 116**	**565 949**	**386 303**	**8.1%**	**3.2%**
Compensation of employees	48 821	52 967	59 447	63 892	9.4%	0.7%	64 404	67 350	70 985	3.6%	0.5%
Goods and services	235 291	205 248	160 038	241 502	0.9%	2.4%	468 712	498 599	315 318	9.3%	2.8%
of which:											
Administration fees	*–*	*–*	*–*	*316*	*–*	*–*	*330*	*345*	*–*	*-100.0%*	*–*
Advertising	*42 758*	*19 827*	*6 040*	*11 902*	*-34.7%*	*0.2%*	*46 258*	*21 668*	*13 322*	*3.8%*	*0.2%*
Assets less than the capitalisation threshold	*270*	*691*	*335*	*1 456*	*75.4%*	*–*	*1 545*	*1 653*	*392*	*-35.4%*	*–*
Catering: Departmental activities	*1 279*	*814*	*656*	*2 794*	*29.8%*	*–*	*2 913*	*3 049*	*887*	*-31.8%*	*–*
Communication	*479*	*406*	*626*	*643*	*10.3%*	*–*	*683*	*737*	*731*	*4.4%*	*–*
Computer services	*22*	*5*	*1*	*115*	*73.6%*	*–*	*129*	*144*	*–*	*-100.0%*	*–*
Consultants and professional services: Business and advisory services	*6 122*	*2 800*	*9 505*	*25 145*	*60.1%*	*0.1%*	*16 511*	*20 066*	*29 522*	*5.5%*	*0.2%*
Contractors	*532*	*25*	*1 099*	*2 715*	*72.2%*	*–*	*2 861*	*2 994*	*2 263*	*-5.9%*	*–*
Agency and support / outsourced services	*1 901*	*1 548*	*1 401*	*5 004*	*38.1%*	*–*	*5 248*	*5 490*	*2 541*	*-20.2%*	*–*
Entertainment	*16*	*11*	*–*	*127*	*99.5%*	*–*	*149*	*200*	*–*	*-100.0%*	*–*
Inventory: Food and food supplies	*–*	*–*	*8*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Fuel, oil and gas	*3*	*6*	*5*	*4*	*10.1%*	*–*	*4*	*4*	*–*	*-100.0%*	*–*

Inventory: Materials and supplies	*2*	*1*	*–*	*11*	*76.5%*	*–*	*2*	*2*	*–*	*-100.0%*	*–*
Inventory: Medical supplies	*116 836*	*124 122*	*112 353*	*140 000*	*6.2%*	*1.4%*	*148 400*	*188 391*	*218 164*	*15.9%*	*1.3%*
Inventory: Medicine	*30 000*	*20 013*	*–*	*–*	*-100.0%*	*0.1%*	*200 000*	*200 000*	*–*	*–*	*0.7%*
Inventory: Other supplies	*5*	*6*	*7*	*34*	*89.5%*	*–*	*44*	*54*	*–*	*-100.0%*	*–*
Consumable: Stationery, printing and office supplies	*4 380*	*9 942*	*1 386*	*15 857*	*53.5%*	*0.1%*	*11 473*	*17 190*	*2 515*	*-45.9%*	*0.1%*
Operating leases	*279*	*317*	*369*	*626*	*30.9%*	*–*	*701*	*753*	*406*	*-13.4%*	*–*
Travel and subsistence	*17 342*	*16 281*	*18 870*	*18 637*	*2.4%*	*0.2%*	*8 398*	*11 682*	*31 041*	*18.5%*	*0.1%*
Training and development	*2 204*	*569*	*–*	*–*	*-100.0%*	*–*	*–*	*–*	*–*	*–*	*–*
Operating payments	*4 412*	*4 046*	*5 383*	*5 134*	*5.2%*	*0.1%*	*11 612*	*12 173*	*10 438*	*26.7%*	*0.1%*
Venues and facilities	*6 449*	*3 818*	*1 994*	*10 982*	*19.4%*	*0.1%*	*11 451*	*12 004*	*3 096*	*-34.4%*	*0.1%*
Transfers and subsidies	**6 186 121**	**7 655 430**	**8 948 443**	**10 734 853**	**20.2%**	**96.9%**	**12 515 080**	**14 160 824**	**15 911 346**	**14.0%**	**96.7%**
Provinces and municipalities	6 051 757	7 492 962	8 762 848	10 533 886	20.3%	94.9%	12 311 322	13 957 043	15 696 765	14.2%	95.2%
Departmental agencies and accounts	–	–	7 000	10 951	–	0.1%	15 000	15 000	15 795	13.0%	0.1%
Higher education institutions	2 000	5 562	–	3 000	14.5%	–	3 000	3 138	3 304	3.3%	–
Public corporations and private enterprises	–	–	40	–	–	–	–	–	–	–	–
Non-profit institutions	132 095	156 904	178 507	187 016	12.3%	1.9%	185 758	185 643	195 482	1.5%	1.4%
Households	269	2	48	–	-100.0%	–	–	–	–	–	–
Payments for capital assets	**917**	**791**	**989**	**1 727**	**23.5%**	**–**	**1 727**	**1 804**	**1 900**	**3.2%**	**–**
Machinery and equipment	917	776	989	1 727	23.5%	–	1 727	1 804	1 900	3.2%	–
Software and other intangible assets	–	*15.0*	–	–	–	–	–	–	–	–	–
Payments for financial assets	**187.0**	**1 519.0**	**54.0**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Total	**6 471 337.0**	**7 915 955.0**	**9 168 971.0**	**11 041 974.0**	**19.5%**	**100.0%**	**13 049 923.0**	**14 728 577.0**	**16 299 549.0**	**13.9%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**28.7%**	**30.8%**	**32.9%**	**36.2%**			**38.4%**	**40.2%**	**41.4%**		

Details of transfers and subsidies

Non-profit institutions											
Current	**132 095**	**156 904**	**178 507**	**187 016**	**12.3%**	**1.9%**	**185 758**	**185 643**	**195 482**	**1.5%**	**1.4%**
Lifeline	16 243	16 478	17 627	18 308	4.1%	0.2%	19 023	19 898	–	-100.0%	0.1%
LoveLife	38 690	62 023	66 124	70 430	22.1%	0.7%	69 843	64 396	105 901	14.6%	0.6%
Soul City	16 960	12 977	13 876	20 820	7.1%	0.2%	15 561	16 277	–	-100.0%	0.1%
HIV and AIDS Non Profit Institutions	57 763	65 020	67 903	76 115	9.6%	0.8%	79 921	83 597	88 028	5.0%	0.6%
TB non-governmental organisations	2 439	–	–	–	-100.0%	–	–	–	–	–	–
South African AIDS Vaccine Institute	–	–	12 977	–	–	–	–	–	–	–	–
Maternal, child and women's health Non Profit institutions	–	406	–	1 343	–	–	1 410	1 475	1 553	5.0%	–
Households											
Social benefits											
Current	**269**	**2**	**48**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	269	2	48	–	-100.0%	–	–	–	–	–	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**–**	**–**	**7 000**	**10 951**	**–**	**0.1%**	**15 000**	**15 000**	**15 795**	**13.0%**	**0.1%**
Human Science Research Council	–	–	7 000	–	–	–	–	–	–	–	–
South African National AIDS Council	–	–	–	10 951	–	–	15 000	15 000	15 795	13.0%	0.1%

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment														Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate								Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17			2013/14 - 2016/17
HIV and AIDS, Tuberculosis, Maternal and Child Health			**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	
Salary level	**137**	**20**	**101**	**59.4**	**0.6**	**137**	**66.0**	**0.5**	**132**	**64.4**	**0.5**	**132**	**67.4**	**0.5**	**132**	**71.0**	**0.5**	**-1.2%**	**100.0%**
1 – 6	10	13	6	1.0	0.2	10	1.9	0.2	19	3.7	0.2	19	3.9	0.2	19	4.1	0.2	23.9%	12.6%
7 – 10	80	1	49	17.5	0.4	80	27.2	0.3	75	27.4	0.4	75	28.9	0.4	75	30.5	0.4	-2.1%	57.2%
11 – 12	29	3	27	15.1	0.6	29	16.2	0.6	21	12.2	0.6	21	12.9	0.6	21	13.6	0.6	-10.2%	17.3%
13 – 16	18	3	19	18.1	1.0	18	17.5	1.0	17	16.6	1.0	17	16.9	1.0	17	18.4	1.1	-1.9%	12.9%
Other	–	–	–	7.8	–	–	3.2	–	–	4.5	–	–	4.8	–	–	4.4	–	–	–

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

Expenditure trends

The spending focus over the medium term will be on providing for the treatment of HIV and AIDS by making transfers to provinces through the comprehensive HIV and AIDS conditional grant. Expenditure on medical supplies, mainly male and female condoms, will is projected to increase annually by an average of 15.9 percent over the medium term. The *HIV and AIDS* sub programme has grown significantly since 2010/11, which: lowered the child mortality rates by reducing mother to child HIV transmission from 3.5 percent to 2.5 percent; increased antiretroviral treatment coverage by an average of 500 000 new patients per year, lowered adult mortality rates, increased the number of medical male circumcisions; and maintained HIV testing at high levels.

The comprehensive HIV and AIDS grant will continue to grow at an average of 14.2 percent over the medium term to strengthen HIV and AIDS testing and prevention programmes and increase the number of people on antiretroviral treatment. The programme will receive an additional R15 million in 2015/16 and R15.8 million for 2016/17 for the transfer to the South African National AIDS Council to support the implementation of the national strategic plan on HIV, sexually transmitted infections and tuberculosis 2012 - 2016.

The growth in spending in the *Women's, Maternal and Reproductive Health* sub programme since 2010/11was due to the expansion of women's health activities, such as supporting deployment of obstetric ambulances, strengthening family planning services and establishing maternity waiting homes to ensure that the relevant millennium development goals were being met.

The bulk of the child, youth and school health subprogramme's budget over the medium term is allocated to the introduction of the vaccination against the human papilloma virus in 2014/15 and 2015/16, which is why spending on medical supply inventory is set to increase significantly in those years. The subprogramme receives additional amounts of R200 million in both 2014/15 and 2015/16 for this purpose. However, from 2016/17, the grant will be transferred through the provincial equitable share, which is why expenditure in the subprogramme is set to decrease significantly in that year. With these additional allocations, the department aims to provide the vaccine to 80 per cent of Grade 4 girls in 2014/15.

The decline in expenditure between 2010/11 and 2013/14 was a result of once-off allocations in 2010/11 for the start-up of new pneumococcal and rotavirus vaccine programmes, which are now funded from provincial health budgets.

There were 14 vacancies as at 30 November 2013. The number of employees is expected to decrease slightly from the current 137 to 132 in 2014/15 due to reprioritisation. The decrease is mainly seen in the lowest salary level category.

PROGRAMME 4: PRIMARY HEALTH CARE SERVICES (PHC)

4.1. PROGRAMME PURPOSE

District Health Services: The District Health System (DHS) is the vehicle for the delivery of Primary Health Care services. The sub-programme is therefore central to supporting the health system to be efficient and effective. The National Health Act, Act 61 of 2003 makes provision for the establishment of health districts and the organization and delivery of services within the DHS. The Act also makes provision for the establishment of district health councils. District health councils however need to be strengthened into oversight bodies that will ensure that well functioning district health management offices manage the primary health care facilities such that they meet the standards of the Office of Health Standards Compliance (OHSC) as well as achieve their key population health indicators. There are 52 health districts in South Africa whose boundaries are coterminous with the municipal boundaries. The National Health Facilities Audit report (2012) lists 3760 health facilities as primary health care facilities (different categories of clinics, community health centers and district hospitals). Over the next five years this sub-programme will collaborate with other programmes within the national department of health, other government departments, development partners, private sector and civil society organizations to ensure that weaknesses within the DHS are addressed over this term. We will:

- Improve district governance and *strengthen* leadership and management of the district health system through establishment of District Health Authorities;
- Improve the governance of primary health care facilities;
- Facilitate the establishment of a service delivery platform for provision of primary health care services within the District Health System;
- Improve the integration of services at all levels of the health system and between private sector and other government departments to address the social determinants of health;
- Organise health services in the community and in primary health care facilities optimally to meet the Office of Health Standards Compliance (OHSC) standards and to achieve targets set for population health outcomes and
- Strengthen the provision of environmental health services

Health Promotion: Optimal health promotion and disease prevention is essential to the success of PHC. In recognizing South Africa's quadruple burden of disease whereby HIV, TB, maternal and child morbidity and mortality, non-communicable diseases and violence and injuries still remain a problem, this sub-programme will over the next five years improve health promotion strategies focussing on South Africa's burden of disease and reduce risk factors for Non-Communicable Diseases (NCDs) by designing and implementing a mass mobilization strategy focusing on healthy options.

Non-Communicable Diseases:The World Health Organization reports that more than 36 million people died globally from NCDs in 2008, which constituted 63% of all deaths. This was mainly from

cardiovascular diseases (48%), cancers (21%), chronic respiratory diseases (12%), and diabetes (3%). Critically more than 9 million of these deaths could have been prevented. Premature deaths from NCDs are particularly high in poorer countries with around 80% of such deaths occurring in low and middle income countries. Globally deaths due to NCDs are projected to increase by 17% over the next ten years, but the greatest increase (24%) is expected in the African region. NCDs are also associated with Disability Adjusted Lost Years (DALYS) which has implications for the optimal functioning of people, preventing them from being gainfully employed and or financially independent. This situation exacerbates the risk of out of pocket expenditure thereby impacting on the development of the person and their family. Around 40% of deaths and 33% of the burden of disease in South Africa are attributable to NCDs.

Mental health is an integral element of health and improved mental health is fundamental to achieving government's goal of "A Long and Healthy life for all South Africans". Mental disorders are associated with the growing burden of NCDs The mental health epidemiological surveys conducted from 2003-2004 found that the 12-month prevalence of adult mental disorders in South Africa was 16.5% and of these only 25% accessed and received treatment. The most prevalent disorders are anxiety disorders, substance abuse disorders and mood disorders.

During this term, this sub-programme will focus on the reduction of risk factors for NCDs, improvement of health systems and services for detection and control of NCDs, improvement of the service delivery platform for PHC focused eye-care, oral health, care of the elderly, rehabilitation, disability and mental health. The sub-programme will expand services to prevent disability through coordinated multidisciplinary rehabilitation services. With regard to mental health we will collaborate with other sectors to increase public awareness regarding mental health and reduce stigma and discrimination associated with mental illness and scale up decentralized integrated primary mental health services, which include community-based care, PHC clinic care, and district hospital level care.

Communicable Disease Control:The breakdown of control of Malaria in cross-border areas, especially Mozambique poses a risk to South Africa reaching its elimination target with the concomitant risk of morbidity and mortality related to Malaria. Poor water quality and sanitation in South Africa especially in Mpumalanga, Limpopo, KwaZulu-Natal and the Eastern Cape put South Africa at risk of increased risk of outbreaks of Typhoid, Cholera and other diarrhoeal diseases. The current global risk of respiratory diseases (Avian Influenza H7N9, MERS-Corona virus) points to the importance of providing financial resources to counter the threat of influenza.

This sub-programme will devote this term to strengthening disease detection through improved surveillance, strengthening preparedness and core response capacities for public health emergencies in line with International Health Regulations, implementation of the Influenza prevention and control programme and the elimination of Malaria.

Violence, Trauma and EMS formulates and monitors policies, guidelines, and norms and standards for the management of violence, trauma and emergency medical services. In 2013/14, the strategic plan for violence and injury prevention was developed and policy guidelines for the management for sexual assault and related offences were finalised. Both the plan and guidelines will be implemented to reduce the burden of violence and injury prevention on the health sector.

