STRATEGIC PLAN

2014/15 - 2018/19

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Contents

Strategic Plan

Department of Health

2014/15 to 2018/19

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Acronyms

AG	Auditor-General
AMC	Academic Medical Center
APP	Annual Performance Plan
ART	Antiretroviral Treatment
BoD	Burden of Disease
CCOD	Compensation Commission for Occupational Diseases
CHC	Community Health Center
CHW	Community Health Worker
CMS	Council for Medical Schemes
CRA	Comparative Risk Assessment
CSIR	Council for Scientific and Industrial Research
CTOP	Choice of Termination of Pregnancy
DBSA	Development Bank of Southern Africa
DHIS	District Health Information System
EDMS	Electronic Document Management System
EMS	Emergency Medical Services
FBO	Faith-Based Organisation
GDP	Gross Domestic Product
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counselling and Testing
HDACC	Health Data Advisory and Coordination Committee
HSRC	Human Sciences Research Council
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illness
LBW	Low Birth Weight
MBOD	Medical Bureau for Occupational Diseases
MDG	Millennium Development Goal
MISP	Master Information Systems Plan
MMR	Maternal Mortality Rate
MRC	Medical Research Council
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NHRC	National Health Research Committee
NHREC	National Health Research Ethics Committee
NICD	National Institute for Communicable Diseases
NIMSS	National Injury Mortality Surveillance System
NSDA	Negotiated Service Delivery Agreement
OPV	Oral Polio Vaccine
OSD	Occupation Specific Dispensation
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPIP	Perinatal Problem Identification Programme
PPP	Public Private Partnership
QIP	Quality Improvement Plan
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SANHANES	South African National Health and Nutrition Examination Survey
SDA	Service Delivery Agreement
SRH	Sexual and Reproductive Health
STATSSA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YFS	Youth Friendly Services

FOREWORD BY THE MINISTER OF HEALTH

When this Administration assumed office in 2009, we were still faced with a divided health-care system. There remained stark differences between the public and private health sectors in terms of access and quality.

South Africa's has a quadruple burden of diseases, namely; *a very high prevalence of HIV and AIDS which has now entered into a synergistic relationship with TB; maternal and child morbidity and mortality; exploding prevalence of non-communicable diseases mostly driven by risk factors related to life-style; and violence, injuries and trauma.*

In response to these burdens, the country developed a Ten Point Plan to overhaul the health system. In addition, the National Service Delivery Agreement was signed with the President. In this agreement, there are four outputs namely; Increasing Life Expectancy; *Decreasing Maternal and Child mortality; Combating HIV and AIDS and Decreasing the Burden of Diseases from TB; and Strengthening Health System Effectiveness.*

Since launching the HIV Counselling and Testing (HCT) Campaign with the President in 2009, we have tested more than 20 million people. This is an enormous achievement and has assisted in early detection and treatment as well as prevention. This Campaign was renewed on World AIDS Day 2013.

The success of the ARV roll out was as a result of the Nurse Initiated Management of Antiretroviral Therapy (NIMART) Programme. To date, 23 000 nurses have been trained. Due to this programme, we have been able to increase the number of facilities able to provide Antiretrovirals (ARVs). Therefore, NIMART made it possible to increase the number of people on treatment from 923 000 in February 2010 to 1.9 million by the end 2012 – effectively doubling the number on treatment.

The Prevention of Mother to Child Transmission (PMTCT) in South Africa has yielded heartening results. The MRC conducted systematic studies of mother and baby pairs to periodically monitor the effectiveness of the PMTCT Programme in reducing perinatal transmission of HIV from mothers to infants, measured at 4-8 weeks after infant birth. In 2008, the MRC found the mother to child transmission rate to be on average 8,5%, nationally. In 2010, the MRC's PMTCT study found that 31,4% of babies were exposed to HIV, but the mother to child transmission rate had decreased substantially to 3,5%. In a follow up study in 2011, 32,2% of babies were found to have been exposed to HIV, and the transmission rate had decreased further, to 2,67%. All researchers attributed the decline in mortality and the concomitant increase in life expectancy to our comprehensive response to the HIV epidemic, especially the ARV treatment programme.

In the field of TB, many exciting new programmes have been launched. The first is the GeneXpert technology. GeneXpertallows for faster diagnoses. Whereas previously it could take up to a week to diagnose TB, with GeneXpert, it now takes only 2 hours to make a diagnosis. This has huge positive implications for health outcomes for the patients. The National Development Plan has clearly indicated that by 2030, we must have a generation of under twenties (20) being free of HIV and AIDS and we must have a decrease in TB contact indices.

The NCDs have been found to be on the increase in South Africa. These NCDs disproportionately affect poor people living in urban settings, and are driving the rising demand for chronic disease care. Studies have predicted that the burden of disease related to NCDs will increase substantially in South Africa over the next decade, if measures are not taken to combat the trend. The Ministry has consulted widely and developed policies for NCDs that are guided by the WHO. Already there is emerging evidence from the 3 pilot sites in the country that the Integrated Management of Chronic Diseases Model is an ideal, practical and patient centred model to manage the double burden of HIV and NCD's.

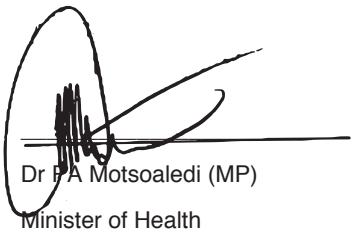
The Campaign on the Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) strategy was launched in 2012 with the aim of reducing maternal and child mortality and achieving positive health outcomes. One of the areas of focus is the reduction of mortality associated with cervical cancer and improvement of family planning. More than 50% of women affected by cervical

cancer are in the ages between 35 and 55 years. This cancer is caused by the Human Papilloma Virus (HPV). A vaccine for HPV will be introduced progressively, as part of our School Health Programme as from March 2014.

With regard to improving the efficiency and effectiveness of the healthcare system in the country, our flagship programme is the National Health Insurance (NHI) system. At the core of Universal Health Coverage in South Africa is that every citizen has a right to access good quality, affordable health care, and that the access should not be determined by the socio-economic conditions of the individual, but based on the principles of social solidarity, equity and fairness. The success of National Health Insurance will be dependent on improved quality in the public sector and reduced costs in the private sector.

The National Health Amendment Act was assented to on 24t July 2013 and proclaimed into law on 2nd September 2013. With the establishment of the Board, this brings into being a new public entity, the Office of Health Standards Compliance. Its legislative mandate is to protect and promote the health and safety of users of health services by monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister, and ensuring the consideration, investigation, and disposal of complaints relating to non-compliance with prescribed norms and standards. The Office will be listed as a Schedule 3A public entity in terms of the Public Finance Management Act (1998) from 1 April 2014.

The Competition Commission has initiated a market inquiry on health care costs. We will await the outcome of the inquiry and respond accordingly.



Dr PA Motsoaledi (MP)

Minister of Health

STATEMENT BY THE DIRECTOR-GENERAL

The public health sector works to: promote health, protect health, prevent illness and injury, and influence the socio-economic and environmental determinants of health – including the social, economic, physical and environmental factors that affect health.

Our success in achieving better health outcomes as a country depends on our collective ability to build relationships and work across sectors to create cohesive communities and enabling environments that promote health. The public health sector is uniquely positioned to create the bridge between the health sector and all other sectors that influence health.

Government is committed to forge ahead with the implementation of the National Health Insurance (NHI) scheme. However for this to happen, a certain levels of health quality standards needs to be adhered to by the country's hospitals and clinics. Quality has to be the precondition for health care. It is evident from the findings of the Health Facility Audit conducted in 2011 and 2012 that a lot of investment for improved quality is needed. The first initial steps to address this were the establishment of facility improvement teams in the NHI Pilot Districts. In order to ensure long term sustainability of these improvements, dedicated effort is required in partnership with the community , private sector and development partners.

Quality can best be achieved through a planned set of actions designed to meet expectations of the users. The goal of the establishment of the independent Office of Health Standards Compliance is to ensure that patient care meets acceptable standards.

We have recognised the scaling up of the health workforce as key. In that regard an institution has been established to translate this into action. An Academy of Health Leadership that determines how training is designed and accredited was established.