4.2. STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Improve district governance and strengthen management and leadership of the district health system	Functional district management offices with an oversight body with the required authority established	New Indicator	New Indicator	New Indicator	Functional district management offices with an oversight body with the required authority established	Pilot report and roll out plan completed	15 Functional district management offices with an oversight body with the required authority established	30 Functional district management offices with an oversight body with the required authority established	20 Functional district management offices with an oversight body with the required authority established
	Number of primary health care facilities with functional clinic committees/ district hospital boards	New Indicator	New Indicator	New Indicator	2256 primary health care facilities with functional clinic committees/ district hospital boards	Implementation (i) strategy approved (ii) Monitoring and evaluation system implemented	3000 health care facilities with functional clinic committees	3200 health care facilities with functional clinic committees	3760 primary health care facilities with functional clinic committees/ district hospital boards
	Number of districts with uniform management structures for primary health care facilities	New Indicator	New Indicator	New Indicator	Zero districts with uniform management structures for primary health care (PHC) facilities	Uniform management structures for PHC facilities approved and resources secured	15 districts with uniform management structures for primary health care facilities	30 districts with uniform management structures for primary health care facilities	52 districts with uniform management structures for primary health care facilities

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Establish an intersectoral forum that will plan and oversee the implementation of interventions across all sectors to specifically target the incidence of diarrhoea in children under 5 years of age	Intersectoral forum established and functioning, specifically targeting the incidence of diarrhoea in children under 5 years of age	New Indicator	New Indicator	Draft Framework for addressing the social determinants of Health developed	Zero	Intersectoral forum established	Intersectoral work plan for targeting diarrhoea in children under 5 years of age implemented	Intersectoral work plan for targeting diarrhoea in children under 5 years of age implemented	Intersectoral forum established and functioning, specifically targeting the incidence of diarrhoea in children under 5 years of age
Improve access to community based PHC services and quality of services at primary health care facilities	Number of primary health care clinics in the 52 districts that qualify as Ideal Clinics	New Indicator	New Indicator	New Indicator	Zero primary health care clinics in the 52 districts qualify as Ideal Clinics	Roll out plan approved and resourced	300 primary health care clinics in the 52 districts qualify as Ideal Clinics	600 primary health care clinics in the 52 districts qualify as Ideal Clinics	2325 (75%) primary health care clinics in the 52 districts qualify as Ideal Clinics
	Number of functional WBPHCOTs[4]	New Indicator	New Indicator	New Indicator	673 functional WBPHCOTs	1000 functional WBPHCOTs	1500 functional WBPHCOTs	2000 functional WBPHCOTs	3000 functional WBPHCOTs
Ensure that the Port Health services are rendered in line with the	Number of Ports of entry that are compliant with the	New Indicator	New Indicator	New indicator	0	10 ports of entry compliant with the International	17 ports of entry compliant with the International	24 ports of entry compliant with the International	36 ports of entry compliant with the International

[4] A functional WBPHCOT is one that is constituted according to the prescripts of the policy on WBPHCOTs and reports its activities on the District Health Information System

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
International Health Regulations	International Health Regulations					Health Regulations	Health Regulations	Health Regulations	Health Regulations
Improve environmental health services in all 52 districts and metropolitan municipalities in the country	Number of municipalities that meet environmental health norms and standards in executing their environmental health functions	New Indicator	New Indicator	New Indicator	None	Environmental Health strategy developed	Environmental Norms and Standards available for: • Water Monitoring •Waste Management • Chemical Safety • Health surveillance of premises • Port Health	52 municipalities meet environmental health norms and standards in executing their environmental health functions	52 district and metropolitan municipalities meet environmental health norms and standards in executing their environmental health functions
Reduce risk factors and improve management for Non-Communicable Diseases (NCDS) by implementing the Strategic Plan for NCDs 2012-2017	% reduction in obesity in men and women	New Indicator	New Indicator	New Indicator	New Indicator	65% obese women 31% obese men	65% obese women 31% obese men	60% obese women 26% obese men	55% obese women 21% obese men
	Number of people counseled and screened for high blood pressure	New Indicator	New Indicator	New Indicator	New Indicator	500 000 people for high blood pressure	1 000 000 people for high blood pressure	2 000 000 people for high blood pressure	5 million people screened for high blood pressure

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
	Number of people counseled and screened for raised blood glucose levels	New Indicator	New Indicator	New Indicator	New Indicator	500 000 people for raised blood glucose levels	1 000 000 people for raised blood glucose levels	2 000 000 people for raised blood glucose levels	5 million people screened for raised blood glucose levels
Improve access to and quality of mental health services in South Africa	Percentage people screened for mental disorders	New Indicator	New Indicator	New Indicator	25% of 16.5% (prevalence) people are screened for mental disorders	25 % of 16.5% (prevalence) people screened for mental disorders	28 % of 16.5% (prevalence) people screened for mental disorders	30 % of 16.5% (prevalence) people screened for mental disorders	35% prevalent population screened for mental disorders
	Percentage of people treated for mental disorders	New Indicator	New Indicator	New Indicator	25% of 16.5% (prevalence) people are treated for mental disorders	25 % of 16.5% (prevalence) people treated for mental disorders	28 % of 16.5% (prevalence) people treated for mental disorders	30 % of 16.5% (prevalence) people treated for mental disorders	35% prevalent population treated for mental disorders
Improve access to disability and rehabilitation services through the implementation of the framework and model for rehabilitation and disability services	Number of Districts implementing the framework and model for rehabilitation services	New Indicator	New Indicator	New Indicator	Draft framework and model for rehabilitation services	Model approved and costed	15 Districts implementing the framework and model for rehabilitation services	30 Districts implementing the framework and model for rehabilitation services	52 Districts implementing the framework and model for rehabilitation services
	Cataract Surgery Rate	New indicator	New indicator	New indicator	1 000 cataract surgeries per million un-insured population	1 500 operations per million un-insured population	1 500 operations per million un-insured population	1 500 operations per million un-insured population	1700 cataract surgeries per million uninsured population

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Eliminate Malaria by 2018, so that there is zero local cases of malaria in South Africa	Reduce the local transmission of malaria cases to 0 per 1000 population at risk	0.66 confirmed local cases	0.4 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	0.30 per 1000 population at risk	0.3 malaria cases per 1000 population at risk	0.2 malaria cases per 1000 population at risk	0.2 malaria cases per 1000 population at risk	0 malaria cases per 1000 population at risk
	Number of malaria endemic districts reporting malaria cases within 24 hours of diagnosis	New Indicator	New Indicator	New Indicator	1 malaria endemic district reporting malaria cases within 24 hours of diagnosis	3 malaria endemic districts reporting malaria cases within 24 hours of diagnosis	5 malaria endemic districts reporting malaria cases within 24 hours of diagnosis	7 malaria endemic districts reporting malaria cases within 24 hours of diagnosis	10 malaria endemic districts reporting malaria cases within 24 hours of diagnosis
Ensure access to and effeicient effective delivery of quality Emergency Medical Services (EMS)	Number of provinces that are compliant with the EMS regulations	New Indicator	New Indicator	New Indicator	None	Draft EMS Regulations developed	EMS Regulations consulted	EMS Regulations gazetted	9 Provinces compliant to EMS regulations
	Review EMS Response Time monitoring system	New indicator	New indicator	New indicator	New Indicator	Review pre-hospital EMS response times indicators and finalise definitions	Pre hospital indicators to be embedded into the Policy manual for EMS and collected and reported on monthly	Data collected and indicators recommended and the application of targets where appropriate reviewed	

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
To improve Forensic Chemistry Laboratory turnaround times for blood, alcoholic, toxicology and food samples	Median waiting time for blood alcohol results	New indicator	New indicator	New indicator	Unknown	Baseline established	6 weeks	5 weeks	3 weeks
	Turnaround times of toxicology tests and reports	New indicator	New indicator	New indicator	Unknown	Baseline established	6 months	7 months	8 months
	Turnaround times of food products tests and reports	New indicator	New indicator	New indicator	Unknown	Baseline established	60 days for perishable food product and 120 days for non-perishable products	45 days for perishable food product and 90 days for non-perishable products	30 days for perishable food product and 60 days for non-perishable products
Improve South Africa's response with regard to Influenza prevention and control	Number of high risk population covered by the seasonal influenza vaccination	New Indicator	New Indicator	New Indicator	730 816 high risk individuals covered with seasonal influenza vaccination	750 000 high risk individuals covered with seasonal influenza vaccination	800 000 high risk individuals covered with seasonal influenza vaccination	1 000 000 high risk individuals covered with seasonal influenza vaccination	1 228 000 high risk individuals covered with seasonal influenza vaccination

4.3. QUARTERLY TARGETS FOR 2014/15

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Functional district management offices with an oversight body with the required authority established	Annual	Pilot report and roll out plan completed				
Number of primary health care facilities with functional clinic committees/ district hospital boards	Annual	Implementation (i) strategy approved (ii) Monitoring and evaluation system implemented				
Number of districts with uniform management structures for primary health care facilities	Annual	uniform management structures for primary health care facilities approved and resources secured				
Intersectoral forum established and functioning, specifically targeting the incidence of diarrhoea in children under 5 years of age	Annual	Intersectoral forum established				
Number of primary health care clinics in the 52 districts that qualify as Ideal Clinics	Annual	Roll out plan approved and resourced				

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Number of functional WBPHCOTs[5]	Quarterly	1000 functional WBPHCOTs	750 functional WBPHCOTs	800 functional WBPHCOTs	900 functional WBPHCOTs	1000 functional WBPHCOTs
Number of Ports of entry that are compliant with the International Health Regulations	Quarterly	38 ports of entry compliant with the International Health Regulations	34 ports of entry compliant with the International Health Regulations	35 ports of entry compliant with the International Health Regulations	36 ports of entry compliant with the International Health Regulations	38 ports of entry compliant with the International Health Regulations
Number of municipalities that meet environmental health norms and standards in executing their environmental health functions	Annual	Environmental Health strategy developed				
% reduction in obesity in men and women	Annual	65% obese women 31% obese men				
Number of people counseled and screened for high blood pressure	Annual	500 000 people for high blood pressure				
Number of people counseled and screened for raised blood glucose levels	Quarterly	500 000 people for raised blood glucose levels	10 000	150 000	400 000	500 000

[5] A functional WBPHCOT is one that is constituted according to the prescripts of the policy on WBPHCOTs and reports its activities on the District Health Information System

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Percentage people screened and treated for mental disorders	Quarterly	25 % of 16.5% (prevalence) people screened and tested for mental disorders	10 000	150 000	400 000	500 000
Percentage of people treated for mental disorders	Annual	25 % of 16.5% (prevalence) people treated for mental disorders				
Number of Districts implementing the framework and model for rehabilitation services	Annual	Model approved and costed				
Cataract Surgery Rate	Annual	1 500 operations per million un-insured population				
Reduce the local transmission of malaria cases to 0 per 1000 population at risk	Quarterly	0.3 malaria cases per 1000 population at risk	0.3 malaria cases per 1000 population at risk	0.3 malaria cases per 1000 population at risk	0.3 malaria cases per 1000 population at risk	0.3 malaria cases per 1000 population at risk
Number of malaria endemic districts reporting malaria cases within 24 hours of diagnosis	Annual	3 malaria endemic districts reporting malaria cases within 24 hours of diagnosis				
Number of provinces that are compliant with the EMS regulations	Annual	Draft EMS Regulations developed				
Review EMS monitoring systems	Annual	Review pre-hospital EMS response times indicators and finalise definitions				
Median waiting time for blood alcohol results	Annual	Baseline established				

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Turnaround times of toxicology tests and reports	Annual	Baseline established				
Turnaround times of food products tests and reports	Annual	Baseline established				
Number of high risk population covered by the seasonal influenza vaccination	Annual	750 000 high risk individuals covered with seasonal influenza vaccination				

4.4 RECONCILING THE PERFORMANCE TARGETS FOR THE BUDGET AND MTEF

Expenditure estimates

Primary Health Care Services

Subprogramme	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Programme Management	–	2 468	1 897	3 332	–	2.0%	3 007	3 155	3 324	-0.1%	3.2%
District Services and Environmental Health	28 868	45 009	24 932	21 585	-9.2%	30.6%	25 762	26 962	28 405	9.6%	25.8%
Communicable Diseases	13 985	9 706	43 624	15 098	2.6%	21.0%	13 553	14 187	14 945	-0.3%	14.5%
Non-Communicable Diseases	25 685	24 155	22 692	25 890	0.3%	25.0%	25 718	26 954	28 576	3.3%	26.9%
Health Promotion and Nutrition	10 232	12 288	14 114	23 062	31.1%	15.2%	21 768	22 852	24 152	1.6%	23.1%
Violence, Trauma and EMS	3 523	3 699	3 699	13 649	57.1%	6.2%	3 707	3 959	4 251	-32.2%	6.4%
Total	**82 293**	**97 325**	**110 958**	**102 616**	**7.6%**	**100.0%**	**93 515**	**98 069**	**103 653**	**0.3%**	**100.0%**
Change to 2013 Budget estimate				(6 799)			(5 703)	(5 510)	(1 717)		
Economic classification											
Current payments	**75 523**	**94 647**	**106 219**	**98 644**	**9.3%**	**95.4%**	**87 603**	**93 978**	**99 345**	**0.2%**	**95.4%**
Compensation of employees	34 766	41 051	40 444	48 815	12.0%	42.0%	50 567	53 297	56 174	4.8%	52.5%
Goods and services	40 757	53 596	65 775	49 829	6.9%	53.4%	37 036	40 681	43 171	-4.7%	42.9%
of which:											
Administration fees	*89*	*–*	*2*	*60*	*-12.3%*	*–*	*62*	*65*	*–*	*-100.0%*	*–*
Advertising	*286*	*1 780*	*1 104*	*824*	*42.3%*	*1.0%*	*838*	*876*	*2 104*	*36.7%*	*1.2%*
Assets less than the capitalisation threshold	*137*	*267*	*322*	*437*	*47.2%*	*0.3%*	*454*	*475*	*349*	*-7.2%*	*0.4%*
Audit costs: External	*–*	*–*	*–*	*129*	*–*	*–*	*134*	*140*	*–*	*-100.0%*	*0.1%*
Catering: Departmental activities	*704*	*672*	*377*	*2 422*	*51.0%*	*1.1%*	*1 537*	*1 609*	*1 414*	*-16.4%*	*1.8%*
Communication	*366*	*337*	*352*	*3 691*	*116.1%*	*1.2%*	*4 302*	*4 500*	*1 349*	*-28.5%*	*3.5%*
Computer services	*4*	*1*	*14*	*1 727*	*655.8%*	*0.4%*	*1 796*	*1 879*	*11*	*-81.5%*	*1.4%*
Consultants and professional services: Business and advisory services	*21 380*	*35 004*	*4 364*	*14 725*	*-11.7%*	*19.2%*	*8 379*	*9 879*	*6 066*	*-25.6%*	*9.8%*
Contractors	*37*	*15*	*18*	*132*	*52.8%*	*0.1%*	*133*	*139*	*–*	*-100.0%*	*0.1%*
Agency and support / outsourced services	*112*	*14*	*8 734*	*21*	*-42.8%*	*2.3%*	*22*	*23*	*7 959*	*623.7%*	*2.0%*
Entertainment	*12*	*14*	*–*	*67*	*77.4%*	*–*	*70*	*73*	*–*	*-100.0%*	*0.1%*
Inventory: Food and food supplies	*–*	*–*	*8*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Fuel, oil and gas	*1*	*3*	*3*	*203*	*487.7%*	*0.1%*	*211*	*221*	*–*	*-100.0%*	*0.2%*
Inventory: Learner and teacher support material	*–*	*–*	*–*	*177*	*–*	*–*	*184*	*192*	*–*	*-100.0%*	*0.1%*

Inventory: Materials and supplies	*2*	*1*	*–*	*17*	*104.1%*	*–*	*17*	*17*	*–*	*-100.0%*	*–*
Inventory: Medical supplies	*2 106*	*65*	*–*	*–*	*-100.0%*	*0.6%*	*–*	*–*	*–*	*–*	*–*
Inventory: Medicine	*–*	*–*	*32 083*	*1 026*	*–*	*8.4%*	*1 067*	*1 116*	*2 905*	*41.5%*	*1.5%*
Inventory: Other supplies	*10*	*38*	*9*	*62*	*83.7%*	*–*	*66*	*69*	*–*	*-100.0%*	*–*
Consumable: Stationery, printing and office supplies	*2 785*	*3 790*	*2 103*	*5 667*	*26.7%*	*3.6%*	*5 808*	*5 075*	*3 660*	*-13.6%*	*5.1%*
Operating leases	*300*	*343*	*325*	*463*	*15.6%*	*0.4%*	*477*	*499*	*347*	*-9.2%*	*0.4%*
Travel and subsistence	*6 627*	*7 154*	*8 340*	*14 532*	*29.9%*	*9.3%*	*7 919*	*10 110*	*8 890*	*-15.1%*	*10.4%*
Training and development	*25*	*241*	*13*	*15*	*-15.7%*	*0.1%*	*16*	*17*	*14*	*-2.3%*	*–*
Operating payments	*5 370*	*2 243*	*5 859*	*1 862*	*-29.7%*	*3.9%*	*1 918*	*2 006*	*6 064*	*48.2%*	*3.0%*
Venues and facilities	*404*	*1 614*	*1 745*	*1 570*	*57.2%*	*1.4%*	*1 626*	*1 701*	*2 039*	*9.1%*	*1.7%*
Transfers and subsidies	**6 338**	**2 004**	**3 530**	**2 498**	**-26.7%**	**3.7%**	**4 438**	**2 550**	**2 685**	**2.4%**	**3.1%**
Departmental agencies and accounts	4 600	–	–	–	-100.0%	1.2%	–	–	–	–	–
Non-profit institutions	1 708	1 504	3 528	2 498	13.5%	2.3%	4 438	2 550	2 685	2.4%	3.1%
Households	30	500	2	–	-100.0%	0.1%	–	–	–	–	–
Payments for capital assets	**432**	**660**	**523**	**1 474**	**50.5%**	**0.8%**	**1 474**	**1 541**	**1 623**	**3.3%**	**1.5%**