Our real challenge as a nation is finding people with practical experience to manage hospitals. We need to refocus our workforce so that more on-the-job training takes place. The first line of effort is to focus on improving the management skills and competencies of mangers at all levels of the health care system. We are working with academic institutions and international partners to offer our chief executives best practice skills through relevant case study material. Our intention is to get results much faster by focusing on a more practical approach.

Healthy Early childhood development will have to be one area of our strategic focus. Healthy babies are more likely to grow up to be healthy children, teens, adults and seniors. The first 2,000 days of life are critical to long-term health.

The main factors that put children at risk are poverty, stress, neglect and abuse. Factors that protect babies and help them develop include their mother eating well and not smoking or drinking alcohol during pregnancy, being breastfed exclusively until six months of age, receiving positive parenting and living in supportive environments.

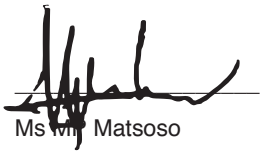
The uptake of vaccines is not as high as it should be to protect both individual's and population's health. There's a need to improve our mass immunisation campaign to reach as many children as possible.

Improve health by reducing preventable diseases and injuries are another strategic area of focus. Today, the greatest challenges facing South Africa are not rare illnesses, but the increasing impact of chronic disease and injuries. Overweight and obesity are threatening the health and well-being of South Africans'. Overweight and obesity are well-established risks independent factors for cardiovascular diseases. The South African Human Science Research Council (SAHRC) has found that almost 30 per cent of our children and youth are overweight or obese. The rates are even higher in some population groups. Overweight children and youth are more likely to develop cardiovascular disease related health problems later in life. To reduce childhood obesity, we must act aggressively now by reinforcing healthy lifestyles.

We have to upscale our health promotion and nutrition interventions over this five year period. We must find effective ways to engage the whole population in healthy eating habits, physical activity and responsible lifestyles.

We will need to create healthy communities. Our interventions will have to cover everything from pre-natal and post-natal care to the food supply and marketing chain to built environments that promote healthy eating and active living. To achieve this, the public health sector will have to forge strategic working partnerships with both the health and non-health sectors – with parents, child care providers, schools, health care providers, community organisations, the food industry, store owners and retailers and the media.

I call upon all our health workers and partners to join government and do our part to implement this plan and help us achieve a healthy and long life for all South Africans.



Ms MP Matsoso

Director-General: Health

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OFFICIAL SIGN-OFF

It is hereby certified that this Draft Strategic Plan:

Was developed by the management of the National Department of Health under the guidance and support of the Ministry of Health;

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

Accurately reflects the strategic outcome oriented goals and objectives which the Department of Health will endeavour to achieve over the period 2014/15 - 2018/19.

MR I VAN DER MERWE

CHIEF FINANCIAL OFFICER

DATE: 10/ 03/ 2014

MS M WOLMARANS

CHIEF DIRECTOR: POLICY CO-ORDINATION AND INTEGRATED PLANNING

DATE: 10/ 03/ 2014

MS MP MATSOSO

DIRECTOR-GENERAL: HEALTH

DATE: 10/ 03/ 2014

DR PA MOTSOALEDI

MINISTER OF HEALTH

DATE: 10/ 03/ 2014

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 me dicinal products to ensure their safety, quality and effi cacy, 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 im portation 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.

3.5.1. 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.

3.5.2. 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.

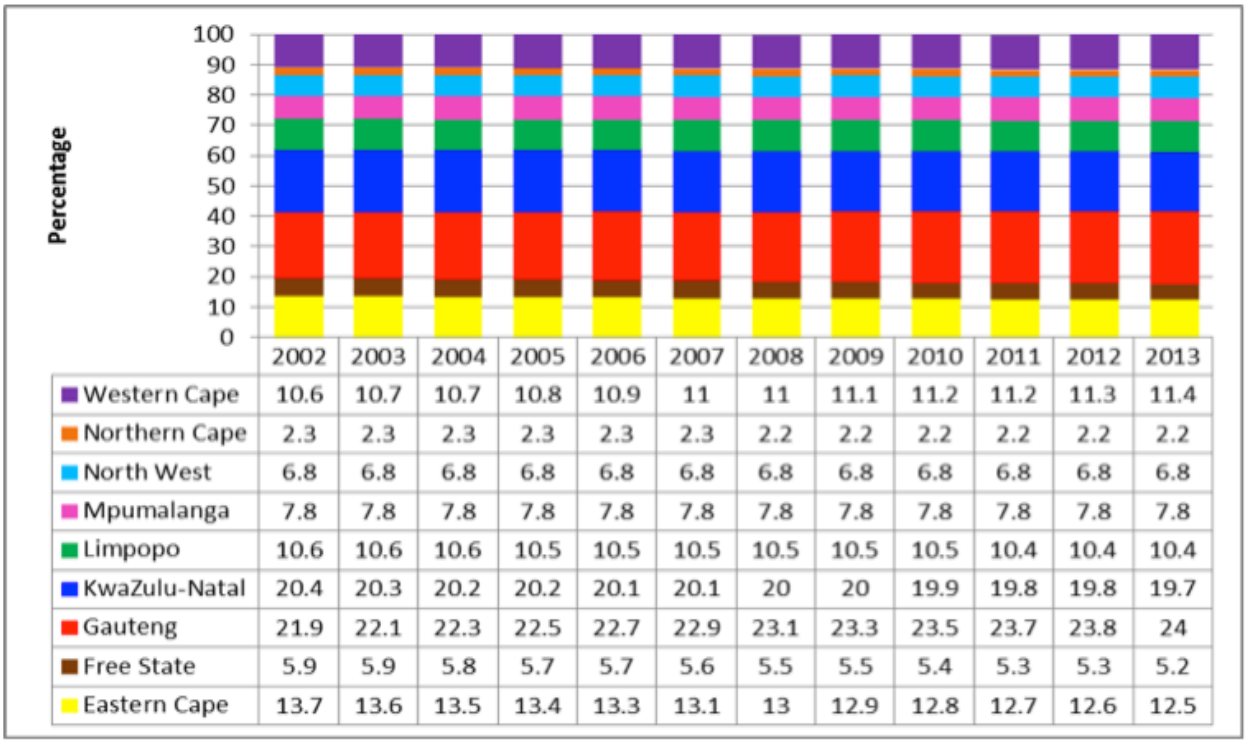
The proposal is to bring the medical devices industry, cosmetics and foodstuffs as well as pharmaceuticals under the jurisdiction of the SAHPRA. The SAHPRA will be established as an organ of State within the public service and would thus be able to regulate its own income.

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



	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)

experienced a significant population influx between 2002 and 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.

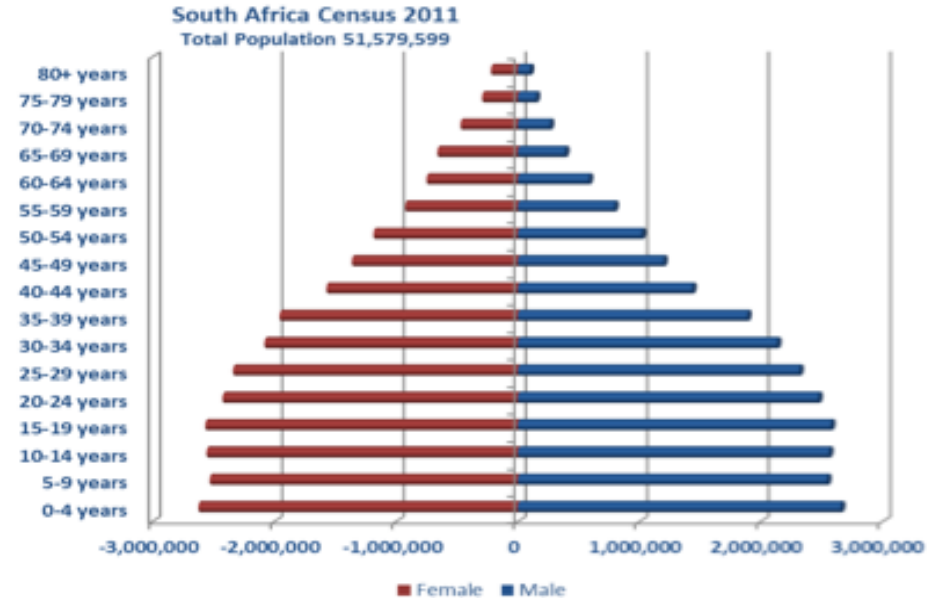


Figure 2: South Africa's Mid-year Population Estimates for 2001 Source: Census 2001 (StatsSA)

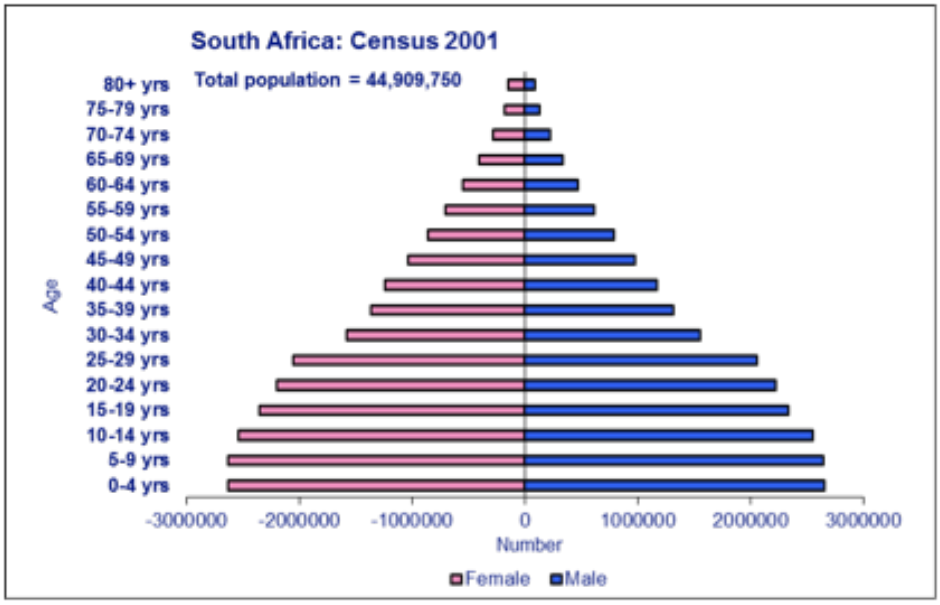


Figure 3: South Africa's Mid-year Population Estimates for 2011 Source: Census 2011 (StatsSA)

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.

4.2. Social Determinants of Health

Progress is being made towards providing basic services that are social determinants of health. 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 be low 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%

d) Progress has also been made towards achieving uni versal primary education 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
  - 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
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.

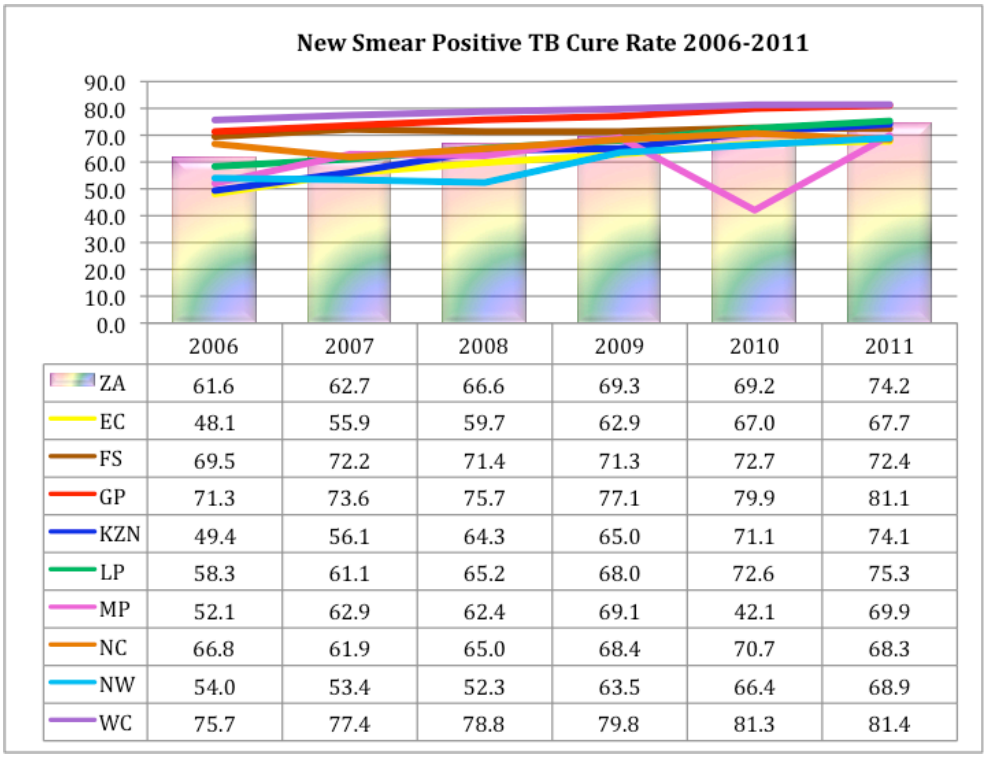
There were more than 389 000 new tuberculosis cases reported in 2011. The 2012 Global WHO TB report indicates that, even though notified cases have been declining since 2009, South Africa still has one of the highest TB incidence rates in the world at 993 cases per 100 000 population. Case detection 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 im provement. 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.

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

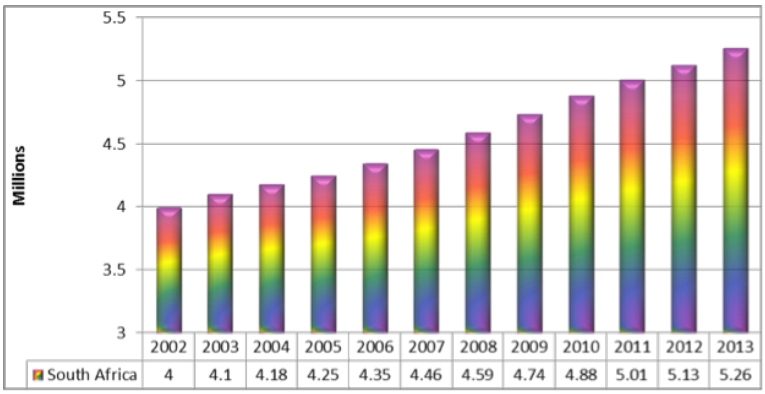


Figure 5: Estimated number of people living with HIV 2002-2013 (Source: Source: StatsSA, Statistical Release P0302, Mid-year population estimates 2013)

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.

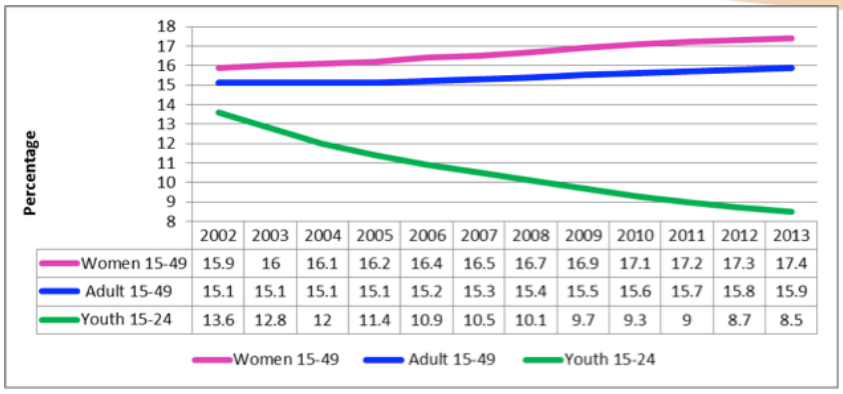


Figure 6: HIV prevalence rate in for women and men 15-49 years as well as Youth 14-24 years in South Africa from 2002 to 2013 (Source: Source: StatsSA, Statistical Release P0302, Mid-year population estimates 2013)

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	Source1	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 births2
Under five Mortality Rate		56 per 1000 live births	50 per 1 000 live births	45 per 1 000 live births2
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 years2 56.9 years for Males2 years for females2

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 . 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 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-communi cable diseases
5. Reduce injury, accidents and violence by 50 per cent 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

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 d. Prevent and reduce the disease burden and promote health	Prevent disease and reduce its burden, and promote health;
Tuberculosis (TB) prevention and cure progressively improved;		
Maternal, infant and child mortality reduced		
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 system 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 g. Review management positions and appointments and strengthen accountability mechanisms	Improve human resources for health by ensuring adequate training and accountability measures.

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.