Primary Health Care Services

Economic classification	**Audited outcome**			**Adjusted appropri-ation**	**Average growth rate (%)**	**Expen-diture/ total: Average (%)**	**Medium-term expenditure estimate**			**Average growth rate (%)**	**Expen-diture/ total: Average (%)**
R thousand	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2010/11 - 2013/14**		**2014/15**	**2015/16**	**2016/17**	**2013/14 - 2016/17**	
Machinery and equipment	432	660	523	1 474	50.5%	0.8%	1 474	1 541	1 623	3.3%	1.5%
Payments for financial assets	**–**	**14.0**	**686.0**	**–**	**–**	**0.2%**	**–**	**–**	**–**	**–**	**–**
Total	**82 293.0**	**97 325.0**	**110 958.0**	**102 616.0**	**7.6%**	**100.0%**	**93 515.0**	**98 069.0**	**103 653.0**	**0.3%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**0.4%**	**0.4%**	**0.4%**	**0.3%**			**0.3%**	**0.3%**	**0.3%**		

Details of transfers and subsidies

Non-profit institutions											
Current	**1 708**	**1 504**	**3 528**	**2 498**	**13.5%**	**2.3%**	**4 438**	**2 550**	**2 685**	**2.4%**	**3.1%**
Non-Communicable Disease non-governmental organisations	–	–	1 100	–	–	0.3%	–	–	–	–	–
District Services & Environmental Health non-governmental organisations	–	–	844	–	–	0.2%	–	–	–	–	–
South African Federation for Mental Health	261	277	290	305	5.3%	0.3%	320	335	–	-100.0%	0.2%
South African National Council for the Blind	585	620	651	684	5.3%	0.6%	718	751	792	5.0%	0.7%
Public Health Association of South Africa	–	–	–	100	–	–	–	–	–	-100.0%	–
Inter-Academy Medical Panel	–	–	–	100	–	–	–	–	–	-100.0%	–
Medical Research Council: South African Community Epidemiology Network on Drug Use	366	303	351	428	5.4%	0.4%	450	471	1 048	34.8%	0.6%
Downs Syndrome South Africa	146	11	–	173	5.8%	0.1%	182	190	–	-100.0%	0.1%
National Council Against Smoking	350	293	292	708	26.5%	0.4%	768	803	845	6.1%	0.8%

Health Systems Global - South Africa	–	–	–	–	–	–	2 000	–	–	–	0.5%
Households											
Social benefits											
Current	**30**	**–**	**2**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	30	–	2	–	-100.0%	–	–	–	–	–	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**4 600**	**–**	**–**	**–**	**-100.0%**	**1.2%**	**–**	**–**	**–**	**–**	**–**
Humans Sciences Research Council	4 600	–	–	–	-100.0%	1.2%	–	–	–	–	–
Households											
Other transfers to households											
Current	**–**	**500**	**–**	**–**	**–**	**0.1%**	**–**	**–**	**–**	**–**	**–**
Donation	–	500	–	–	–	0.1%	–	–	–	–	–

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment														Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate								Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17			2013/14 - 2016/17	
Primary Health Care Services			**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**		
Salary level	**103**	**1**	**101**	**40.4**	**0.4**	**107**	**48.8**	**0.5**	**106**	**50.6**	**0.5**	**106**	**53.3**	**0.5**	**106**	**56.2**	**0.5**	**-0.3%**	**100.0%**
1 – 6	24	–	24	4.2	0.2	25	4.5	0.2	23	4.6	0.2	23	4.9	0.2	23	5.1	0.2	-2.7%	22.1%
7 – 10	37	–	42	14.0	0.3	41	15.0	0.4	43	17.0	0.4	43	17.9	0.4	43	18.9	0.4	1.6%	40.0%
11 – 12	25	–	20	10.9	0.5	23	14.1	0.6	24	15.3	0.6	24	16.2	0.7	24	17.0	0.7	1.4%	22.4%
13 – 16	17	1	15	11.4	0.8	18	15.2	0.8	16	13.6	0.8	16	14.4	0.9	16	15.1	0.9	-3.9%	15.5%

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

2. Rand million.

Expenditure trends

The spending focus over the medium term will be on promoting health, preventing non-communicable diseases such as hypertension and diabetes, and combating malaria and vector borne diseases in South Africa and the SADC. As such, *Non-Communicable Diseases* and *Communicable Diseases* subprogrammes are expected to be the largest spending items in the programme over the MTEF period. Pursuing these objectives requires significant spending on compensation of employees, consultants, and travel and subsistence, which is why a large proportion of the programme's budget is allocated to these items over the medium term.

The significant increase in spending in the *District Services and Environmental Health* subprogramme in 2011/12 was due to the once-off payment of R24.8 million for the health facilities audit carried out, which increased expenditure on consultants and professional services. The audit was carried out to establish baselines for future inspections by the Office of Standards Compliance and to enable comparison between facilities.

In 2012/13, spending in the *Communicable Diseases* subprogramme was higher due to the rollover of funds to purchase avian flu influenza vaccines, which were needed in the provincial departments due to the severity of the epidemic. The increase in spending in the *Violence, Trauma and EMS* subprogramme in 2013/14 was mainly due to a once-off allocation for emergency services to cover for the 2014 African Nations Championship.

PROGRAMME 5: HOSPITAL, TERTIARY HEALTH SERVICES AND HUMAN RESOURCE DEVELOPMENT

5.1 PROGRAMME PURPOSE

The purpose of the programme is to develop policies, delivery models and clinical protocols for hospitals and emergency medical services. Ensure alignment of academic medical centres with health workforce programmes, training of health professionals and to ensure the planning of health infrastructure to meet the health needs of the country.

HOSPITALS AND TETIARY HEALTH SERVICES is responsible for tertiary services planning, policies that guides the management of and service standards in hospitals as well as to ensure the production of appropriate numbers, staff mix and appropriately qualified health professionals

***OFFICE OF NURSING SERVICES*:** The purpose of the Office of Nursing Services is to develop, reconstruct and revitalize the profession to ensure that nursing and midwifery practitioners are equipped to address the disease burden and population health needs within a revitalized healthcare system in South Africa. This sub-programme is responsible for the promotion and maintenance of a high standard and quality of nursing and midwifery education and training, to enhance and maintain professionalism and professional ethos amongst members of the nursing and midwifery professions by providing strong leadership leadership at all levels of nursing and midwifery practice.It is also the responsibility of this programme to promote and maintain an enabling, well-resourced and positive practice environment for nursing, midwifery and patients/clients throughout the lifespan as well as to ensure the production of sufficient numbers and the appropriate numbers and categories of nurses.

***HEALTH FACILITIES INFRASTRUCTURE PLANNING*:** The Sub Programme coordinates and funds health infrastructure to enable provinces to plan, manage, modernise, rationalise and transform infrastructure, health technology, hospital management and improve quality of care; and it is responsible for two conditional grants for health infrastructure: the provincial health facility revitalisation grant and, since 2013/14, the infrastructure component of the national health grant. In 2012/13, guidance was provided on infrastructure planning and design through the infrastructure unit systems support and 32 sets of national infrastructure norms, standards, guidelines and benchmarks for all levels of health care facilities were developed. In addition, the project monitoring information system was configured, tested and piloted.

***WORKFORCE DEVELOPMENT AND PLANNING:* T**he sub-programme is responsible for medium to long-term health workforce planning, development and management in the national health system. this entails facilitating implementation of the national human resources for health strategy, health workforce capacity development for sustainable service delivery, and development, and co-ordination of transversal human resources management policies. The functions of the Sub Programme also focus on the following: Facilitate the process of increasing the number of health professionals in the health sector, facilitate implementation of the HRH Strategy, development of health workforce staffing norms and standards, facilitate in-service training of the health workforce, including Community Health Workers.

5.2 .STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR 2014/15 TO 2016/17

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Increase capacity of central hospitals to strengthen for local decision making accountability to facilitate semi-autonomy of 10 central hospitals	No. of central hospital with reformed management and governance structures as per the prescripts	New indicator	New indicator	New indicator	None of the Central Hospitals function semi-autonomously	0	4	6	All 10 Central Hospitals with reformed management and governance structures according to the prescripts
Ensure equitable access to tertiary service through implementation of the National Tertiary services plan	Number of gazetted hospitals providing the full package of Tertiary1 Services	New indicator	New indicator	New indicator	None	2 gazetted tertiary hospitals providing the full package of Tertiary 1 services	2 gazetted tertiary hospitals providing the full package of Tertiary 1 services	2 gazetted tertiary hospitals providing the full package of Tertiary 1 services	17 gazetted tertiary hospitals providing the full package of Tertiary 1 services
Ensure quality health care by improving compliance with National Core Standards at all Central, Tertiary,	% compliance with extreme and vital measures of the National Core Standards all Central, Tertiary, Regional and Specialised	New indicator	New indicator	New indicator	Non-compliance with extreme and vital measures of the National Core Standards	100% compliance with extreme and vital measures of the National Core Standards in 5 Central	100% compliance with extreme and vital measures of the National Core Standards in 10 Central	100% compliance with extreme and vital measures of the National Core Standards in	100% compliance with extreme and vital measures of the National Core Standards in 10 Central, 17 Tertiary, 46

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
Regional and Specialised Hospitals	Hospitals					Hospitals	hospitals and 10 Tertiary Hospitals	10 Central, 17 Tertiary, 23 Regional Hospitals	Regional and 63 Specialised Hospitals
Develop health workforce staffing norms and standards.	Develop guidelines for HRH norms and standards using the WISN methodology	New indicator	New indicator	New indicator	Draft guidelines for PHC- HR norms and standards available	Determine norms for PHC. Orientate District Hospital managers	Determine norms for District and specialised hospitals. Orientate Tertiary, Regional and Central Hospital managers	Determine norms for Regional, Tertiary and Central Hospitals	Guidelines for HR Norms and standards published for all levels of care
Ensure that the number, distribution, quality and standard of health facilities are in compliance with norms and standards	Number of RTC's established		New indicator	New indicator	Three RTC's established, but non-compliant with all requirements	3 RTCs established	5 RTCs established	8 RTCs established	
Improve quality of Nursing training and practice by ensuring that	The number of public nursing colleges accredited to offer the new nursing qualification	New indicator	New indicator	New indicator	None available	5 public nursing colleges accredited to offer the new nursing	10 public nursing colleges accredited to offer the new nursing	15 public nursing colleges accredited to offer the new nursing	220 Public Nursing colleges accredited to offer the new nursing qualification

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2018/19
all Nursing colleges are accredited to offer the new Nursing qualification						qualification	qualification	qualification	
Improve quality of health infrastructure in South Africa by ensuring all new health facilities are compliant with health facility norms and standards	Percentage of facilities that comply with gazetted infrastructure Norms & Standards	New indicator	New indicator	New indicator	None	100% from date of gazetting	100% from date of gazetting	100% from date of gazetting	Health facility Norms & Standards developed and gazetted by 2015 100% of new facilities comply with gazetted health facility Norms & Standards Norms & Standards

5.3 QUARTERLY TARGETS FOR 2014/15

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
No. of central hospital with reformed management and governance structures as per the prescripts	Annual	0				
Number of gazetted hospitals providing the full package of Tertiary 1 Services	Bi Annual	2 gazetted tertiary hospitals providing the full package of Tertiary 1 services		1		1
% compliance with extreme and vital measures of the National Core Standards all Central, Tertiary, Regional and Specialised Hospitals	Quarterly	100% compliance with extreme and vital measures of the National Core Standards in 5 Central Hospitals		100% compliance with extreme and vital measures of the National Core Standards in 1 Central Hospitals	100% compliance with extreme and vital measures of the National Core Standards in 2 Central Hospitals	100% compliance with extreme and vital measures of the National Core Standards in 5 Central Hospitals
Develop guidelines for HRH norms and standards using the WISN methodology	Annual	Determine norms for PHC. Orientate District Hospital managers				
Number of RTC's established	Annual	3 RTCs established				
The number of public nursing colleges accredited to offer the new nursing qualification	Annual	5 public nursing colleges accredited to offer the new nursing qualification				
Percentage of facilities that	Annual	100% from date of				

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
comply with gazetted infrastructure Norms & Standards		gazetting				

5.4 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Expenditure estimates

Hospitals, Tertiary Health Services and Human Resource Development

Subprogramme	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Programme Management	–	1 681	798	2 556	–	–	3 570	3 748	3 950	15.6%	–
Health Facilities Infrastructure Management	5 191 544	5 985 910	6 314 812	5 790 415	3.7%	34.8%	6 275 300	6 467 573	6 828 200	5.6%	32.9%
Tertiary Health Care Planning and Policy	7 400 741	8 051 780	8 882 258	9 623 920	9.2%	50.8%	10 171 405	10 639 296	11 203 181	5.2%	54.0%
Hospital Management	2 993	9 432	21 427	5 528	22.7%	0.1%	5 426	4 672	5 976	2.6%	–
Human Resources for Health	1 880 530	2 000 988	2 111 834	2 217 324	5.6%	12.3%	2 344 652	2 452 565	2 582 610	5.2%	12.4%
Nursing Services	–	–	503	3 760	–	–	2 531	2 663	2 808	-9.3%	–
Forensic Chemistry Laboratories	589 929	650 322	64 221	78 883	-48.9%	2.1%	122 896	122 824	134 306	19.4%	0.6%
Total	**15 065 737**	**16 700 113**	**17 395 853**	**17 722 386**	**5.6%**	**100.0%**	**18 925 780**	**19 693 341**	**20 761 031**	**5.4%**	**100.0%**
Change to 2013 Budget estimate				(188 812)			(150 594)	(213 223)	25 550		