PART B

Programmes And Strategic Objectives

PROGRAMME 1: ADMINISTRATION

1.1 PROGRAMME PURPOSE

- To provide support services and ensure compliance with relevant legislation.
- To ensure efficiencies in the administration of the Department.

The Administration programme plays a crucial role in the delivery of the Department's services through providing a full range of support services in the areas of organizational development, HR and Administration including Labour Relations Services; Information Technology; Property management services; Security Services; Legal Services; Communication Services and facilitation of integrated planning and policy coordination. Corporate Services is critical to the strategic direction of the Department since the way in which support services are delivered directly influences every aspect of the organizational culture, policies, human resource capability, and corporate systems and processes. It is therefore necessary that we ensure effective and efficient business processes for the optimal client support which will contribute to the achievement of the set goals and objectives of the programmes and priorities outlined in the MTSF; NDP and APP.

1.2 STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2018/19)
Ensure effective financial management and accountability	Ensure effective financial management and accountability by improving audit outcomes	Audit opinion from Auditor General	Unqualified audit opinions	Clean Audit Opinion for the NDOH
		Audit opinion from Auditor General for Provincial Departments of Health	2 Unqualified audit opinions	7 Unqualified audit opinions
Develop and implement the ICT Governance framework for NDoH	Develop and implement the ICT Governance framework by focusing on the business continuity plan inclusive of a disaster recovery plan	Develop and Implement Business Continuity Plan inclusive of a disaster recovery plan	Draft Disaster Recovery Plan available	Full implementation of Business Continuity Plan and disaster recovery plan
Provide support for effective communication	Provide support for effective communication by developing an integrated communication strategy and implementation plan	Develop an integrated communication strategy and implementation plan	Fragmented communication programme	Integrated Communication strategy and implementation plan developed and implemented
Ensure efficient and responsive Human Resource Services to the National Department of Health	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	6 months	3 months
		Develop and Implement Employee wellness programme that comply with Public Service Regulations (PSR) and Employee Health and Wellness Strategic Framework (EHWSF)	Inadequate compliance with Employee Health Wellness regulations	Employee Health and Wellness Programme that adhere to Part VI of the PSR and EHWSF
Improve and coordinate integrated planning for health	Provide leadership in the health sector by integrating all health sector plans and providing support for developing identified plans	Develop and implement a framework for Integrated Health Service Plans at all levels of the Health sector	New Indicator	Framework for Integrated Health Service Plans at all levels of the Health care sector developed and implemented

1.3 RESOURCE CONSIDERATION

The spending focus since 2010/11 and over the medium term is on accommodation and corporate services needs to ensure it has the necessary capacity to deliver on its mandate. This can be observed in operating leases being the largest spending item following compensation of employees in this period. Filled posts increased from 498 in 2012/13 to 530 in 2013/14, but are expected to decrease again to 488 in 2014/15 and remain constant for the rest of the medium term. The decrease is mainly due to the shifting of the programme managers from this programme to their respective programmes. As a result of this, the spending on compensation of employees in this programme will drop in 2014/15, after which it will increase at a steady rate. As of November 2013, there were 24 vacant posts in the programme.

Accommodation costs rose significantly in 2011/12 after the Department relocated back to the upgraded Civitas building as part of the payment for this upgrading to the Department of Works over the longer term. Over the medium term, spending in the Financial Management subprogramme aims to support effective management and accountability in the department and assist all nine provincial health departments to improve audit opinions. The budget of the Management sub-programme is slightly lower in all years than published last year due to the shifting of the offices of the deputy director-generals to their respective programme budgets. Audit costs have increased sharply from R14.7 million in 2010/11 toR25.6 million in 2013/14, due to the introduction of a mid-year audit of performance information.

Risk	Mitigation Strategy
Liquidity and use of financial resources	• Strict implementation of fraud prevention plan with zero tolerance for fraud and corruption • Disciplinary processes for transgressors to be reported to relevant statutory bodies, including SAPS within 30 days.
Integrity of financial information	• Effective Audit committee to have oversight and encourage accountability within NDOH for financial management
Adequacy and suitability of ICT infrastructure	• Service Level Agreements with service providers, including penalty clauses on non or late deliverables • Management of agreement and support from SITA • Training and skill transfer from service providers to perform maintenance in house • Business Continuity Plan and Disaster Recovery Plan funded and implemented
Effective and appropriate Internal and external communication	• Broad consultation on Integrated Communication strategy • Implementation and monitoring of Integrated Communication strategy
Critical skills attraction, retention and development	• Provide clear delegation of authority for Human Resource Services • Review and re-engineering of human resource processes to meet strategic objectives of the • Department • Improve processes for dealing with Disciplinary cases
	• Accelerated awareness on the submission of the completed job description and JE questionnaires
	• Develop strategy to share Employee Health and Wellness Strategic Framework (EHWSF) with all employees • Review and communicate Employee Health and Wellness management practises to all employees to encourage compliance

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.

There are five budget sub programmes:
Technical Policy and Planning provides advisory and strategic technical assistance on policy and planning, and supports policy analysis and implementation, commissions health financing research including , oversees research into alternative healthcare financing mechanisms for achieving universal health coverage develops policy for the medical schemes industry and provides technical oversight over the Council for Medical Schemes;

Health Information Management, Monitoring and Evaluation sub- programme develops and maintains a national health information system, commissions and coordinates research, develops and implements disease surveillance programmes,and monitors and evaluates strategic health programmes.

The eHealth Strategy has been adopted by National Health Council and provides the roadmap for achieving a well-functioning national health information system with the patient located at the centre. The strategy also seeks to ensure that the integrated national patient-based information system will be based on agreed scientific standards for interoperability, which improves the efficiency of clinical care, produces the indicators required by management, and facilitates patient mobility.

Surveys are conducted including the national HIV and Herpes Simplex type 2 surveillance. It has been conducted in the past 23 years (since 1990) . The National Department of Health conduct this research on the epidemiological characteristic of the HIV epidemic and HSV2 at national, provincial and district level. Since 2002, UNAIDS and WHO use the annual data generated from this survey to feed into

the EPP and Spectrum Models in order to extrapolate HIV prevalence estimates and HIV incidence among 15 - 49 year olds in the general population annually, at national and provincial level in South Africa.

Health Research in South Africa has been prioritised with a strategic framework for health research being developed. The Research Summit which was convened in 2011 adopted seven (7) themes as the main priorities for action by all key stakeholders in the public health sector namely: Funding ; Human Resources; Health Research Infrastructure; Priority Research Fields; National Regulatory Framework; Planning and Translation; and Monitoring and Evaluation. One of the key outputs expected is the establishment of a Research Observatory for South Africa. Further, building on the findings of the National Research Ethics Audit (2012), the Department will continue to audit research ethics committees (human and animal) and to ensure that ethical research is conducted in the country while supporting good governance of all Research Ethics Committees (RECs) nationally.

The two statutory bodies that are pivotal in creating a conducive environment for health research in South Africa are the National Health Research Committee and the National Health Research Ethics Council. They derive their mandate from the National Health Act, 61 of 2003, Chapter 9. There are two other institutions that drive the research agenda , the MRC which is a public entity and HST which is a NGO.

Sector-wide Procurement sub programme is responsible for developing systems to ensure access to essential pharmaceutical commodities. This is achieved through the selection of essential medicines, development of standard treatment guidelines, administration of health tenders, licensing of persons and premises that deliver pharmaceutical services and related policies

The Essential Medicines List (EML) and Standard Treatment Guidelines (STGs) are available for all levels of care and published on a 3 year cycle. These tools are used to promote access to affordable medicines that are safe and effective at the relevant level of care in both the public and private sector. Each chapter is disseminated for peer review by relevant stakeholders prior to publication. The EML and STGs are published in book, web and cell phone application formats in order to improve acceptability by health care professionals

The Department of Health develops a procurement plan to ensure valid contracts are available for the procurement of essential medicines and pharmaceutical commodities. Prior to the issue of a contract, market intelligence is undertaken in order to facilitate the most economic tender and promote security of supply. Supplier performance is monitored and used to exclude poorly performing suppliers from participation in future tenders. Bar code technologies are being implemented to improve the efficiencies of the supply chain.

Medicines availability - a network of linked stock system will be established throughout the supply chain value chain to improve availability. In order to simplify the supply chain and its responsiveness direct deliveries are being implemented to central and regional hospitals. The National Department of Health maintains a buffer stock of vital medicines at the central procurement unit for deployment in the event of stock shortages.

In order to improve access, a system of central chronic medicines dispensing and distribution service providers linked to pick up points have been established in order improve access through extended service hours and closer proximity to the patient's place of residence or work.

Permits are issued to various health care professionals in order to promote access to medicines in a manner that maintains safety of patients.

The Traditional Health Practitioners interim council (ITHPC) has been established and systems developed to manage knowledge of African Traditional Medicines.

Health Financing and National Health Insurance sub-programme develops and implements policies, legislation and frameworks for the achievement of universal health coverage through the phased implementation of National Health Insurance; and to provide technical and implementation oversight for the National Health Insurance conditional grants. The sub-programme also comprises the Directorate for Pharmaceutical Economic Evaluations which plays an integral role to ensuring the effective implementation of 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 of health care.

International Health and Development sub programme 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 emerging economic groupings such as Brazil-Russia-India-China-South Africa (BRICS) to strengthen the health system and coordinates international development support

Over the medium term, and in line with NDP 2030, the cluster will mobilize resources for national and regional health activities; establish strategic bilateral cooperation, especially with BRICS countries on areas of mutual and measurable benefit; facilitate participation in various multilateral and other global engagements such as AU, SADC, WHO, UN and BRICS; implement cross border initiatives to manage cross border care and enhance harmonization of regulations, treatment guidelines and policies; improved management and related capacity of Health Attachés to identify and analyse emerging issues and trends in global health; and establishment of global health dialogue forums with other stakeholders on

intersectoral issues such as climate change, trade and foreign policy.

South Africa is signatory to a number of international treaties and instruments such as International Health Regulations (2005), Framework Convention on Tobacco Control (FCTC), including other human rights conventions such as International Covenant on Civil and Political Rights, International Convention on the Elimination of All Forms of Racial Discrimination, African Charter on Human and Peoples' Rights and the SADC Protocol on Health. Furthermore, South Africa has supported adoption of some important international reports and resolutions such as WHO Action Plan for the prevention of avoidable blindness and visual impairment, follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health, Follow-up of the report of the Consultative Expert Working Group on Research and

STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2018/19)
Achieve Universal Health Coverage through the phased implementation of National Health Insurance	Achieve Universal Health Coverage through the phased implementation of National Health Insurance	Legislation for NHI	None	NHI Bill finalized and promulgated into law.
		Piloting of NHI in selected districts across the country.	10 NHI pilot districts across the country.	NHI pilots expanded for implementation in 50% of the 52 health districts.
		Establishment of the National Health Insurance Fund	Conceptual document of the NHI Fund as per the Draft White Paper on National Health Insurance	Functional National Health Insurance Fund purchasing services on behalf of the population from accredited and contracted providers established.
Regulate health care in the Private sector	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	None	Functional National Pricing Commission to regulate health care in the private sector established by 2017
		Publish revised SEP adjustment methodology.	The previous cycle SEP as calculated by previous annual announcement.	New methodology implemented for the adjustment of prices for generics and originator drugs.
Strengthen revenue collection	Strengthen revenue collection by incentivising central hospitals to increase their revenue collection	Develop and implement a Revenue Retention model	None	A revenue retention model for Central Hospitals developed and implemented by 2016
Implement eHealth Strategy	Develop Business and Enterprise Architecture for eHealth	Develop a complete System design for a National Integrated Patient based information system	Normative Standards for eHealth developed and approved	System design for a National Integrated Patient based information system completed
Ensure research contribute to the improvement of health outcomes.	Establish a National Health Research Observatory.	Functional National Health Research Observatory	Draft Concept paper for the establishment of the National Health Research Observatory and Report from HST on best practice health research observatory	National Health Research Observatory established by 2019
Develop and implement an integrated monitoring and evaluation plan	Develop and implement an integrated monitoring and evaluation plan aligned to health outcomes and outputs contained in the Health Sector Strategy	Develop and implement Integrated monitoring and evaluation plan	Draft Monitoring and Evaluation plan	Integrated monitoring and evaluation plan developed and implemented
Establish a coordinated disease surveillance systems	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	Manual disease notifications	Strategy and plan to coordinate and integrate surveillance systems for NMC developed and implemented
Ensure SA meets it international obligation	Domestication of international treaties and implementation of multilateral cooperation on areas of mutual and measurable benefit	Implement International treaties and multilateral frameworks	New indicator	International treaties and multilateral frameworks implemented
	Implementation of bilateral cooperation on areas of mutual and measurable benefit	Number of Bilateral projects implemented	New indicator	Eight strategic bilateral projects implemented

Development: Financing and Coordination, patient safety and Global strategy to reduce the harmful use of alcohol, Abuja Call for Action and Maseru Declaration on HIV and AIDS. As such, the cluster will accelerate the domestication and implementation of these treaties and resolutions in this mid-term cycle.

2.2 RESOURCE CONSIDERATIONS

The spending focus over the medium term will be working to ensure universal health coverage by funding the 10 national health insurance pilot projects and conducting health economics research, particularly regarding the rollout of national health care and alternative health care financing mechanisms. These activities will be carried out within Health Financing and National Health Insurance sub-programme, which grew significantly in 2012/13 and 2013/14. The pilot projects began in 2012/13, with funds allocated through the national health insurance conditional grant to provinces. Over the medium term, the pilot projects are allocated R70 million, R74 million and R77.9million. In 2013/14, the new national health conditional grant, with a component for national health insurance, was introduced. The grant is allocated R420 million, R444 million and R467.5 million over the MTEF period, which explains the significant increase expected in sub-programme's spending over the period. The largest spending item in the grant, which is used by the national department, is contractors, which pays for the contracting of general practitioners to the pilot projects.

Expenditure on goods and services is projected to increase substantially over the MTEF period because of the new function of contracting general practitioners through the national health grant. Spending on transfer payments grew in 2012/13 as the national health insurance scheme was formed and is projected to decline over the medium term as much of the scheme's funds were shifted into the new national health grant in 2013/14.

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 to conduct the South African demographic health survey, which is normally carried out every five years but has not been conducted since 2003/04. Demographic health surveys are globally used and seen as one of the best ways to collect population-based health data.

Spending in the International Health and Development sub-programme has increased since 2010/11due to a new health attaché position in Cuba, additional students sent to Cuba for medical training, and the increased annual membership fees to the World Health Organisation. The students sent to Cuba are recruited from rural areas with a shortage of doctors and are contracted to work in these areas when returning from training. The health attaché position was created to oversee and support this programme. The payment of members of the Traditional Healers Council, which was appointed at the end of 2012/13, was reallocated from the Sector-wide Procurement sub-programme in 2014/15 to the Hospital, Tertiary Health Services and Human Resource Development programme, which explains the slight decrease projected in expenditure in the sub-programme.

2.3 RISK MANAGEMENT

Risk	Mitigation Strategy
Financing of various service delivery improvement programmes	Negotiation with key stakeholders to facilitate appropriate funding
Capacity to manage the health system	Partnerships with local and international partners to improve management capacity, i.e. Leadership Academy with University of Pretoria and Harvard University
Health sector cost fluctuations	Establishment of the National Pricing Commission through collaboration with Department of Economic Development (and Competition Commission)
Collaboration level with the private sector	Ongoing communication with the private sector on planned interventions and policy priorities
Empirical evidence of conditions to support the formulation of regulation	Ensure relevance of regulation and guidelines for enforcement

The number of posts in this programme is expected to decrease slightly from the current 161 to 155 in 2014/15 and then remain stable over the medium term. The budget for compensation of employees is therefore decreasing slightly in 2014/15, after which it will increase steadily over the medium term. There were 5 vacant posts at the end of November 2013.

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 sub programme 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 sub programme 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 sub programme has received a large Global Fund grant which will be used to respond to these challenges.