Hospitals, Tertiary Health Services and Human Resource Development

Economic classification	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Current payments	**70 421**	**132 323**	**203 437**	**165 585**	**33.0%**	**0.9%**	**185 946**	**193 189**	**210 595**	**8.3%**	**1.0%**
Compensation of employees	40 081	53 932	63 962	77 426	24.5%	0.4%	104 722	110 372	116 352	14.5%	0.5%
Goods and services	30 340	78 391	139 475	88 159	42.7%	0.5%	81 224	82 817	94 243	2.2%	0.4%
of which:											
Administration fees	*28*	*37*	*78*	*391*	*140.8%*	*–*	*108*	*133*	*–*	*-100.0%*	*–*
Advertising	*205*	*2 638*	*283*	*1 162*	*78.3%*	*–*	*1 220*	*1 299*	*351*	*-32.9%*	*–*
Assets less than the capitalisation threshold	*150*	*199*	*845*	*1 488*	*114.9%*	*–*	*1 653*	*1 728*	*1 823*	*7.0%*	*–*
Bursaries: Employees	*–*	*–*	*–*	*68*	*–*	*–*	*69*	*72*	*–*	*-100.0%*	*–*
Catering: Departmental activities	*152*	*229*	*188*	*962*	*85.0%*	*–*	*1 008*	*1 062*	*187*	*-42.1%*	*–*
Communication	*935*	*862*	*963*	*1 255*	*10.3%*	*–*	*1 216*	*1 490*	*2 925*	*32.6%*	*–*
Computer services	*636*	*917*	*1 842*	*1 749*	*40.1%*	*–*	*1 849*	*2 103*	*1 817*	*1.3%*	*–*
Consultants and professional services: Business and advisory services	*14 542*	*52 926*	*112 944*	*51 678*	*52.6%*	*0.3%*	*46 900*	*48 302*	*49 390*	*-1.5%*	*0.3%*
Consultants and professional services: Laboratory services	*–*	*–*	*9*	*75*	*–*	*–*	*80*	*80*	*374*	*70.8%*	*–*
Contractors	*1 577*	*2 141*	*1 990*	*4 143*	*38.0%*	*–*	*4 502*	*1 082*	*4 550*	*3.2%*	*–*
Agency and support / outsourced services	*965*	*2 179*	*2 627*	*1 723*	*21.3%*	*–*	*1 832*	*1 993*	*5 753*	*49.5%*	*–*
Entertainment	*6*	*5*	*2*	*23*	*56.5%*	*–*	*18*	*18*	*–*	*-100.0%*	*–*
Inventory: Food and food supplies	*–*	*–*	*5*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Fuel, oil and gas	*218*	*88*	*416*	*150*	*-11.7%*	*–*	*160*	*175*	*457*	*45.0%*	*–*
Inventory: Materials and supplies	*91*	*75*	*23*	*52*	*-17.0%*	*–*	*59*	*64*	*–*	*-100.0%*	*–*
Inventory: Medical supplies	*10*	*6*	*33*	*60*	*81.7%*	*–*	*65*	*90*	*–*	*-100.0%*	*–*
Inventory: Medicine	*2*	*14*	*11*	*30*	*146.6%*	*–*	*30*	*40*	*12*	*-26.3%*	*–*
Inventory: Other supplies	*4 167*	*5 125*	*6 291*	*9 201*	*30.2%*	*–*	*8 587*	*11 647*	*12 379*	*10.4%*	*0.1%*
Consumable: Stationery, printing and office supplies	*759*	*698*	*939*	*2 442*	*47.6%*	*–*	*1 561*	*1 723*	*868*	*-29.2%*	*–*
Operating leases	*490*	*1 237*	*804*	*4 664*	*111.9%*	*–*	*4 760*	*4 992*	*1 838*	*-26.7%*	*–*
Travel and subsistence	*4 210*	*6 706*	*8 355*	*5 052*	*6.3%*	*–*	*4 188*	*2 911*	*10 151*	*26.2%*	*–*
Training and development	*29*	*–*	*–*	*29*	*–*	*–*	*30*	*31*	*–*	*-100.0%*	*–*
Operating payments	*434*	*1 899*	*111*	*428*	*-0.5%*	*–*	*539*	*618*	*612*	*12.7%*	*–*
Venues and facilities	*734*	*410*	*693*	*1 334*	*22.0%*	*–*	*790*	*1 164*	*731*	*-18.2%*	*–*
Rental and hiring	*–*	*–*	*23*	*–*	*–*	*–*	*–*	*–*	*25*	*–*	*–*
Transfers and subsidies	**14 990 221**	**16 549 043**	**17 181 216**	**17 105 539**	**4.5%**	**98.4%**	**17 730 004**	**18 453 354**	**19 409 265**	**4.3%**	**94.3%**
Provinces and municipalities	14 990 204	16 541 820	17 158 834	17 101 539	4.5%	98.4%	17 730 004	18 453 354	19 409 265	4.3%	94.3%
Higher education institutions	–	7 200	21 000	4 000	–	–	–	–	–	-100.0%	–
Non-profit institutions	–	–	1 326	–	–	–	–	–	–	–	–
Households	17	23	56	–	-100.0%	–	–	–	–	–	–
Payments for capital assets	**4 945**	**18 747**	**11 186**	**451 262**	**350.2%**	**0.7%**	**1 009 830**	**1 046 798**	**1 141 171**	**36.2%**	**4.7%**

Buildings and other fixed structures	–	–	–	440 025	–	0.7%	979 862	1 021 169	1 115 244	36.3%	4.6%
Machinery and equipment	4 883	18 747	11 186	11 237	32.0%	0.1%	29 968	25 629	25 927	32.1%	0.1%
Software and other intangible assets	*62.0*	–	–	–	*-100.0%*	–	–	–	–	–	–
Payments for financial assets	**150.0**	**–**	**14.0**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Total	**15 065 737.0**	**16 700 113.0**	**17 395 853.0**	**17 722 386.0**	**5.6%**	**100.0%**	**18 925 780.0**	**19 693 341.0**	**20 761 031.0**	**5.4%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**66.9%**	**64.9%**	**62.4%**	**58.1%**			**55.7%**	**53.8%**	**52.7%**		
Details of transfers and subsidies											
Non-profit institutions											
Current	**–**	**–**	**1 326**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Health facilities and infrastructure management: Non-profit institutions	–	–	1 326	–	–	–	–	–	–	–	–
Households											
Social benefits											
Current	**–**	**23**	**56**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	–	23	56	–	–	–	–	–	–	–	–
Households											
Other transfers to households											
Current	**17**	**–**	**–**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	17	–	–	–	-100.0%	–	–	–	–	–	–

Hospitals, Tertiary Health Services and Human Resource Development

Details of transfers and subsidies											
	Audited outcome			**Adjusted appropri-ation**	**Average growth rate (%)**	**Expen-diture/ total: Average (%)**	**Medium-term expenditure estimate**			**Average growth rate (%)**	**Expen-diture/ total: Average (%)**
R thousand	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2010/11 - 2013/14**		**2014/15**	**2015/16**	**2016/17**	**2013/14 - 2016/17**	
Provinces and municipalities											
Provinces											
Provincial Revenue Funds											
Current	**9 820 349**	**10 616 568**	**12 869 239**	**11 810 723**	**6.3%**	**67.5%**	**12 490 023**	**13 064 564**	**13 756 985**	**5.2%**	**66.3%**
Health professions training and development grant	1 865 387	1 977 310	2 075 248	2 190 366	5.5%	12.1%	2 321 788	2 428 590	2 557 305	5.3%	12.3%
National tertiary services grant	7 398 000	8 048 878	8 878 010	9 620 357	9.2%	50.8%	10 168 235	10 635 974	11 199 680	5.2%	54.0%
Health Infrastructure grant	–	–	1 800 981	–	–	2.7%	–	–	–	–	–
Nursing Colleges grant	–	–	100 000	–	–	0.1%	–	–	–	–	–
Forensic pathology services grant	556 962	590 380	–	–	-100.0%	1.7%	–	–	–	–	–
2013 African Cup of Nations medical services grant	–	–	15 000	–	–	–	–	–	–	–	–
Capital	**5 169 855**	**5 925 252**	**4 289 595**	**5 290 816**	**0.8%**	**30.9%**	**5 239 981**	**5 388 790**	**5 652 280**	**2.2%**	**28.0%**
Health facility revitalisation grant	5 169 855	5 925 252	4 289 595	5 290 816	0.8%	30.9%	5 239 981	5 388 790	5 652 280	2.2%	28.0%
Higher education institutions											

Current	**–**	**7 200**	**21 000**	**4 000**	**–**	**–**	**–**	**–**	**–**	**-100.0%**	**–**
University of Limpopo	–	–	4 000	–	–	–	–	–	–	–	–
University of Cape Town	–	–	4 000	–	–	–	–	–	–	–	–
University of the Witwatersrand	–	7 200	9 000	–	–	–	–	–	–	–	–
University of Stellenbosch	–	–	4 000	–	–	–	–	–	–	–	–
Walter Sisulu University	–	–	–	4 000	–	–	–	–	–	-100.0%	–

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment													Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate							Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17		
Hospitals, Tertiary Health Services and Human Resource Development			**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**2013/14 - 2016/17**	
Salary level	**212**	**–**	**195**	**64.0**	**0.3**	**208**	**77.4**	**0.4**	**291**	**104.7**	**0.4**	**291**	**110.4**	**0.4**	**291**	**116.4**	**0.4**	**11.8%**	**100.0%**
1 – 6	50	–	54	9.1	0.2	50	9.6	0.2	71	13.0	0.2	71	13.7	0.2	71	14.5	0.2	12.4%	24.3%
7 – 10	128	–	111	33.2	0.3	125	40.6	0.3	180	61.0	0.3	180	64.3	0.4	180	67.8	0.4	12.9%	61.5%
11 – 12	18	–	15	8.5	0.6	18	11.1	0.6	21	13.2	0.6	21	13.9	0.7	21	14.4	0.7	5.3%	7.5%
13 – 16	16	–	15	13.1	0.9	15	16.2	1.1	19	17.5	0.9	19	18.4	1.0	19	19.7	1.0	8.2%	6.7%

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

2. Rand million.

Expenditure trends

This is the largest programme of the department due to the three large provincial grants and the one national conditional grant that fall under it. The spending focus over the MTEF period will continue to be on planning for health infrastructure and strengthening tertiary services. As the bulk of this work is done at the provincial level, 91.8 per cent of the programme's allocation over the MTEF period is transferred to provinces.

The health facility revitalisation grant, managed by the *Health Facilities Infrastructure Management* subprogramme, has been allocated R16.3 billion over the MTEF period.

The health facilities revitalisation component of the national health grant, which was established in 2013/14, is an indirect grant to which R3.1 billion has been allocated over the MTEF period. The department plans to use these funds to deliver infrastructure on behalf of provinces. In its first year, the grant was used to build doctors' consulting rooms at national health insurance pilot sites, upgrade nursing colleges, rehabilitate clinics in pilot districts, and purchase equipment. Due to slower than anticipated spending, Cabinet has approved reductions on the national health grant of R704.3 million over the medium term.

Expenditure in the *Tertiary Health Care and Planning* subprogramme mainly consists of the national tertiary services grant, through which tertiary hospitals receive subsidies to provide specialised services. A new model that will price tertiary services more accurately and provide a basis for the interprovincial funding determination is being developed. The slight decrease in spending in the *Hospital Management* subprogramme was partly due to the violence and trauma components being shifted to the *Primary Health Care Services* programme.

Spending on compensation of employees grew at an average rate of 24.5 per cent between 2010/11 and 2013/14. The number of employees is projected to increase from 208 in 2013/14 to 291 in 2014/15, where it is set to remain in the outer years of the MTEF period. This increase is due to the recruitment of forensic analysts and other forensic staff, particularly for the new laboratory in Durban. There were 5 vacant posts at the end of November 2013 due to natural attrition.

PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT

6.1 PROGRAMME PURPOSE

Food Control Pharmaceutical Trade & Product Regulation: The cluster Food Control Pharmaceutical Trade and Product Regulation is responsible for the regulation of pharmaceutical products for human and animal use with an aim of ensuring that they are safe, efficacious and of quality. It does this through evaluation of products being introduced to the South African market, post marketing surveillance, monitoring safety signals and taking appropriate remedial action where necessary. It also licenses manufacturers, exporters, importers, wholesalers and distributors of medicines and ensures compliance with standards. With respect to Food Control, the cluster is responsible for developing safety standards, monitoring compliance thereto and taking appropriate remedial action where necessary. The cluster is also responsible for approval and oversight of clinical trials.

The cluster has been regulating allopathic medicines and has just started working on inclusion of poorly or unregulated products, namely complementary and alternative medicines (CAMS) as well as medical devices and in vitro diagnostics. During 2014/15 – 2016/17, the cluster will begin work on more robust regulation of African traditional medicines and cosmetics.

Flowing from the country's commendable pro-access policies coupled with the introduction of more complex technologies as well as the need to be responsive to the burden of disease, the regulator (the Medicines Control Council, MCC) has been experiencing an increasing workload both for new applications and post- registration variations. This has resulted in inordinately long review timelines and a backlog. In response to the burden of disease the cluster has managed to register 114 antiretrovirals within 15 months of which 34 are fixed dose combinations. It is against this background that the Medicines Control Council is being re –engineered to a more responsive structure, the South African Health Products Regulatory Authority. Legislation to create SAHPRA is already advanced. Internal capacity and information sharing with identified regulators will be strengthened; cooperation and over-reliance on external evaluators will be reduced progressively.

Public Entities Management: The Public Entities Management Cluster supports the Executive Authority's (EA) oversight function and provides guidance to health entities and statutory councils (herein after referred to as entities') falling within the mandate of the Health legislation with regard to planning, budget procedures, and performance and financial reporting, remuneration, governance and accountability.

Governance oversight over entities' is conducted through monitoring compliance to legislative requirements based on entities' enabling legislation, certain prescripts of the Public Finance Management Act, No. 1 of 1999 (PFMA) in conjunction with the principles contained in the King III report on Corporate Governance as well as other relevant policies and legislative prescripts.

The enabling legislation6 (and the PFMA) gives authority to the EA to not only exercise governance oversight over entities' but also to appoint and dismiss the Board/Council of an entity and in doing so, must ensure that appropriate mix of executive and non-executive directors are appointed and that directors have the necessary skills to guide the entity.

The challenge with exercising the oversight function relates to the fact that most enabling legislation is not in line with the current legislative developments which promotes good corporate governance practices i.e. accountability, transparency, efficiency etc. Thus is may be necessary to amend certain provisions of the enabling legislation over the five year period. In the meantime, the current members and subsequent Board/Council appointments will undergo induction and training in corporate governance practices to ensure proper implementation of the mandate of the entities' as well as to ensure adhere to corporate governance practices.

During the first year of this Strategic Plan, the current Office of Standards Compliance Cluster will become an independent public entity. The strategic objectives relating to provincial support that will ensure compliance with norms and standards and quality improvement are to be pursued during the 5-year period by the Office of the Chief Operating Officer.

The Cluster supports the EA's oversight role over the following entities falling within the mandate of the Department of Health:

HEALTH ENTITIES	HEALTH STATUTORY COUNCILS
The National Health Laboratory Service (NHLS)	Allied Health Professions Council (AHPC)
The South African Medical Research Council (MRC)	South African Dental Technicians Council (SADTC)
The Council for Medical Schemes (CMS)	South African Nursing Council (SANC)
Office of Health Standards Compliance (OHSC)	South African Pharmacy Council (SAPC)
Compensation Commissioner for Occupational Diseases in Mines and Works (CCOD)	Health Professions Council of South Africa (HPCSA)
	Interim Traditional Health Practitioners Council of South Africa (ITHPCSA)
	Medicines Control Council (MCC)

The strategic objectives of the Cluster are to improve oversight and promote good corporate governance practices over health entities and statutory councils by ensuring by ensuring compliance to applicable legislative prescripts and the production of governance reports bi – annually.

[6] Legislation that establishes an entity and statutory council.

6.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR 2014/15 TO 2016/17

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Regulate Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Traditional Medicines in South Africa	Regulate Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Traditional Medicines.	New Indicator	New Indicator	New Indicator	Guidance documents for registration of CAMS	CAMS for Oncology, Cardiovascular Diseases, HIV/AIDS and Diabetes Regulated	CAMS for weight reduction and sexual stimulation Regulated	CAMS for Immune boosters, sports supplements and medicines acting on muscular system Regulated	All Complementary and Alternative Medicines (CAMS) Medical Devices, Invitro Diagnostics regulated, and Framework for African Traditional Medicines published
Improve the efficiency of the Regulator through restructuring by establishing South African Health Product Regulation Authority (SAHPRA) as a public entity	Establish SAHPRA as a public entity	New Indicator	New Indicator	New Indicator	Draft legislation going through parliamentary processes	National Health Amendment Bill drafted	National Health Amendment Act promulgated	SAHPRA established as a public entity	SAHPRA fully established & performing expanded functions

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Strengthen food safety through expanding testing capabilities for adulterants (colourants, protein, and allergens)	Develop and establish MOUs with food testing institutions to enable testing for adulterants in food products	New Indicator	New Indicator	New Indicator	New Indicator	Consultations and two draft MOUs with testing institutions	One MOU with a testing institution	One additional MOUs with another testing institution	At least two MOUs with food testing institutions finalised and operationalised for testing adulterants in food products
Improve registration of response times for antiretroviral, oncology, TB medicines and vaccines used to treat high burden diseases	Percentage of prioritised medicines (antiretroviral, oncology, TB medicines and vaccines) registered within 22 Months for New Chemical Entities (NCEs), and 15 months for multisource medicines	New indicator	New indicator	New indicator	New indicator	70% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	75% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	80% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	90% of all prioritised medicines (antiretroviral, oncology, TB medicines and vaccines) registered within 22 months (NCEs) and 15 months (multisource medicines)
Improve oversight and Corporate Governance practices by reviewing the Governance Framework and	Develop and Implement Governance Framework and Implementation Plan for Public Entities and	New indicator	New indicator	New indicator	New indicator	Approved Governance Framework and Implementation Plan	Approved Governance Framework and Implementation Plan	Approved Governance Framework and Implementation Plan	Governance Framework approved and Implementation Plan biennially reviewed

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Implementation Plan biennially	Statutory Councils								
	Functional governance structures established	New indicator	New indicator	New indicator	New indicator	Fully constituted Boards/ Councils for health entities and statutory councils of the Department (MRC, NHLS, CMS, OHSC, AHPCSA, HPCSA, SAPC, SANC, SADTC, ITHPCSA, MCC)	Fully constituted Boards/ Councils for health entities and statutory councils of the Department (MRC, NHLS, CMS, OHSC, AHPCSA, HPCSA, SAPC, SANC, SADTC, ITHPCSA, MCC)	Fully constituted Boards/ Councils for health entities and statutory councils of the Department (MRC, NHLS, CMS, OHSC, AHPCSA, HPCSA, SAPC, SANC, SADTC, ITHPCSA, MCC)	Fully constituted Boards/ Councils
To monitor the existence of and progress on annual and regular plans that addresses breaches of quality, safety and compliance in all public sector establishments addresses breaches of quality, safety and compliance in all public sector	Percentage of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self-assessment (gap assessment) or OHSC inspection	New Indicator	New Indicator	New Indicator	40% of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self-assessment (gap assessment) or OHSC inspection	45%	60%	75%	100% of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self-assessment (gap assessment) or OHSC inspection

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
establishments									
Enhance governance and management by establishing all committees at the CCOD/MBOD	Audit opinion from the Auditor-General for CCOD	Disclaimer	No Financial Statements	Disclaimer	No Financial Statements	Governance structures enhanced to improve audit outcome	Qualified Audit Opinion	Unqualified Audit Opinion from Auditor-General for CCOD	Unqualified Audit Opinion from Auditor-General for CCOD
Establish occupational health services within the public health system	Number of provinces with occupational health services within their facilities	New Indicator	New Indicator	New Indicator	No provinces with occupational health services within their health facilities for workers	Establishment of one occupational health service in one health facility in each of Eastern Cape and Gauteng provinces	one occupational health service in one health facility in 4 provinces (Eastern Cape, Northern Cape, Gauteng and Limpopo) established	one occupational health service in one health facility in 6 provinces (Eastern Cape, Northern Cape, Gauteng, Limpopo Mpumalanga and KwaZulu-Natal) established	one occupational health service in one health facility in each of 6 provinces (Eastern Cape, Northern Cape, Gauteng, Limpopo Mpumalanga and KwaZulu-Natal) established
Provide for coordinated disease and injury surveillance and research by establishing National Public	Establish National Public Health Institutes of South Africa (NAPHISA)	New Indicator	New Indicator	New Indicator	Draft concept document for NAPHISA	Conceptual framework and Business case for NAPHISA approved	Consolidation of NIOH, NICD and NCR	Assessment and Consolidation of other business areas	Business Case and conceptual framework for NAPHISA developed by 2015 NAPHISA

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance 2013/14	Medium-term targets			Strategic Plan Target
		2010/11	2011/12	2012/13		2014/15	2015/16	2016/17	2018/19
Health Institute of South Africa (NAPHISA)									established by 2019
To improve the acceptability, quality and safety of health services by increasing user and community feedback and involvement	Patient satisfaction surveys rate	New Indicator	New Indicator	New Indicator	65%	70%	80%	95%	100%
	Patient satisfaction rate	New Indicator	New Indicator	New Indicator	New Indicator	Determine Baseline	65%	70%	80%

6.3 QUARTERLY TARGETS FOR 2014/15

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Regulate Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Traditional Medicines.	Annual	CAMS for Oncology, Cardiovascular Diseases, HIV/AIDS and Diabetes Regulated				
Establish SAHPRA as a public entity	Annual	National Health Amendment Bill drafted				
Develop and establish MOUs with food testing institutions to enable testing for adulterants in food products	Annual	Consultations and two draft MOUs with testing institutions				
Percentage of prioritised medicines (antiretroviral, oncology, TB medicines and vaccines) registered within 22 Months for New Chemical Entities (NCEs), and 15 months for multisource medicines	Quarterly	70% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	60% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	63% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	67% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)	70% of all prioritised medicines registered within 22 months (NCEs) and 15 months (multisource medicines)
Develop and Implement Governance Framework and Implementation Plan for Public Entities and Statuary Councils	Bi-annual	Approved Governance Framework and Implementation Plan		Review Governance Framework Document and Implementation Plan		Approved Governance Framework Document and Implementation Plan

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Functional governance structures established	Bi-annual	Fully constituted Boards/ Councils for health entities and statutory councils of the Department (MRC, NHLS, CMS, OHSC, AHPCSA, HPCSA, SAPC, SANC, SADTC, ITHPCSA, MCC)		Public entities governance and compliance report produced		Public entities governance and compliance report produced
Establish the Traditional Health Practitioners Council	Annual	Traditional Health Practitioners Act reviewed				
Percentage of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self- assessment (gap assessment) or OHSC inspection	Quarterly	45%	42%	43% (cumulative)	44% (cumulative)	45% (cumulative)
Audit opinion from the Auditor-General for CCOD	Annual	Governance structures enhanced to improve audit outcome				
Number of provinces with occupational health services within their facilities	Annual	Establishment of one occupational health service in one health facility in each of Eastern Cape and Gauteng provinces				

Performance indicator	Reporting period	Annual target 2014/15	Quarterly targets			
			1st	2nd	3rd	4th
Establish National Public Health Institutes of South Africa (NAPHISA)	Annual	Conceptual framework and Business case for NAPHISA approved				
Patient satisfaction surveys rate	Annualy	70%				
Patient satisfaction rate	Annual	Determine baseline				

6.4 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Expenditure estimates

Health Regulation and Compliance Management

Subprogramme	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Programme Management	–	2 441	2 693	3 437	–	0.4%	4 127	4 332	4 564	9.9%	0.4%
Food Control	5 894	5 850	9 928	8 277	12.0%	1.3%	7 512	7 918	8 370	0.4%	0.8%
Pharmaceutical Trade and Product Regulation	67 538	71 341	77 707	98 400	13.4%	13.3%	96 248	100 886	106 319	2.6%	10.5%
Public Entities Management	418 000	378 135	384 716	540 494	8.9%	72.6%	592 532	767 274	808 032	14.3%	70.9%
Office of Standards Compliance	18 723	26 153	36 994	58 144	45.9%	5.9%	108 953	125 764	134 761	32.3%	11.2%
Compensation Commissioner for Occupational Diseases and Occupational Health	30 567	33 883	36 181	54 900	21.6%	6.6%	55 912	58 644	61 643	3.9%	6.1%
Total	**540 722**	**517 803**	**548 219**	**763 652**	**12.2%**	**100.0%**	**865 284**	**1 064 818**	**1 123 689**	**13.7%**	**100.0%**
Change to 2013 Budget estimate				9 535			33 896	47 602	42 609		
Economic classification											
Current payments	**117 729**	**136 595**	**162 554**	**221 329**	**23.4%**	**26.9%**	**271 152**	**295 860**	**313 976**	**12.4%**	**28.9%**
Compensation of employees	71 059	92 294	106 256	110 852	16.0%	16.1%	148 717	164 960	176 539	16.8%	15.7%
Goods and services	46 670	44 301	56 298	110 477	33.3%	10.9%	122 435	130 900	137 437	7.6%	13.1%
of which:											
Administration fees	*13*	*78*	*35*	*841*	*301.4%*	*–*	*48*	*51*	*29*	*-67.5%*	*–*
Advertising	*906*	*1 981*	*1 457*	*1 938*	*28.8%*	*0.3%*	*2 017*	*2 110*	*4 075*	*28.1%*	*0.3%*
Assets less than the capitalisation threshold	*465*	*1 084*	*728*	*10 837*	*185.6%*	*0.6%*	*11 486*	*13 968*	*6 798*	*-14.4%*	*1.1%*
Audit costs: External	*1 411*	*2 709*	*1 000*	*3 770*	*38.8%*	*0.4%*	*4 234*	*4 536*	*3 100*	*-6.3%*	*0.4%*
Bursaries: Employees	*–*	*–*	*1*	*–*	*–*	*–*	*–*	*–*	*451*	*–*	*–*
Catering: Departmental activities	*325*	*360*	*420*	*668*	*27.1%*	*0.1%*	*696*	*729*	*912*	*10.9%*	*0.1%*
Communication	*1 662*	*1 718*	*1 813*	*2 352*	*12.3%*	*0.3%*	*2 437*	*2 549*	*4 983*	*28.4%*	*0.3%*
Computer services	*995*	*140*	*939*	*5 673*	*78.6%*	*0.3%*	*6 367*	*5 614*	*1 533*	*-35.3%*	*0.5%*
Consultants and professional services: Business and advisory services	*20 895*	*16 169*	*21 530*	*36 475*	*20.4%*	*4.0%*	*43 558*	*39 695*	*45 045*	*7.3%*	*4.3%*
Consultants and professional services: Legal costs	*34*	*42*	*–*	*242*	*92.4%*	*–*	*254*	*266*	*–*	*-100.0%*	*–*
Contractors	*507*	*376*	*744*	*1 397*	*40.2%*	*0.1%*	*1 459*	*1 526*	*1 819*	*9.2%*	*0.2%*
Agency and support / outsourced services	*972*	*900*	*1 898*	*3 559*	*54.1%*	*0.3%*	*3 600*	*9 720*	*12 089*	*50.3%*	*0.8%*
Entertainment	*11*	*14*	*10*	*143*	*135.1%*	*–*	*146*	*153*	*–*	*-100.0%*	*–*
Inventory: Food and food supplies	*–*	*–*	*7*	*–*	*–*	*–*	*–*	*–*	*–*	*–*	*–*
Inventory: Fuel, oil and gas	*3*	*28*	*2*	*50*	*155.4%*	*–*	*50*	*52*	*–*	*-100.0%*	*–*

Inventory: Materials and supplies	*12*	*16*	*25*	*201*	*155.9%*	*–*	*210*	*220*	*523*	*37.5%*	*–*
Inventory: Medical supplies	*524*	*16*	*31*	*735*	*11.9%*	*0.1%*	*761*	*796*	*534*	*-10.1%*	*0.1%*
Inventory: Medicine	*–*	*–*	*32*	*52*	*–*	*–*	*55*	*58*	*32*	*-14.9%*	*–*
Inventory: Other supplies	*196*	*127*	*298*	*1 279*	*86.9%*	*0.1%*	*1 328*	*1 389*	*1 325*	*1.2%*	*0.1%*
Consumable: Stationery, printing and office supplies	*1 553*	*1 356*	*1 597*	*5 500*	*52.4%*	*0.4%*	*6 707*	*6 967*	*4 604*	*-5.8%*	*0.6%*
Operating leases	*598*	*851*	*1 145*	*1 592*	*38.6%*	*0.2%*	*1 659*	*1 735*	*3 809*	*33.7%*	*0.2%*
Property payments	*–*	*–*	*28*	*–*	*–*	*–*	*–*	*2 000*	*2 522*	*–*	*0.1%*
Travel and subsistence	*13 444*	*13 243*	*19 820*	*27 594*	*27.1%*	*3.1%*	*28 195*	*28 833*	*36 259*	*9.5%*	*3.2%*
Training and development	*51*	*286*	*6*	*–*	*-100.0%*	*–*	*–*	*–*	*2 273*	*–*	*0.1%*
Operating payments	*1 500*	*2 115*	*2 275*	*4 048*	*39.2%*	*0.4%*	*5 186*	*5 378*	*3 224*	*-7.3%*	*0.5%*
Venues and facilities	*593*	*692*	*457*	*1 531*	*37.2%*	*0.1%*	*1 982*	*2 555*	*1 498*	*-0.7%*	*0.2%*
Transfers and subsidies	**420 729**	**379 924**	**384 531**	**538 635**	**8.6%**	**72.7%**	**590 444**	**765 100**	**805 651**	**14.4%**	**70.7%**
Departmental agencies and accounts	415 698	373 557	375 729	528 383	8.3%	71.4%	579 577	753 733	793 682	14.5%	69.6%
Non-profit institutions	4 922	6 097	8 252	10 252	27.7%	1.2%	10 867	11 367	11 969	5.3%	1.2%
Households	109	270	550	–	-100.0%	–	–	–	–	–	–
Payments for capital assets	**2 121**	**1 282**	**1 103**	**3 688**	**20.2%**	**0.3%**	**3 688**	**3 858**	**4 062**	**3.3%**	**0.4%**
Machinery and equipment	2 121	1 282	1 103	3 688	20.2%	0.3%	3 688	3 858	4 062	3.3%	0.4%
Payments for financial assets	**143.0**	**2.0**	**31.0**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Total	**540 722.0**	**517 803.0**	**548 219.0**	**763 652.0**	**12.2%**	**100.0%**	**865 284.0**	**1 064 818.0**	**1 123 689.0**	**13.7%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**2.4%**	**2.0%**	**2.0%**	**2.5%**			**2.5%**	**2.9%**	**2.9%**		

Health Regulation and Compliance Management

Details of transfers and subsidies											
	Audited outcome			**Adjusted appropri-ation**	**Average growth rate (%)**	**Expen-diture/ total: Average (%)**	**Medium-term expenditure estimate**			**Average growth rate (%)**	**Expen-diture/ total: Average (%)**
R thousand	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2010/11 - 2013/14**		**2014/15**	**2015/16**	**2016/17**	**2013/14 - 2016/17**	
Non-profit institutions											
Current	**4 922**	**6 097**	**8 252**	**10 252**	**27.7%**	**1.2%**	**10 867**	**11 367**	**11 969**	**5.3%**	**1.2%**
Health Systems Trust	4 922	6 097	8 252	10 252	27.7%	1.2%	10 867	11 367	11 969	5.3%	1.2%
Households											
Social benefits											
Current	**109**	**270**	**550**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Employee social benefits	109	270	550	–	-100.0%	–	–	–	–	–	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**413 078**	**370 780**	**372 813**	**525 321**	**8.3%**	**71.0%**	**576 362**	**750 370**	**790 141**	**14.6%**	**69.2%**
South African Medical Research Council	292 769	283 564	283 863	416 460	12.5%	53.9%	446 331	615 802	648 440	15.9%	55.7%
National Health Laboratory Services	120 309	83 022	84 640	104 336	-4.6%	16.6%	125 280	129 598	136 467	9.4%	13.0%
Council for Medical Schemes	–	4 194	4 310	4 525	–	0.5%	4 751	4 970	5 234	5.0%	0.5%
Departmental agencies and accounts											
Social security funds											

Current	**2 620**	**2 777**	**2 916**	**3 062**	**5.3%**	**0.5%**	**3 215**	**3 363**	**3 541**	**5.0%**	**0.3%**
Compensation Fund	2 620	2 777	2 916	3 062	5.3%	0.5%	3 215	3 363	3 541	5.0%	0.3%

Personnel information

Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment													Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate							Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17		
Health Regulation and Compliance Management			**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**Number**	**Cost**	**Unit Cost**	**2013/14 - 2016/17**	
Salary level	**357**	**16**	**323**	**106.3**	**0.3**	**357**	**110.9**	**0.3**	**363**	**148.7**	**0.4**	**363**	**165.0**	**0.5**	**363**	**176.5**	**0.5**	**0.6%**	**100.0%**
1 – 6	153	9	142	25.7	0.2	153	23.4	0.2	150	26.9	0.2	150	28.3	0.2	150	28.9	0.2	-0.7%	41.7%
7 – 10	112	5	118	37.4	0.3	112	21.4	0.2	131	53.0	0.4	131	56.5	0.4	131	59.6	0.5	5.4%	34.9%
11 – 12	80	2	52	28.0	0.5	80	38.0	0.5	61	29.9	0.5	61	37.8	0.6	61	39.9	0.7	-8.6%	18.2%
13 – 16	12	–	11	13.0	1.2	12	28.0	2.3	21	16.9	0.8	21	20.3	1.0	21	21.4	1.0	20.5%	5.2%
Other	–	–	–	2.1	–	–	–	–	–	22.0	–	–	22.0	–	–	26.8	–	–	–

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

Expenditure trends

Most of the programme's budget is transferred to public entities, the largest of which are the Medical Research Council and National Health Laboratory Service. A key focus over the medium term will be on improving the quality of health services and health products through the establishment of the Office of Health Standards Compliance as a public entity.

Spending in the *Pharmaceutical Trade and Product Regulation* programme has increased significantly since 2010/11 to reduce the large backlogs in medicine registration and to prepare for the establishment of the South African Health Products Regulatory Authority. This is an independent public entity that will ultimately replace the Medicines Control Council. This increase in expenditure provided for a 40 per cent reduction in the backlogs on applications for generic medicines.

Over the medium term, spending in the *Public Entities Management* subprogramme is projected to grow significantly to strengthen the capacity and outputs of the Medical Research Council. Expenditure in this subprogramme increased in 2013/14, partially due to the reallocation of the payment of members of the Interim Traditional Healers Council to this subprogramme from the *National Health Insurance, Health Planning and Systems Enablement* programme. The programme's overall staff complement is set to increase slightly, from 357 in 2013/14 to 363 in 2014/15 and then remain stable over the medium term. Spending on compensation of employees is set to increase at an average rate of 17.6 per cent over the medium term as a result. There were 11 vacant posts at the end of November 2013 due to natural attrition.