Women, Maternal and Reproductive Health sub programme 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 sub programme 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 OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2018/19)
To reduce maternal morbidity and mortality	To implement strategies such as the MNCWH&N Strategic Plan 2012-2016 and the CARMMA strategy to reduce the maternal mortality to under 100 per 100 000 live births	Maternal Mortality Ratio	Maternal Mortality Ratio of 269/ 100 000 live births	Maternal Mortality Ratio of <100/100,000 live births
To reduce neonatal morbidity and mortality	To implement strategies such as the MNCWH&N Strategic Plan 2012-2016 and the CARMMA strategy to reduce the neonatal mortality rate < 6 per 1000 live births	Neonatal Mortality Rate	Neonatal Mortality Rate of 14 per 1000 live births	Neonatal Mortality Rate of < 6 per 1000 live births
To improve access to sexual and reproductive health services	To improve access to sexual and reproductive health services by expanding the availability of contraceptives	Couple year protection rate	Couple year protection rate of 36%	Couple year protection rate of 80%
		Cervical cancer screening coverage	55% coverage	> 70% coverage
		HPV 1st dose coverage	New Indicator	90%
Expand the PMTCT coverage to pregnant women	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	90%	100%
		Infant 1st PCR test positive around 6 weeks rate	2.5%	<1%
Reduce under-five mortality rates	To reduce under-five mortality rates to less than 30 per 1,000 live births.	Under five mortality rate	42 per 1,000 live-births	23 per 1,000 live-births
		Child under 5 years diarrhoea case fatality rate	4.2%	<2%
		Child under 5 years severe acute malnutrition case fatality rate	9%	< 5%
		Confirmed measles case incidence per million total population	< 5/ 1,000,000	<1/1,000,000
		Immunisation coverage under 1 year (Annualised)	94%	98%
		DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	8%	<5%
		Measles 2nd dose coverage	81.8%	95%
Improve health and learning amongst school-aged children	To improve health and educational outcomes amongst school-aged children by rolling out ISHP services	School Grade 1 screening coverage (annualised)	7%	60%
		School Grade 8 screening coverage (annualised)	4%	50%

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2018/19)
Strengthen the system for tracing patients lost to follow up before and during treatment	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	79%	>85%
		TB (new pulmonary) defaulter rate	6%	<5%
		Number of trained TB tracing coordinators available	0	52 trained tracing coordinators available
		TB Death rate	6%	<3%
Increase access to MDR-TB treatment initiation	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	5	400 Professional Nurses trained to initiate MDR-TB treatment
		Number of hospitals assessed according to MDR Treatment criteria	0	255 Hospitals assessed
		TB MDR confirmed treatment initiation rate	56%	80%
		TB MDR treatment success rate	42%	>65
Improve TB prevention, diagnosis and treatment in correctional services facilities	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	0	48 Correctional Services Management areas
		Percentage of correctional services centres conducting routine TB screening	23%	95%
To scale-up combination of prevention interventions to reduce new HIV, STI and TB infections	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)	8.9 million (12/13)	10 million annually (cumulative 50 million)
		Number of medical male circumcisions conducted	600,000 (13/14)	1, 000 000 per annum (cumulative 5,000 000)
Providing quality and an appropriate package of treatment care and support to 80% of HIV positive people and their families	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	2.4million	5,100,000
		TB/HIV co-infected client initiated on ART rate	54%	95%

3.3 RESOURCE CONSIDERATIONS

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.

3.4 RISK MANAGEMENT

Risk	Mitigation Strategy
Provincial and district prioritisation and implementation of the most important interventions that will have the greatest impact on maternal mortality such as the recommendations of the NCCEMD	• Robust M&E plan with colour coded dashboards highlighting indicators that are not reaching targets and provinces and districts that are below average. • District clinical specialist teams, who focus on clinical governance and improvement of the quality of care
Poor infrastructure in hospitals preventing optimal neonatal care in the form of respirators and piped air at correct pressure	• Better use of infrastructure grant and closer collaboration with Department of public Works • Improved integration of the work between branches responsible for primary health care systems and maternal and child health pro grammes
Collaboration between Department of Correctional Services (DCS) around implementation of TB services in correctional services facilities	• Memorandum of understanding dealing with responsibilities and accountabilities signed and between DCS and the Department around TB service delivery in correctional services facilities
New contraceptive implant gets poor reputation because of poor quality of care (e.g. failure to remove when side effects) and HPV vaccine immunisation is unsustainable because of poor integrated school health programme	• Improved training of all nurse working in primary care on contraception and specifically on the implant • ISHP bolstered by the use of retired nurses; Specific budget set aside for strengthening of ISHP
Prevention efforts fail to reduce number of new HIV infections and the numbers of patients on HIV medication grow so large that management of health facilities becomes difficult	• Greater focus on known prevention activities including HCT for HIV; condom distribution and usage and medical male circumcision • Innovative ways to deal with chronic patients and their medicines are implemented including courier services for drugs; mHealth messaging; use of private sector such as pharmacists and general practitioners

PROGRAMME 4: PRIMARY HEALTH CARE (PHC) SERVICES

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 recognising 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 focussing 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 Health 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 and 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 OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2018/19)
Improve district governance and strengthen, management and leadership of the district health system	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	Zero 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	2256 primary health care facilities with functional clinic committees/ district hospital boards	3760 primary health care facilities with functional clinic committees/ district hospital boards
		Number of districts with uniform management structures for primary health care facilities	Zero districts with uniform management structures for primary health care facilities	52 districts with uniform management structures for primary health care facilities
Improve the integration of relevant intersectoral services to address the social determinants of health	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	Zero	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	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	Zero 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	673 functional WBPHCOTs	3000 functional WBPHCOTs
Strengthen the provision of environmental health services	Ensure that the Port Health services are rendered in line with the International Health Regulations	Number of Ports of entry that are compliant with the International Health Regulations	Zero Ports of entry that are compliant with the International Health Regulations	36 Ports of entry that are compliant with the International Health Regulations
	Improve environmental health services in all 52 district and metropolitan municipalities in the country	Number of district and metropolitan municipalities meeting environmental health norms and standards in executing their environmental health functions	None	52 district and metropolitan municipalities meet environmental health norms and standards in executing their environmental health functions
Reduce risk factors, and improve management of for Non-Communicable Diseases (NCDs)	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	65% obese women 31% obese men	55% obese women 21% obese men
		Number of people counselled and screened for high blood pressure	Not available	5 million people screened for high blood pressure
		Number of people counselled and screened for raised blood glucose levels	Not available	5million people screened for raised blood glucose levels

4.2 STRATEGIC OBJECTIVES *(Cont)*

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2018/19)
Improve access to mental health services	Improve access to and quality of mental health services in South Africa	% people screened for mental disorders	25% of 16.5% (prevalence) people are screened and tested for mental disorders	35% prevalent population screened for mental disorders
		% of people treated for mental disorders	25% of 16.5% (prevalence) people treated for mental disorders	35% prevalent population treated for mental disorders
Improve access to disability and rehabilitation services	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	Draft framework and model for rehabilitation services	52 Districts implementing the framework and model for rehabilitation services.
		Cataract Surgery Rate	1 000 cataract surgeries per million uninsured population	1 700 cataract surgeries per million uninsured population
Malaria elimination by 2018	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	0.30 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	1 malaria endemic district reporting malaria cases within 24 hours of diagnosis	10 malaria endemic districts reporting malaria cases within 24 hours of diagnosis
Ensure the effective and efficient delivery of Emergency Medical Services	Ensure access to effective and efficient delivery of quality Emergency Medical Services	Number of provinces that are compliant with the EMS regulations	None	9 Provinces compliant to EMS regulations
Improve the efficiencies of the Forensic Chemistry Laboratories	Improve Forensic Chemistry Laboratory turnaround times for blood alcohol, toxicology and food samples	Median waiting time for blood alcohol results	Unknown	3 weeks
		Turn-around times of toxicology tests and reports	Unknown	8 months
		Turn-around times of food products tests and reports	Unknown	30 days for perishable food product and 60 days for non perishable products

4.3 RESOURCE CONSIDERATIONS

The spending focus over the medium term will be on health promotion and the prevention of non-communicable diseases such as hypertension and diabetes. As such, Non-Communicable Diseases will continue to be prioritised and is expected to be the largest spending programme over the MTEF period. In addition, combating malaria and vector borne diseases through Communicable Diseases remains a priority area in South Africa and the larger SADC region.
The largest spending item is compensation of employees, followed by consultants and travel and subsistence. The programme has a staff complement of 107 and this is expected to decrease slightly to 106 in 2014/15. Expenditure on compensation of employees is expected to increase at an average annual rate of 6.6 per cent over the medium term. There were 7 vacant positions at the end of November 2013.