Part C: Links to other plans

1. CONDITIONAL GRANTS

NATIONAL HEALTH INSURANCE GRANT

Name of conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2014/15
National Health Insurance	**PART A: Direct (NHI Pilot Districts)** i. To improve the performance of the District Health System through testing service delivery and provision innovations in readiness for the implementation of National Health Insurance (NHI); ii. Test innovations in health services delivery and provision for implementing NHI, allowing for each district to interpret and design innovations relevant to its specific context in line with the vision for realising universal health coverage for all; iii. To undertake health system strengthening activities in identified focus areas; iv. To assess the effectiveness of interventions/activities undertaken in the district funded through this grant.	1. 10 pilot districts across the country 2. Strengthened district health system 3. Approved business plans for all 10 pilot districts 4. Quarterly and annual performance reports 5. Consolidated annual performance evaluation report	1. Approved business plans for all 10 pilot districts as per the DoRA 2014/15 2. Consolidated quarterly performance reports for 2014/15 submitted to National Treasury 3. Consolidated annual performance evaluation report for 2014/15 submitted to National Treasur

Name of conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2014/15
	PART B: As part of the National Health Grant (Contracting of General Practitioners and development of a Diagnosis Related Grouper and strengthening revenue management at central hospitals) i. To develop and implement innovative models for contracting general practitioners within selected NHI pilot districts; ii. To identify and test alternative reimbursement models for central hospitals in readiness for the phased implementation of NHI; iii. To support central hospitals in strengthening health information systems and revenue management	1. 600 general practitioners contracted to render services within PHC clinics in the 10 NHI pilot districts; 2. Database for use in the development of a DRG algorithm for reimbursement of central hospitals.	1. 600 general practitioners contracted to render services within PHC clinics in the 10 NHI pilot districts 2. Approved business plans for all 10 pilot districts as per the DoRA 2014/15 3. Consolidated quarterly performance reports for 2014/15 submitted to National Treasury 4. Consolidated annual performance evaluation report for 2014/15 submitted to National Treasury 5. Independent evaluation report for 2014/15

HEALTH PROFESSIONS TRAINING AND DEVELOPMENT GRANT

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets
Health Professional Training and Development	Support provinces to fund services costs associated with the training of health science trainees on the public platform	Availability of Business Plans. Number of site visits. Availability of quarterly & annual performance report. Number of audit findings	9 18 9 None
	Co-funding of the National Human Resources for Health in expanding undergraduate medical education for 2012 and beyond 2015	This will no longer be part of the purpose of this grant.	This will no longer be part of the purpose of this grant.

NATIONAL TERTIARY SERVICES GRANT

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets
National Tertiary services	To ensure provision of tertiary services for all South African citizens	9 Service Level Agreements (SLA)	9 SLA
	To compensate tertiary facilities for the costs associated with the provision of these services including cross border patients	100% Expenditure at the end of financial year.	First Quarter 25% Second Quarter 50% Third quarter 75% Fourth quarter 100% Expenditure.

COMPREHENSIVE HIV/AIDS GRANT

Name of conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2014/15
Comprehensive HIV AIDS conditional grant	• To enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing • To support the implements of the National operational plan for comprehensive HIV and AIDS treatment and care • To subsidise in-part funding for the antiretroviral treatment plan	1. Number of new patients that started on ART 2. Number of Antenatal Care (ANC) clients initiated on life-long ART 3. Number of babies Polymerase Chain Reaction (PCR) tested at 6 weeks 4. Number of HIV positive clients screened for TB 5. Number of HIV positive patients that started on IPT 6. Number of HIV tests done 7. Number of Medical Male Circumcisions performed	**525,000** **93,000** **160,000** **1,977,507** **500,000** **10,000,000** **1,000,000**

HEALTH FACILITY REVITALISATION GRANT

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets
Health Facility Revitalisation Grant	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including: health technology, organisational design (OD) systems and quality assurance (QA) • Supplement expenditure on health infrastructure delivered through public-private partnerships • To enhance capacity to deliver health infrastructure	Approved Annual Implementation plans for both Health Facility Revitalisation Grant and National Health Grant	Availability of approved Annual Implementation Plans (AIP) for all projects funded from National Health grant and Health facility Revitalisation Grant
		Monitoring number of projects receive funding from Health Facility Revitalisation Grant and National Health Grant	Monitor implementation of all conditional grant funded projects
National Health Grant: Health Facility Revitalisation Component	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health, including health technology, organisational systems (OD) and quality assurance (QA) in National Health Insurance (NHI) pilot districts • Supplement expenditure on health infrastructure delivered through public-private partnerships	Approved Annual Implementation plans for both Health Facility Revitalisation Grant and National Health Grant	Availability of approved Annual Implementation Plans (AIP) for all projects funded from National Health grant and Health facility Revitalisation Grant
		Monitoring number of projects receive funding from Health Facility Revitalisation Grant and National Health Grant	Monitor implementation of all conditional grant funded projects

	• To enhance capacity to deliver infrastructure in health		

2. PUBLIC ENTITIES

The National Department of Health has oversight over the following public entities

1. Council for Medical Schemes

The Council for Medical Schemes is the national medical schemes regulatory authority established in terms of the Medical Schemes Act (1998). The council's vision for the medical scheme industry is that it is effectively regulated to protect the interests of members and promote fair and equitable access to private health financing.

2. National Health Laboratory Service

In terms of the National Health Laboratory Service Act (2000) the National Health Laboratory Service is required to: provide cost-effective and efficient health laboratory services to all public sector health care providers, other government institutions and any private health care provider in need of its service; support health research; and provide training for health science education.

The service's overarching goals are to restructure and transform laboratory services in order to make them part of a single national public entity and develop policies that will enable it to provide health laboratory services as the preferred provider for the public health sector; and to provide cost-effective and professional laboratory medicine, through competent, qualified professionals and state-of-the-art technology supported by academic and internationally recognised research, training and product development in order to support optimal healthcare delivery for the country.

3. South African Medical Research Council

The South African Medical Research Council was established in 1969 in terms of the South African Medical Research Council Acts (1969 and 1991). The Intellectual Property, Rights from Publicly Financed Research and Development Act (2008) also informs the council's mandate. The Council is required to promote the improvement of health and quality of life through research development and technology transfer. Research and innovation are primarily conducted through council-funded research units located within the council and in higher education institutions. The council's strategic focus is determined in the context of the priorities of the Department of Health and government. The council's research therefore plays a key role in responding to government's key health outcome: a long and healthy life for all South Africans.

4. Compensation Commissioner for Occupational Diseases in Mines and Works

The Compensation Commissioner for Occupational Diseases in Mines and Works was established in terms of the Occupational Diseases on Mines and Works Act (1973). In terms of the act, the commissioner is mandated to compensate ex-miners and miners for impairment of lungs or respiratory organs and reimbursement for loss of earnings incurred during tuberculosis treatment. In the case where the ex-miner is deceased it compensates the beneficiaries of the ex-miner. The commissioner also administrates the government grant for pensioners.

3. PUBLIC PRIVATE PARTNERSHIP

Bio Vac

In 2003 the National Department of Health established the Biologicals and Vaccines Institute of Southern Africa (Biovac) through a strategic equity partnership with the Biovac Consortium (Pty) Ltd. The two aims of the partnership were: revive the declining vaccine production capacity in South Africa; and supply of vaccines for the expanded programme on immunisation (EPI) to the public sector. The project agreement is structured to give effect to these objectives by creating specific Strategic Equity Partnership Undertakings. The current Agreement is effective until 31 December 2016 in accordance with Regulation 16.8 of the Public Financial Management Act.

Infrastructure PPPs

The National Department of Health through its infrastructure unit, is actively involved together with the Provinces in the establishment of seven PPP flagship projects for identified hospitals.

ANNEXURE A: TECHNICAL INDICATOR DESCRIPTIONS

PROGRAMME 1:

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Audit opinion from Auditor General	Audit opinion from Auditor General for National Department of Health	To strengthen financial management monitoring and evaluation	Documented Evidence: Annual Report Auditor General's Report	N/A	N/A	Outcome	N/A	Annual	No	Unqualified Audit Opinion from the Auditor General	Chief Financial Officer
Audit opinion for Provincial Departments of Health	Audit opinion for Provincial Departments of Health	To strengthen financial management monitoring and evaluation	Documented Evidence: Annual Report Auditor General's Report	N/A	N/A	Outcome	N/A	Annual	Yes	Unqualified Audit Opinion from the Auditor General	Chief Financial Officers of Provincial Departments of Health Chief Financial Officer : National DoH
Develop and Implement Business Continuity Plan inclusive of a disaster recovery plan	Development and implementation of a plan that will ensure that operations in the Department continue even in the event of a disaster	Ensure that Department can continue with its operations even if there is a disaster.	Documented Evidence : Business Continuity Plan	N/A	Progress on the indicator is dependent on Departmental staff understanding their business processes and having information on processes readily	Input	N / A	Quarterly	No	Full development and implementation of Phase 1 of both the BCP and DRP	Head of Corporate Services Director of ICT

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					available						
Develop an integrated communication strategy and implementation plan	Integrated Strategic Communication (ISC) is the orchestration or synchronisation of actions, images, and words to achieve a desired effect	To harmonise communication efforts in the Department so as to break the culture of working in silos	N/A	N/A	N/A	Outcome	Cumulative	Quarterly	Yes	N/A	Cluster Manager: Communications
Average Turnaround times for recruitment processes	Rate at which recruitment processes are concluded, represented as the number of average days taken for the recruitment process	Purpose: to measure the time it takes to fill vacancies in the department. Importance: Significant	Personnel Files	Numerator: Total number of Days taken to make all appointments Denominator: Total number of appoint-ments	Turnaround time could be hampered by poor response from SAQA and NIA	Outcome	cumulative	Bi-Annually	Yes	A lower number indicates better performance	Cluster Manager: HR
Develop and Implement Employee wellness programme that comply with Public Service Regulations (PSR) and Employee Health and Wellness Strategic Framework (EHWSF)	The employer approach/activities/programmes to improve employee health and well being for improved productivity and performance.	To provide maximum levels of health, quality of life, work performance and health care to employees.	Documented evidence	N/A	Existence of a customized implementation plan for the Department	Impact	Cumulative	Quarterly	Yes	All 4 EHW Pillars policies are implemented and improved quality of work life	Cluster Manager: Employment Relations
Develop and implement a framework for	Develop and implement a framework for	To integrate plans across the health sector	Documented Evidence: Draft	N/A	N/A	Process	N/A	Annually	Yes	100 % Compliance with Planning	Cluster: Policy Coordination and

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Integrated Health Service Plans at all levels of the Health sector	Integrated Health Service Plans at all levels of the Health sector		Framework							Guidelines and format	Integrated Planning
Review Provincial Annual Performance Plans (APPs)	Provincial APPs reviewed for alignment with national health sector priorities and feedback provided	Facilitate alignment of provincial plans with National Health sector priorities	*Documented Evidence* Document providing review of 9 X Provincial APPs, and/or Agendas for Provincial feedback sessions and/or copies of correspondence to Provinces providing feedback	N/A No calculation required	None	Process	None	Annually	No	All provincial plans reviewed and feedback provided	Cluster: Policy Coordination and Integrated Planning

PROGRAMME 2:

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Legislation for NHI	Determination of the legal framework to enable the implementation of NHI	To measure progress towards ensuring an enabling legal framework to support the implementation of NHI.	Documented evidence: Records in the branch	N/A	The drafting of the NHI Bill is dependent on the finalization and approval of the White Paper	Activity	N/A	Annual	Yes	Full approval and promulgation of the NHI Act	Dr. Anban Pillay Moremi Nkosi
Piloting of NHI in selected districts across the	To undertake various interventions and	To initiate interventions and health	Documented evidence: Records in the	N/A	Implementation and piloting	Activity	N/A	Quarterly	Yes	Full approval and promulgation	Dr. Anban Pillay

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
country.	health system strengthening initiatives in identified pilot districts	system strengthening initiatives in identified pilot districts as part of the preparatory work for the phased implementation of NHI	Branch and relevant Cluster		capacity at the district level varies significantly					of the NHI Act	Moremi Nkosi
Establishment of the National Health Insurance Fund	To initiate work on the creation of a functional NHI Fund.	To initiate work on the NHI Fund as part of the preparatory work for the phased implementation of NHI	Documented evidence: Records in the Branch and relevant Cluster	N/A	Progress on the determination of the concept of the NHI Fund is dependent on the finalization of the White Paper on NHI	Activity	N/A	Annual	Yes	Fully functional NHI Fund established as per the NHI Act	Dr. Anban Pillay Moremi Nkosi
Establish National Pricing Commission to regulate health care in the private sector	Establishment of a pricing system that will determine fair and equitable tariffs for health services in South Africa.	To initiate work on the establishment of a pricing system that will determine fair and equitable tariffs for health services as part of the preparatory work for the phased	Documented evidence: Records in the Branch and relevant Cluster	N/A	The determination of the progress on this work is dependent on the work of other key stakeholders e.g. Competition Commission	Activity	N/A	Annual	Yes	Fully functional National Pricing Commission	Dr. Anban Pillay Moremi Nkosi Annual

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		implementation of NHI Importance: Significant									
Revise and legislate methodology for the determination of the dispensing fee.	To Improve Access and Affordability of Medicines in the Private Sector by Promoting Transparency in the Determination of the Dispensing Fee for Pharmacists and Persons Licensed in terms of Section 22C (1) (a) of the Act	To determine an appropriate dispensing fee to be charged by a pharmacist in terms of section 22G (2) (b) And to publish the appropriate dispensing fee for each Medicine or Scheduled Substance together with other components of the SEP	Records in the Directorate PEE and submissions from interested/relevant stakeholders	N/A	Approval of the draft dispensing fee for comment	Activity	N/A	Annual	Yes	Gazetted maximum dispensing fee for 2015/2016	Dr. Anban Pillay Moremi Nkosi Ntobeko Mpanza
Revise and legislate methodology for the determination of the logistics fee.	To Encourage Market Efficiencies in the Distribution of Medicines and Scheduled Substances by Promoting Transparency in the Determination of the Logistics Fee	To determine an appropriate logistics fee in terms of section 22G (2) (c) And to publish the appropriate logistics fee for each Medicine or Scheduled Substance together with other components of the SEP	Records in the Directorate PEE and submissions from interested/relevant stakeholders	N/A	Approval of the draft logistics fee for comment	Activity	N/A	Annual	Yes	Gazetted maximum logistics fee for 2015/2016	Dr. Anban Pillay Moremi Nkosi Ntobeko Mpanza

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Publish revised SEP adjustment methodology	To Promote a Transparent Pricing System for Medicines and Scheduled Substances Sold in the Republic through Administered SEP Regulations	To review the amount to which the Single Exit Price (SEP) may be adjusted within the regulated time lines (12 months) for 2014	Records in the Directorate PEE and submissions from interested/relevant stakeholders	N/A	Approval of the draft Single Exit Price Adjustment for comment	Activity	N/A	Annual	Yes	Gazetted maximum Single Exit Price Adjustment for 2015/2016	Dr. Anban Pillay Moremi Nkosi Ntobeko Mpanza
Percentage of the PHC Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	EML is required to ensure that the correct medicine is available at the correct facility for treatment of most prevalent conditions in the country. The associated Standard Treatment Guidelines (STGs) are required to promote the rational use of these medicines	The EML is used to establish the list of medicines to be procured and to guide rational prescribing.	Paper or electronic publication available physically or on DoH website. The progress indicator is informed by chapters reviewed and approved by the National EML Committee (NEMLC) for comment by means of a circular.	Numerator: number of chapters approved by NEMLC and circulated for comment denominator: Number of chapters identified for review by NEMLC	Reliance on external reviewers	Output	Cumulative	Quarterly	No	Higher performance will result in earlier access to new medicines	Director: Affordable Medicines
Percentage of the Hospital Level Paediatric Essential Medicines List (EML) and Standard treatment Guidelines (STGs)	EML is required to ensure that the correct medicine is available at the correct facility for treatment of most prevalent conditions in the country. The	The EML is used to establish the list of medicines to be procured and to guide rational prescribing.	Paper or electronic publication available physically or on DoH website. The progress indicator is informed by	Numerator: number of chapters approved by NEMLC and circulated for comment denominator: Number of	Reliance on external reviewers	Output	Cumulative	Quarterly	No	Higher performance will result in earlier access to new medicines	Director: Affordable Medicines