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 during that year, which is also the reason for the large expenditure on consultants and professional services. The purpose of the audit was 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 was higher due to a roll-over of funds to purchase avian-flu influenza vaccines for distribution to provinces, because of the urgency and severity of the epidemic The increase in spending the Violence, Trauma and EMS subprogramme in 2013/14 was mainly due to a once-off increase for emergency services cover for the 2014 African Nations Championship.

4.4 RISK MANAGEMENT

The following table represents possible risks with concomitant mitigation strategies.

Risk	Mitigation Strategy
Availability and reliability of District Health Management and Governance Systems	• Extensive consultation internally and externally • Improve District Health Governance leadership System.
Lack of information to inform decision-making and allocation of funds	• Commission health systems research to complement internal monitoring
Availability of health waste management facilities	• Regulations for healthcare waste management in Health facilities.
Resistance to change at facility level due to perceived increased workload at facility level	• Develop change management communication strategy to ensure that frontline staff understands their contribution to the delivery of quality health care and improved population health outcomes
Under-resourced District Health System	• Ring fence the funding for district health management and service provision

PROGRAMME 5: HOSPITALS, TERTIARY SERVICES AND WORKFORCE MANAGEMENT

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 TERTIARY HEALTH SERVICES: This sub-programme is responsible for tertiary services planning, policies that guide 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

TRAUMA, VIOLENCE, EMS AND PATHOLOGY MEDICAL SERVICES: To improve the governance, management and functioning of Emergency Medical Services (EMS) in the whole country through strengthening the capacity and skills of EMS personnel, identification of needs and service gaps and provision of appropriate and efficient EMS through providing oversight of Provinces.

To provide a quality, effective system of emergency medical care, each EMS System must have in place comprehensive enabling legislation which governs the provision of EMS. The key components of this legislation include authority for national coordination, standardized treatment, transport, communication and evaluation, including licensure of ambulances and designation of emergency care centres.

The Cluster has developed National Regulations governing the provision of EMS and these are in the process of publication for public comment.

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 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: The 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 Cluster 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 OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target 2018/2019
Increase capacity of central hospitals to strengthen for local decision making accountability to facilitate semi-autonomy of central hospitals	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	None of the Central Hospitals function semi-autonomously.	All 10 Central Hospitals with reformed management and governance structures according to the prescripts
Ensure equitable access to tertiary health care	Ensure equitable access to tertiary service through implementation of the National Tertiary services plan	Number of gazetted hospitals providing the full package of Tertiary Services	None	17 gazetted tertiary hospitals providing the full package of Tertiary 1 services
Improve the quality of hospital services	Ensure quality health care by improving compliance with National Core Standards at all Central, Tertiary, Regional and Specialised Hospitals	% compliance with extreme and vital measures of the National Core Standards all Central, Tertiary, Regional and Specialised Hospitals	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 10 Central, 17 Tertiary 46 Regional and 63 Specialised Hospitals
Develop health workforce staffing norms and standards	Develop guidelines for HRH norms and standards using the WISN methodology	Develop and publish guidelines for HRH Staffing Norms and Standards	Draft guidelines for PHC- HR norms and standards available	Guidelines for HR Norms and standards published for all levels of care
Improve quality of Nursing training	Improve quality of Nursing training and practice by ensuring that all Nursing colleges are accredited to offer the new Nursing qualification	The number of public nursing colleges accredited to offer the new nursing qualification	None available	220 Public Nursing colleges accredited to offer the new nursing qualification
Improve quality of health infrastructure in South Africa	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	None	Health facility Norms & Standards developed and gazetted by 2015 100% of new facilities comply with gazetted health facility Norms & Standards

5.3 RESOURCE CONSIDERATIONS

This is the largest programme of the department due to the three large provincial and one national conditional grant it manages. The spending focus over the MTEF period will continue to be on health infrastructure planning, as well as strengthening tertiary services. As the bulk of this work is done at the provincial level, 91.8 percent of the programme's allocation over the MTEF period is transferred to provinces. The health facility revitalisation grant, managed by Health Facilities Infrastructure Management, has been allocated R16.3 billion over the MTEF period (R5.2 billion, R5.3 billion and R5.6 billion). The national in-kind conditional grant capital is the health facilities revitalisation component of the national health grant, which was established in 2013/14. This is an indirect grant of R3.1 billion over the MTEF period, which the department will use to deliver infrastructure on behalf of provinces. In its first year, the new grant focused on the construction of doctors' consulting rooms at national health insurance pilot sites, the upgrading of nursing college, the rehabilitation of clinics in pilot districts and the purchase of equipment. Due to slower than anticipated spending, Cabinet has approved reductions of R704.3 million over the medium term, on the national health grant.

Expenditure on the Tertiary Health Care and Planning sub-programme mainly consists of the national tertiary services grant, through which tertiary hospitals receive subsidies to provide specialised services. A new model is being developed for better costing of tertiary services and to provide a basis for interprovincial funding determination.

The slight decrease in spending in Hospital Management was partly due to shifting of violence and trauma components to Primary Health Care Services.

Spending on compensation of employees grew by 23.6 per cent from 2010/11 to 2013/14. The number of employees is projected to increase from 208 in 2013/14 to 291 in 2014/15 and is expected to remain stable in the following years as the department builds capacity in this programme. This 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.

Risk	Mitigation Strategy
Systems not in place to provide accountability for semi-autonomy of central hospital Capability and capacity of executive management within central hospitals	• Development policy guidelines and systems for to facilitate Semi Autonomous function of Central hospitals
Lack of Health Specialists and bottlenecks in Tertiary Health service delivery, prevent patients from accessing appropriate levels of care	• Gazette tertiary hospitals providing the full package of Tertiary 1 services • Innovative mechanisms to recruit and train Health specialists
Compliance with Extreme and Vital measures of the National Core Standards	• Enforcement of the National Core Standards as prescribed by the Office of the Standards Compliance
Capacity and competency of the health workforce	• Work closely with the professional bodies and training institu tions to ensure appropriate training
Compliance with nursing and midwifery services standards	• Continuous monitoring of the policy framework for nursing and midwifery training
Non-compliance with infrastructure Norms & Standards for some facilities constructed by private sector or donor organisations.	• Continuous awareness campaigns and proactive engage ment with identified stakeholders, on the infrastructure Norms and Standards

PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT

6.1 PROGRAMME PURPOSE

Food Control Pharmaceutical Trade & Product Regulation sub programme 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 sub programme 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 (SAHPRA). 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 sub programme 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.

The sub programme supports the Executive Authority'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.

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 legislation (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 it 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 adherence to corporate governance practices.

Office of Standards Compliance deals with quality assurance, development and inspections for compliance with national standards, patient complaints; and radiation

control. This entails logging and tracking complaints; developing and disseminating standards and audit tools; inspecting health establishments and radiation installations for compliance, and issuing importation licences for ionising radiation irradiating apparatus and for radioactive equipment and sources. In 2012/13, the National Health Amendment Health Act (2013) was signed into law. The board of the ***Office of Standards Compliance*** was inaugurated in January 2014 and on 1 April 2014 the office will start to function as an independent public entity. The subprogramme comprises compliance inspections, quality assurance and radiation control. The purpose of the quality assurance and improvement section is to ensure that the public health system implements the actions needed to improve the quality of care and patients' experience of care, including better responses to complaints

During the first year of this Strategic Plan, the current Office of Health Standards Compliance will become an independent public entity. In terms of the Public Entities Management Cluster's oversight function of public entities, a strategic objective to be pursued by this Cluster has been included. 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.

Compensation Commissioner for Occupational Diseases and Occupational Health sub programme is responsible for the payment of compensation to active and former workers in controlled mines and works who have been certified to be suffering from cardio-pulmonary-related diseases as a result of workplace exposure in the controlled mines or works. Over the medium term, the focus will be on reengineering business processes to ensure sustainability; reducing the turnaround period in settling claims, amending the Occupational Diseases in Mines and Works Act (1973); and improving governance, internal controls and relationships with key stakeholders. The subprogramme also oversees and manages the Compensation Commissioner for Occupational Diseases trading entity.