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
reviewed	associated Standard Treatment Guidelines (STGs) are required to promote the rational use of these medicines		chapters reviewed and approved by the National EML Committee (NEMLC) for comment by means of a circular.	chapters identified for review by NEMLC							
Percentage of the Hospital Level Adult Essential Medicines List (EML) and Standard treatment Guidelines (STGs) reviewed	EML is required to ensure that the correct medicine is available at the correct facility for treatment of most prevalent conditions in the country. The associated Standard Treatment Guidelines (STGs) are required to promote the rational use of these medicines	The EML is used to establish the list of medicines to be procured and to guide rational prescribing.	Paper or electronic publication available physically or on DoH website. The progress indicator is informed by chapters reviewed and approved by the National EML Committee (NEMLC) for comment by means of a circular.	Numerator: number of chapters approved by NEMLC and circulated for comment denominator: Number of chapters identified for review by NEMLC	Reliance on external reviewers	Output	Cumulative	Quarterly	No	Higher performance will result in earlier access to new medicines	Director: Affordable Medicines
Number of medicines review reports approved by the NELMC for inclusion in the tertiary EML	Tertiary level EML is required to ensure that the correct medicine is available at tertiary and academic hospitals.	The EML is used to establish the list of medicines to be procured for use at a tertiary level.	Tertiary EML is published on DoH website and medicines reviews are on record in the affordable medicines knowledge management	Number of medicines review reports approved by the NEMLC	Reliance on external reviewers and availability of member for a quorum.	Output	Non cumulative	Quarterly	No	Higher performance will result in earlier access to new medicines	Director: Affordable Medicines

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
			system.								
Number of Districts implementing centralised chronic medicine dispensing & distribution	Number of Districts implementing centralised chronic medicine dispensing & distribution	Improved access to medicines for patients on long term therapies. Decongestion of facilities and reduction in waiting and travelling times	Quarterly CCMDD reports submitted to DDG	Numerator: Number of participating facilities in identified districts Denominator: Total number of health facilities in identified districts	Availability of data from contracted service providers	Output	Cumulative	Quarterly	Yes	Higher performance will increase access to medicines for patients at participating facilities	Director: Affordable Medicines and provincial project teams
Develop and implement a Revenue Retention model	Develop a Revenue retention model to incentivize hospitals to improve revenue collection	To Improve hospital accountability in revenue generation and minim	Compare actual revenue collection to annual revenue targets	Inter-Year Monitoring of the revenue collection performance	Sound revenue reporting and stable ICT infrastructure	inputs	Revenue collection should exceed the revenue targets	Quarterly	no	Hospitals to increase their revenue collection and retain a portion / percentage to fund hospital operational priorities	Financial Director, Provincial Revenue Director, U. Le Roux
Develop a complete System design for a National Integrated Patient based information system	Develop a complete System design for a National Integrated Patient based information system	To track progress on the implementation of the eHealth Strategy	Documented evidence that confirms the performance	N/A	N/A	Output	N/A	Annual	Yes	Implementation of the eHealth Strategy by commencing with the development of a system design	Health Information Management Monitoring and Evaluation Cluster
Functional National Health Research Observatory	Establish a National Health Research Observatory	Improve focus of Health research in South Africa	Documented evidence that confirms the performance	N/A	N/A	Output	N/A	Annual	Yes	Progress towards an establishment of the National Health	Health Information Management Monitoring and Evaluation

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
										Observatory.	Cluster
Develop and implement Integrated monitoring and evaluation plan	Develop and implement Integrated monitoring and evaluation plan	Improve integration between different M&E Systems	Documented Evidence that demonstrated integration of M&E reports	N/A	N/A	Output	N/A	Annual	No	Integration of M&E reporting	Health Information Management Monitoring and Evaluation Cluster
Develop and implement a strategy and plan for the integration of disease surveillance systems	Develop and implement a strategy and plan for the integration of disease surveillance systems for NMC	Improve disease surveillance	Documented evidence	N/A	N/A	Output	N/A	Annual	Yes	Electronic disease surveillance system for Notifiable medical conditions	Health Information Management Monitoring and Evaluation Cluster
Implement International treaties and multilateral frameworks	Implement International treaties and multilateral frameworks	To strengthen international relations for health	Documented evidence	N/A	N/A	Output	N/A	Annual	Yes	Implement International treaties	International Health Liaison
Number of Bilateral projects implemented	Number of Bilateral projects implemented	To strengthen international relations for health	Documented evidence	N/A	N/A	Output	N/A	Annual	Yes	Impliment Bilateral projects	International Health Liaison

PROGRAMME 3:

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all	Tracks proportion of pregnant women that presented at a health facility within the first 20 weeks of	DHIS	Numerator: Antenatal 1st visit before 20 weeks Denominator: Antenatal 1st	None	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	antenatal 1st visits	pregnancy		visit total							
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Tracks proportion of mothers that received postnatal care within 6 days from giving birth	DHIS	Numerator: Mother postnatal visit within 6 days after delivery Denominator: Delivery in facility total	None	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
Maternal mortality in facility ratio (annualised)	Ratio of the number of maternal deaths in public health facilities (excluding accidental or incidental causes) per 100,000 live births for a specified year	This population based indicator is a measure of women's health across the country	DHIS	Numerator: Maternal death in facility Denominator: Live births	Reliant on accuracy of classification of inpatient death	Impact	Ratio per 100 000 live births	Quarterly	No	Lower rate indicates improved access to SRH services.	MNCWH programme manager
Inpatient Neonatal Death Rate (annualised)	Inpatient deaths within the first 28 days of life per 1,000 estimated live births.	This indicator assists in tracking maternal and child health progress, in line with the MDGs	DHIS	Numerator: Inpatient death neonatal Denominator: Live birth in facility	Reliant on accuracy of classification of inpatient death	Impact	Per 1 000 Live Births	Annual	Yes	Lower rate indicates fewer deaths.	MNCWH programme manager
Couple Year Protection Rate	Women protected against pregnancy by using modern contraceptive methods, including sterilizations, as proportion of	Track the extent of the use of contraception (any method) amongst women of child bearing age	DHIS	Numerator (SUM([Oral pill cycle]) / 13) + (SUM([Medroxy progesterone injection]) / 4) + (SUM([Norethisterone enanthate	Reliant on accuracy of data collection	Outcome	Percentage	Annual	No	Higher percentage indicates higher usage of contraceptive methods.	Health Information, Epidemiology and Research Programme MCWH&N Programme

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	female population 15-44 year. Contraceptive years are the total of (Oral pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) +)Male condoms distributed / 200) + (Male sterilization x 20) + (Female sterilization x 10)s			injection]) / 6) + (SUM([IUCD inserted]) * 4) + (SUM([Male condoms distributed]) / 200) + (SUM([Sterilisation - male]) * 20) + (SUM([Sterilisation - female]) * 10) Denominator: SUM {[Female 15-44 years]} + SUM{[Male 45-49 years]}							
Cervical cancer screening coverage (annualised)	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older.	Monitors implementation of policy on cervical screening	DHIS	Numerator: SUM([Cervical cancer screening 30 years and older]) Denominator: (SUM([Female 30-34 years]) + SUM([Female 35-39 years]) + SUM([Female 40-44 years]) + SUM([Female 45 years and older])) / 10	Reliant on population estimates from StatsSA for women in age category 30 years and older and accurate recording of women screened according to the policy (i.e. correct	Output	Percentage	Annually	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					age group AND counted only once every 10 years)						
HPV 1st dose coverage	Proportion of grade 4 girl learners ≥ 9 years vaccinated per year with the 1st dose of the HPV vaccine during the first round	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	DHIS	Numerator: Girls 9 years and older that received HPV 1st dose Denominator: Grade 4 girl learners ≥ 9 years	None	Output	Percentage annualised	Annually	Yes	Higher percentage indicate better coverage	MNCWH Programme Manager
Antenatal client initiated on ART rate	Antenatal client initiated on ART	Monitors implementation of PMTCT guidelines in terms of ART initiation of eligible HIV positive antenatal clients.	DHIS	Numerator: SUM([Antenatal client INITIATED on ART]) Denominator: SUM([Antenatal client HIV 1st test positive]) + SUM([Antenatal client HIV re-test positive]) + SUM([Antenatal client known HIV positive but NOT on ART at 1st visit])	None	Process	Percent	Quarterly	No	Higher percentage indicate better ART coverage amongst HIV Positive pregnant women	MNCWH Programme Manager
Infant 1st PCR test positive around 6 weeks rate	Infants PCR tested for the first time around 6 weeks after birth as proportion of live births to HIV	This indicator is used to measure mother to child transmission rate	DHIS	Numerator: SUM[Infant 1st PCR test positive around 6 weeks Denominator:	None	Output	Rate	Quarterly	Yes	Lower percentage indicates fewer infants received HIV from their	PMTCT Programme

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	positive women			SUM [Live birth to HIV positive woman]						mothers	
Child under 5 years diarrhoea case fatality rate	Proportion of children under 5 years admitted into any public health facility with diarrhoea who died	Monitors treatment outcome for children under 5 years who were admitted with diarrhoea. Include under 1 year diarrhoea deaths	DHIS	Numerator: SUM [Child under 5 years with diahorrea death] Denominator: SUM [Child under 5 years with Diahorrea admitted]	Reliant on accuracy of diagnosis / cause of death	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
Child under 5 years severe acute malnutrition case fatality rate	Proportion of children under 5 years admitted into any public health facility with severe acute malnutrition who died	Monitors treatment outcome for children under 5 years who were admitted with severe acute malnutrition. Includes under 1 year severe acute malnutrition deaths as defined in the	DHIS	Numerator: SUM [Child under 5 years severe acute malnutrition deaths] Denominator: SUM [Children under 5 years severe acute malnutrition admitted]	Reliant on accuracy of diagnosis / cause of death	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
Confirmed measles case incidence per million total population	Incidence of Measles per million total population	To monitor measles vaccine coverage		Numerator SUM [Number of Measles cases] Denominator: SUM [Total population]	None	Outcome	Rate: Per Million population	Annually	Yes	Incidence rate should decrease	MNCWH
Immunisation coverage under 1 year (Annualised)	Percentage children under 1 year who completed their	Monitor the implementation of Extended Programme in	DHIS	Numerator: SUM([Immunised fully under 1 year new])	Reliant on under 1 population estimates	Output	Percentage Annualised	Annually	No	Higher percentage indicate better	EPI Programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	primary course of immunisation The child should only be counted ONCE as fully immunised when receiving the last vaccine in the course (usually the 1st measles and PCV3 vaccines) AND if there is documented proof of all required vaccines (BCG, OPV1, DTaP-IPV/Hib 1, 2, 3, HepB 1, 2, 3, PCV 1,2,3, RV 1,2 and measles 1) on the Road to Health Card/Booklet AND the child is under 1 year old	Immunisation (EPI)		Denominator: SUM([Female under 1 year]) + SUM([Male under 1 year])	from StatsSA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered.)					immunisation coverage	
DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	DTaP-IPV/ Hib3 to Measles1st dose drop-out	Monitors children who drop out of the vaccination program after 14 week vaccination.	DHIS	Numerator: SUM([DTaP-IPV/Hib 3rd dose]) - SUM([Measles 1st dose under 1 year]) Denominator: SUM([DTaP-IPV/Hib 3rd dose])		Outcome	Percent	Quarterly	No	Lower dropout rate indicates better vaccine coverage	EPI

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Measles 2nd dose coverage	Measles 2nd dose	Monitors protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	DHIS	Numerator: SUM([Measles 2nd dose]) Denominator: SUM([Female 1 year]) + SUM([Male 1 year])	None	Output	Percent	Annually	No	Higher coverage rate indicate greater protection against measles	EPI
School Grade 1 screening coverage (annualised)	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Numerator: DHIS Denominator: Department of Basic Education	Numerator: SUM [School Grade 1 - learners screened} Denominator: SUM [School Grade 1 - learners total]	None	Process	Percentage	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
School Grade 8 screening coverage (annualised)	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Numerator: DHIS Denominator: Department of Basic Education	Numerator: SUM [School Grade 8 - learners screened] Denominator: SUM [School Grade 1 - learners total]	None	Process	Percentage	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health	School health services

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
										services at their school	
TB new client treatment success rate	Proportion TB patients (ALL types of TB) cured or those who completed treatment	Monitors success of TB treatment for ALL types of TB	ETR.net	Numerator: SUM [TB client cured OR completed treatment] Denominator: SUM [TB client (new pulmonary) initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	Yes	Higher percentage suggests better treatment success rate.	TB Programme Manager
TB (new pulmonary) defaulter rate	Percentage of smear positive PTB cases who interrupted (defaulted) treatment	Monitor patients defaulting on TB treatment	ETR	Numerator: SUM [TB (new pulmonary) treatment defaulter] Denominator: SUM [TB (new pulmonary) client initiated on treatment]	None	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager
Number of trained TB tracing coordinators available	Number of employed trained tracing coordinators trained on the TB tracing training programme	Improve the quality of the TB tracing co-ordinators	Attendance Register of the training programme	Number of employed trained tracing coordinators trained on the TB tracing training programme	None	Input	Number	Quarterly	Yes	Higher number indicate greater number of trained TB Coordinators	TB Programme Manager
TB death rate	Proportion TB patients who died during treatment period	Monitors death during TB treatment period. The cause of death may not necessarily be due	ETR	Numerator: SUM([TB client death during treatment]) Denominator: SUM([TB (new	None	Outcome	Percentage	Quarterly	Yes	Lower levels of death desired	TB Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		to TB.		pulmonary) client initiated on treatment])							
Number of professional nurses trained to initiate MDR-TB treatment	Number of professional nurses trained to initiate MDR-TB treatment	Measure progress against the MDR-TB Training Programme	Attendance Register of the training programme	Number of professional nurses trained to initiate MDR-TB treatment	None	Input	Number	Quarterly	Yes	Higher number indicate greater number of trained professional nurses to initiate MDR-TB Treatment	TB Programme Manager
Number of hospitals assessed for TB according to MDR treatment criteria	Number of hospitals assessed for TB Infection control measures	Improve TB infection control at hospitals	Assessment Reports	Number of hospitals assessed for TB Infection control measures	None	Input	Number	Quarterly	Yes	Higher number indicate greater no. of hospitals assessed	TB Programme Manager
TB MDR confirmed treatment initiation rate	Proportion confirmed new MDR-TB patients initiated on treatment	Monitors treatment of MDR TB patients	ETR.net (TB information system)	Numerator: SUM [TB MDR confirmed client initiated on treatment] Denominator: SUM [TB MDR confirmed new client]	Accuracy dependent on quality of data from reporting facility	Output	Percentage	Quarterly	Yes	Higher percentage indicate better treatment rate for the province	TB Programme Manager
TB MDR treatment success rate	TB MDR client successfully treated	Monitors success of MDR TB treatment	ETR.net (TB information system)	Numerator: SUM([TB MDR client successfully treated]) Denominator: SUM([TB MDR confirmed client initiated on	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	Yes	Higher percentage indicates a better treatment rate	TB Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				treatment])							
Number of Correctional Services Management areas with risk assessments undertaken	Number of Correctional Services Management areas with risk assessments undertaken	To ensure safety standards are upheld	Documented evidence	Numerator: SUM [Number of Correctional Services Management areas with risk assessments undertaken] Denominator: SUM [Total number of Correctional services management areas]	Relies on accurate data from correctional services	Output	Number	Annually	Yes	Number should increase	TB Programme manager
Percentage of correctional services centres conducting routine TB screening	Percentage of correctional services centres conducting routine TB screening	To decrease TB incidence in correctional service centres	Documented evidence	Numerator: SUM [Number correctional services centres conducting routine TB screening Denominator: SUM [Number of correctional Services]	Relies on accurate data from correctional services	Process	%	Quarterly	Yes	% should increase	TB Programme manager
HIV testing coverage (annualised)	Clients HIV tested as proportion of population 15-49 years	Monitors annual testing of persons 15-49 years who are not known HIV positive	DHIS	Numerator: SUM [HIV test client 15-49 years] Denominator: SUM([Female 15-44 years]) + SUM([Male 15-44 years]) + SUM([Female 45-	Dependent on the accuracy of tick and tally sheets	Process	Percentage	Quarterly	Yes	Higher percentage indicate increased population knowing their HIV status.	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				49 years]) + SUM([Male 45-49 years])							
Number of Medical Male Circumcisions conducted	Total number of Medical Male Circumcisions (MMCs) conducted	Tracks the number of the MMCs conducted	DHIS	Total number of Medical Male Circumcisions (MMCs) conducted	None	Output	Sum	Quarterly	Yes	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager
Total clients remaining on ART (TROA) at the end of the month	Total clients remaining on ART (TROA) are the sum of the following: - Any client that has a current regimen in the column designating the month at the end of the reporting period. - Any client that has a star without a circle (someone who is not yet considered lost to follow-up (LTF) in the column designating the month at the end of the reporting period.	Track the number of patients on ARV Treatment	DHIS	Numerator: SUM [Total clients remaining on ART at end of the reporting period] Denominator: SUM Clients remaining on ART equals [Naive (including PEP and PMTCT) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + Lost to follow-up (LTF) + Transfer out (TFO)]	None	Input	Cumulative total	Quarterly	No	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
TB/HIV co-infected client initiated on ART	HIV/TB co-infected client started on ART	Monitors TB/HIV co-infection at point of ART	DHIS	Numerator SUM([TB/HIV co-infected	None	Process	Percent	Quarterly	No	Higher percentage indicates a	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
rate		initiation		client initiated on ART]) Denominator SUM([TB/HIV co-infected client - total])						higher proportion of co-infected clients	

* Note: All population figures are sourced from StatsSA and imported in the DHIS to calculate performance.

PROGRAMME 4:

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Functional district management offices with an oversight body with the required authority established	Determines the capacity of a district's governance and leadership body to guide planning, implementation and monitoring and evaluation of health services within a health district	Poor governance and leadership is a huge contributor to poor quality of services within PHC facilities	District Reports	Number	Dependent on auditable records kept by districts	Process	Annual status	Annual	Yes	Increase	CD DHS
Number of primary health care facilities with functional clinic committees/ district hospital boards	Determines whether a clinic's health service provision activities are planned, implemented and monitored and evaluated in collaboration with community representatives	Services at clinic level that are not planned and executed in collaboration with the communities may not meet communities' needs. Clinics benefit in multiple ways from community involvement	District Reports	Number	Dependent on auditable records kept by districts	Process	Annual status	Annual	yes	Increase	Cd DHS
Number of districts with uniform management structures for primary health care facilities	Determines whether clinics have the management capacity to ensure that clinics meet the requirements of the OHSC	Ensures that clinic has the processes in place to meet OHSC standards	District Reports	Number	Dependent on auditable records kept by districts	Process	Annual status	Annual	yes	Increase	CD DHS
Intersectoral forum established and functioning,	Measures the existence of a forum to	Determines whether a mechanism exists	Report on establishment of forum and	N/A	None	Process	Annual status	Annual	yes	Intersectoral forum established	CD DHS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
specifically targeting the incidence of diarrhoea in children under 5 years of age	specifically target key social determinants of health	to address South Africa's Social Determinants of Health	forum activities								
Number of primary health care clinics in the 52 districts that qualify as Ideal Clinics	Measures the number of clinics where weakness have been systematically and sustainably addressed to meet OHSC standards	To function optimally and provide quality services to communities there are prerequisites that clinics must meet. The Ideal Clinic project aim to address this and ensure that clinics are compliant with OHSC standards.	District Reports	Number	Dependent on auditable records kept by districts	Process	Annual status	Annual	yes	Roll out plan approved and resourced	CD DHS
Number of functional WBPHCOTs[7]	Measures the number WBPHCOTs that report their activities on the DHIS	Functional WBOTs are an essential component in delivery PHC to communities	DHIS	Number	Provinces not submitting reports due to structural problems	Input	Cumulative	Quarterly	yes	Increase	CD DHS
Number of Ports of entry that are compliant with the International Health Regulations	Measures the number of ports that provide services in line with International Health	This indicator will facilitate compliance that will facilitate protection of South African	Inspection reports	Number	Inspectors need to be calibrated	process	Cumulative	Quarterly	yes	Increase	CD DHS

[7] A functional WBPHCOT is one that is constituted according to the prescripts of the policy on WBPHCOTs and reports its activities on the District Health Information System

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	Regulations	Citizens against the threat of communicable diseases from outside of the country's borders.									
Number of municipalities that meet environmental health norms and standards in executing their environmental health functions	Measures the number of municipalities that meet environmental health norms and standards in executing their environmental health functions	The status of the environment impacts on other population health indicators and has to be monitored to prevent negative effects on these	Inspection reports	Number	Inspectors need to be calibrated	Process	Annual status	Annual	yes	Environmental Health strategy developed	CD DHS
Percentage reduction in obesity in men and women	Measures the proportion by which obesity is reduced after targeted interventions	Incidence of obesity needs to be tracked and reduce since obesity contributes to the incidence of high blood pressure and diabetes	SANHANES (ii NDoH Mini Survey	Numerator: Number of people with BMI equal or greater than 25 in a specific age category Denominator: Total number of people in specific age category	Possible Delay in conducting surveys	Outcome	Annual proportion	Annual	yes	Decrease	CD DHS
Number of people counseled and screened for high blood pressure	Measures the number of people counseled and screened for high blood pressure	Counseling and screening increases early detection and treatment before complications set in	To be determined	number	To be determined	output	cumulative	Annual	yes	Increase	CD HP
Number of	Measures the	Counseling and	To be	number	To be	output	cumulative	Quarterly	yes	Increase	CD HP

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
people counseled and screened for raised blood glucose levels	number of people counseled and screened for raised blood glucose levels	screening increases early detection and treatment before complications set in	determined		determined						
Percentage people screened for mental disorders	Measures proportion of population screened for mental disorders	Monitored to increase early detection	NDoH Mini Survey	Numerator: Number of people screened for mental disorder Denominator Total population in survey area:	To be determined	Output	Annual status	Quarterly	yes	Increase	CD NCD
Percentage of people treated for mental disorders	Measures proportion of population treated for mental disorders	Monitored to decrease the incidence of mental disorders going untreated	NDoH Mini Survey	**Numerator** Number of people being treated for a mental disorder: **Denominator** Number of people with mental disorder in that population:	To be determined	Output	Annual status	Annual	yes	Increase	CD NCD
Number of Districts implementing the framework and model for rehabilitation services	Measure number of Districts implementing the framework and model for rehabilitation services	Tracking this will ensure that communities receive access to rehabilitation services	District reports	Number	None	Process	Annual status	Annual	yes	Model approved and costed	CD NCD
Cataract Surgery Rate	Clients who had cataract surgery per 1 million	Monitors access to cataract surgery	DHIS Or Facility	Numerator: Total number of Cataract	Accuracy dependant on quality	Outcome	Rate per 1mil population	Annual	No	Higher levels reflects a good	CD: Non communicable Diseases

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	uninsured population	(preventing disability through blindness)	Register	surgeries completed <u>Denominator:</u> Uninsured population	of data from health facilities					contribution to sight restoration, especially amongst the elderly population	
Reduce the local transmission of malaria cases to 0 per 1000 population at risk	Decrease incidence of malaria	The further decrease in the incidence of malaria will further contribute to the objective of increasing life expectancy.	MRC Malaria information system	Numerator: Number of New cases reported for the period. Denominator: Population at risk /1000	None	Outcome	Rate	Quarterly	No	Lower number of incidence indicate lower number of cases	CD CDC
Number of malaria endemic districts reporting malaria cases within 24 hours of diagnosis	Malaria case notification among endemic provinces	Tracks performance of districts to report malaria cases within 24 hours of diagnosis and allowing active surveillance	MRC Malaria information system	Number malaria districts reporting malaria cases in endemic provinces (No numerator and denominator	None	Process	Number	Quarterly	Yes	Increase	CD CDC
Number of provinces that are compliant with the EMS regulations	Number of provinces that are compliant with the EMS regulations	Track implementation of EMS regulations	Documented Evidence confirming compliance	Sum of Provinces that comply to EMS regulations	None	Output	Sum	Annual	Yes	Higher number indicates greater number of provinces compliant to the EMS Regulations	Chief Director: Violence Trauma and Injury
Review EMS Response Time monitoring system	Review EMS Response Time monitoring system	Improve the quality and reliability of EMS monitoring system	Documented evidence confirming the review	N/A	None	Input	N/A	Annual	Yes	Overhauled EMS response time monitoring system	Chief Director: Violence Trauma and Injury

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Median waiting time for blood alcohol results	Median waiting time for blood alcohol results	Track efficiency of blood alcohol tests	Blood Alcohol result reports	Numerator: Total number of days taken to process all blood alcohol results Denominator: Total number of blood alcohol tests conducted	None	Output	Average	Annual	Yes	Lower number indicated better efficiency	Chief Director: Violence Trauma and Injury
Turnaround times of toxicology tests and reports	Mean Turnaround times of toxicology tests and reports	Track efficiency of toxicology tests	Toxicology test reports	Numerator: Total number of days taken to produce toxicology test and report Denominator: Total number of toxicology tests conducted	None	Output	Average	Annual	Yes	Lower number indicated better efficiency	Chief Director: Violence Trauma and Injury
Turnaround times of food products tests and reports	Mean Turnaround times of food products tests and reports	Track efficiency for testing food products	Food product test reports	Numerator: Total number of days taken to process perishable (and non-perishable) food tests Denominator: Total number of perishable (and non-perishable) food tests conducted	None	Output	Average	Annual	Yes	Lower number indicated better efficiency	Chief Director: Violence Trauma and Injury

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Number of high risk population covered by the seasonal influenza vaccination	Influenza vaccination of high risk individuals	Vaccination reduce mortality from influenza and therefore contribute towards the objective of increasing life expectancy	DHIS	Number of high risk individuals vaccinated against influenza (No numerator and denominator	None	Process	Annual status	Annual	Yes	Increase	CD CDC

PROGRAMME 5:

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
No. of central hospital with reformed management and governance structures as per the prescripts	Central hospitals with functioning semi-autonomous governance structures	Tracks the capacity and competency for local decision making and accountability	NDoH Conditional Grant reporting Template	Reflected as a number out of a total of 9 central hospitals	None	Process indicator	Cummulative	quarterly	yes	A higher number indicates greater number of central hospitals with autonomy.	Cluster manager
Number of gazetted hospitals providing the full package of Tertiary 1 Services	Number of Tertiary Hospitals where all the general tertiary services are provided as defined as Level 1 or Provincial Tertiary Services	Tracks the number of Tertiary Hospitals where all the general tertiary services are provided as defined as Level 1 or Provincial Tertiary Services	NDoH Conditional Grant reporting Template	Reflected as a number out of a total of 19 Tertiary hospitals	None	Input indicator	Cummulative	quarterly	yes	A higher number indicates greater number of tertiary hospitals providing full package of care	Cluster manager
% compliance with extreme and vital measures of the National Core Standards all	Average Percentage compliance with Extreme and vital measures of the	Tracks quality standards as measured by compliance with Extreme and vital	Hospital self assessment report	Numerator: Sum of hospitals (central, tertiary,	Subject to bias because performanc e	Output indicator	Annualised	quarterly	yes	Higher percentage	Cluster manager

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Central, Tertiary, Regional and Specialised Hospitals	NCS in all Central, Tertiary, Regional and Specialised Hospitals	measures of the NCS		regional and specialized) compliant with all extreme and vital measures of National Core Standards	dependant on self-assessment						
Develop guidelines for HRH norms and standards using the WISN methodology	Develop guidelines for Human Resources for Health norms and standards using the WISN methodology	Establish guidelines for HRH Norms to ensure equitable distribution of HRH	Guidelines		None						
Number of RTC's established	Number of RTC's established	Establish RTCs	Documented Evidence	Sum of RTC's established	None	Input	Cumulative	Annual	Yes	Higher Number	Cluster manager
The number of public nursing colleges accredited to offer the new nursing qualification	To determine the extent to which nursing training complies with the required standards.	To ensure that nursing training complies with the required standards.	Chief Nursing Officer records obtained from SANC records	SANC register from accreditation tool.	None	Input indicator	Cumulative	quarterly	No	All 19 crieria for accreditation met by all nursing colleges	Cluster manager
Percentage of facilities that comply with gazetted infrastructure Norms & Standards	To determine the extent to which health facilities comply with proper working environment and reduced occupational health and safety risks.	To ensure quality of care and proper working environment with reduced occupational health and safety risks	Health facility audit	Health facility audit	None	Input indicator	Annualised	quarterly	No	All new facilities	Cluster manager

PROGRAMME 6:

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Regulate Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Traditional Medicines	Regulate Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Traditional Medicines	Ensuring safety and efficacy of all medicines, medical devices and IVDs sold in the market	Documented evidence : Gazetted Regulations	N/A	N/A	Output	N/A	Quarterly	New	Call in notices and regulations gazetted	Cluster: FPTPR
Establish SAHPRA as a public entity	Establish SAHPRA as a public entity	To transition the MCC to SAHPRA to improve efficiency	Government gazette	N/A	N/A	Output	N/A	Bi-annually	Continues from previous year	SAHPRA established	Cluster: FPTPR Legal
Develop and establish MOUs with food testing institutions to enable testing for adulterants in food products	Develop and establish MOUs with food testing institutions to enable testing for adulterants in food products	To strengthen quality assurance of food	Copies of MOUs	N/A	N/A	Output	N/A	Quarterly	New	Two MOUs finalised	Cluster: FPTPR
Percentage of prioritised medicines (antiretroviral, oncology, TB medicines and vaccines) registered within 22 Months for New Chemical Entities (NCEs), and 15 months for multisource medicines	% of registered and rejected products within stipulated timeline	Responsiveness to burden of disease and transparency	SIAMED database	% of products reviewed with stipulated timeline	There are products in the backlog that may confound new data. Calculation of stop clock not automated	Output	%	Quarterly	New	Stipulated timelines met by at least 90%	Cluster: FPTPR,
Develop and Implement	Review Governance	Review governance	Documented evidence.	N/A	None	Output	None	Annually	Yes	Improved governance	Cluster: Public Entities

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Governance Framework and Implementation Plan for Public Entities and Statuary Councils	Framework and Implementation Plan	framework and implementation in order to align it to latest legislative developments and governance practices.	Revised Governance Framework document				Documented evidence			and compliance of entities and statutory health professional councils	Management
Functional governance structures established	Ensure functionality of Boards and Councils by managing the appointment processes to ensure fully constituted structures in terms of enabling legislations and filling of vacancies within 3 months of notification for all Boards and Councils falling within the mandate of the Mandate	To ensure the functionality of the governance structures	Documented evidence. Public entities governance and compliance report produced	N/A	Dependent on submission of information from entities	Output	None Documented evidence	Bi - annually	Yes	Functional governance structures	Cluster: Public Entities Management
Establish the Traditional Health Practitioners Council	Legislation to establish the Traditional Health Practitioners Council	Effective governance and management of the traditional health practitioners profession	Revised Traditional Health Practitioners Act	N/A	Budget	Output	None Documented evidence	Annual	New	Traditional Health Practitioners Act reviewed and draft document tabled to the Interim Council	Cluster: Public Entities Management

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Audit opinion from the Auditor-General for CCOD	Audit opinion from the Auditor-General for CCOD	Measure outcome of all the interventions to improve governance and management of CCOD	Documented Evidence	N/A	None	Outcome	N/A	Annual	Yes	Unqualified Audit opinion	Commissioner : CCOD
Percentage of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self-assessment (gap assessment) or OHSC inspection	% of HE that have submitted a plan to improve quality and safety	Monitors whether HE are developing a plan to address areas of non-compliance identified during a self-assessment or external inspection by the OHSC	DHIS for self-assessments/ Provincial offices for QIPs	Numerator: Number of HE submitting a Quality Improvement Plan Denominator: Number of HE that have either been inspected by the OHSC and/ or who have conducted a self-assessment	Submission of QIP reports to NDOH	Process	Non - cumulative	Quarterly	No	A higher percentage indicates a better focus on quality health care	Office of the COO
Number of provinces with occupational health services within their facilities	Number of provinces with occupational health services within their facilities	Expand the availability of occupational health services	Documented evidence indicating the provision of occupational health service	Sum of provinces with at least one facility providing occupational health services	None	Input	N/A	Annual	Yes	A higher number of provinces providing occupational health services indicate greater availability of such services	CD: CCOD
Establish National	Establish National	Improve disease	Documented	N/A	None	Input	N/A	Annual	Yes	Framework	CD: CCOD

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Public Health Institute of South Africa (NAPHISA)	Public Health Institute of South Africa (NAPHISA)	surveillance research and M&E	Evidence							and Business case developed	
Patient satisfaction surveys rate	Percentage health facilities are conducting patient satisfaction surveys once a year	To determine how many health facilities are obtaining the views of users of health services on how they experience such services	DHIS	Numerator: Number of HE that conducted a patient satisfaction survey Denominator: Total number of health facilities		Outcome	Annualized rate	Annual	Yes	A higher percentage will indicate that more health facilities know how the services they provide are experienced by their users	Office of the COO
Patient satisfaction rate	The percentage of users which participated in the survey that were satisfied with the services	Tracks the service satisfaction of the all public health facility users	Patient Satisfaction Survey results	Numerator: Total number of users that were satisfied with the services rendered at public health facilities Denominator: Total number of users that participated in the Client Satisfaction at public health facilities	Generalizability depends on the number of users participating in the survey.	Quality	Percentage	Annual	Yes	Higher percentage indicates better levels of satisfaction at hospital level	Office of the COO

Department of Health
Switch Board 012 395 8000
Physical address Civitas Building
Cnr Thabo Sehume and Struben Streets
Pretoria
Postal address Private Bag x828
Pretoria
0001

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