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE (2013/14)	TARGET (2018/19)
Expansion of the regulatory functions by including poorly regulated or unregulated pharmaceutical products	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.	Guidance documents for registration of CAMS	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 re-structuring	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	Draft legislation going through parliamentary processes	SAHPRA fully established & performing expanded functions
Strengthen food safety through expanding testing capabilities	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.	At least two MOUs with food testing institutions finalised and operationalised for testing adulterants in food products
Improve registration of response times for medicines used to treat high burden diseases	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	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 at all Public entities and Statuary councils	Improve oversight and Corporate Governance practices by reviewing the Governance Framework and Implementation Plan biennially	Develop and Impliment Governance Framework and Implementation Plan for Public Entities and Statutory Councils	New indicator	Governance Framework approved and Implementation Plan biennially reviewed
		Functional governance structures established	New indicator	Fully constituted Boards/ Councils
Implement and monitor annual plans to improve quality, safety and compliance in all public health establishments	Monitor the existence of and progress on annual and regular plans that addresses breaches of quality, safety and compliance in all public sector establishments	Percentage of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self- assessment (gap assessment) or OHSC inspection	40% of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self- assessment (gap assessment) or OHSC inspection	100% of Health Establishments that have developed an annual Quality Improvement Plan (QIP) based on a self- assessment (gap assessment) or OHSC inspection
Improve the acceptability, quality and safety of health services	Improve the acceptability, quality and safety of health services by increasing user and community feedback and involvement	Patient satisfaction surveys rate	65%	100%
		Patient satisfaction rate	New indicator	80%

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	INDICATOR	BASELINE (2013/14)	TARGET (2018/19)
Enhance governance and management of the CCOD/ MBOD	Enhance governance and management by establishing all committees at the CCOD/MBOD	Audit opinion from the Auditor-General for CCOD	Disclaimer Audit opinion from Auditor-General	Unqualified Audit Opinion from Auditor-General for CCOD
Develop Occupational Health Services for South Africa	Establish occupational health services within the public health system	Number of provinces with occupational health services within their facilities	No provinces with occupational health services within their health facilities for workers	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	Provide for coordinated disease and injury surveillance and research by establishing National Public Health Institute of South Africa (NAPHISA)	Establish National Public Health Institute of South Africa (NAPHISA)	Draft concept document for NAPHISA	Business Case and conceptual framework for NAPHISA developed by 2015 NAPHISA established by 2019

6.3 RESOURCE CONSIDERATIONS

The majority 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 through the establishment of the Office of Health Standards Compliance as a public entity.

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

Over the medium term, spending in the Public Entities Management sub-programme is projected to grow significantly to strengthen the capacity and outputs of the Medical Research Council. Expenditure in this sub-programme increased in 2013/14 partially due to the reallocation of the payment of the members of the Traditional Healers Council to this sub programme from the National Health Insurance, Health Planning and Systems Enablement programme.

The programme's overall staff complement will increase slightly from 357 in 2013/14 to 363 in 2014/15 and then remain stable over the medium term. The spending on

Risk	Mitigation Strategy
Compliance with Regulations and lack of resources to monitor Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Traditional Medicines in a phased approach	• Review poorly crafted regulations for unregulated pharmaceuti cal products (Complementary and Alternative Medicines (CAMS), Medical Devices, Invitro Diagnostics and African Tradi tional Medicines) • Develop regulations for unregulated pharmaceutical products (on Complementary and Alternative Medicines (CAMS), Medi cal Devices, Invitro Diagnostics and African Traditional Medi cines)
Implementation of SAHPRA	• Dedicated resources to establish SAHPRA • Detailed project plan for the successful establishment of SAH PRA
Compliance with prescribed legislation by the Public Entities and Statutory Councils.	• Provide an oversight role on all the Public Entities and Statu tory Councils based on the prescribed legislation. • Provide guidelines for an Open and transparent process for the appointment of Boards of Public Entities and Statutory Council members
Dependency on provinces to respond to health service users complaints impacts on turnaround time and patient satisfaction rates	• Service Level agreement with provinces to agree and the standards for responses

PART C

Links To Other Plans

1. CONDITIONAL GRANTS

Name of Grant	National Tertiary Services Grant
Purpose	To ensure provision of tertiary health services for all South African citizens and to compensate tertiary facilities for the costs associated with provision of these services including cross boundary patients.
Performance Indicator	Modernised and transformed tertiary services and Compliance with Division of Revenue Act
Continuation	Yes
Motivation for Continuation	Tertiary services are the key to Health care and the cost of maintaining them cannot be afforded by the equitable share.

Name of Grant	Health Professions Training and Development Grant
Purpose	To support provinces to fund service costs associated with training of health science trainees on the public service platform
Performance Indicator	Compliance with Division of Revenue Act
Continuation	Yes
Motivation for Continuation	Health training will continue as long there are health facilities.

Name of Grant	Comprehensive HIV/AIDS Grant
Purpose	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 implementation of the national operational plan for comprehensive HIV and AIDS treatment and care andto subsidise in-part funding for the antiretroviral treatment programme.
Performance Indicator	Reduction of new HIV infections and universal coverage of HIV treatment need
Continuation	Yes
Motivation for Continuation	HIV/AIDS is a National Priority and therefore treatment and prevention can only be effectively achieved through the conditional grant

Name of Grant	Health Facility Revitalisation Grant
Purpose	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including health technology, organisation systems and quality assurance, supplement expenditure on health infrastructure delivered through public-private partnerships and to enhance capacity to deliver infrastructure in health
Performance Indicator	Accelerate the revitalisation of facilities including the acquisition of health technology equipment.
Continuation	Yes
Motivation for Continuation	Funding infrastructure through conditional grant enables National Department of Health to ensure the delivery and maintenance of health infrastructure in a coordinated and efficient manner and ensure it is consistent with national norms, standards and guidelines of health facilities.

Name of Grant	National Health Insurance Grant
Purpose	To test innovations in health services provision for implementing National Health Insurance, allowing for each district to interpret and design innovations relevant to its specific context to undertake health system strengthening initiatives; to assess the feasibility, acceptability, effectiveness and affordability of innovative ways of engaging private sector resources for public purpose
Performance Indicator	NHI piloting rolled out to all 52 health districts
Continuation	Yes

Motivation for Continuation	National Health Insurance is a high national priority .it allows both national and provincial departments to test innovations on service delivery and to undertake other health system strengthening initiatives in readiness for roll out of NHI.

Name of Grant	**National Health Grant**
Purpose	To address capacity constraints in the provinces and to create an alternate track to speed up infrastructure delivery; To improve spending, performance, monitoring and evaluation on National Health Insurance pilots and infrastructure projects
Performance Indicator	Acceleration of infrastructure on the NHI pilot districts DRG tool developed and implemented in all 10 central hospitals General Practitioners and other health professionals contracted to render services in identified facilities
Continuation	Yes
Motivation for Continuation	As the rollout is continuing to other districts, there will be a need for the revitalisation of infrastructure to continue. Strengthening aspects of public health care system. It lays the foundation for developing contracting mechanisms for various health professions and other private providers e.g. private hospitals. It helps in developing alternative funding mechanisms for hospitals

Name of Grant	**Human Papilloma Virus (HPV) vaccine Grant**
Purpose	To enable the health sector to develop an effective response to preventing cervical cancer by making available HPV vaccination for grade 4 school girls; To fund the introduction of HPV vaccination programme in schools
Performance Indicator	100% grade 4 school girls received HPV vaccination
Continuation	Yes
Motivation for Continuation	Cervical cancer is a high national priority and to have the desired impact of reducing cervical cancer significantly, the minimum coverage should be 80%.

2. PUBLIC ENTITIES

Name of Public Entity	Mandate	Outputs	Current Annual Budget (R thousand)	Date of next evaluation
Council for Medical Schemes	The Medical Schemes Act (1998) established the Council for Medical Schemes as the regulatory authority responsible for overseeing the medical schemes industry in South Africa.	• ensure that access to good quality medical scheme cover is maximised • ensure that medical schemes are properly governed and beneficiaries are informed and protected • enhance the effectiveness and efficiency of the organisation • provide strategic advice and support for the development and implementation of national health policies, • including the development of national health insurance.	2014/15 R123 075	2015/16
National Health Laboratory Service	The National Health Laboratory Service was established in 2001 in terms of the National Health Laboratory Service Act (2000). In terms of the act, the 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.	• develop a new service delivery model that is more affordable for the public sector • deliver high quality, customer focused service • become the laboratory services employer of choice • prioritise innovation and research so that it is relevant, appropriate and leading edge • become a leading resource for information on health • drive stakeholder collaboration • protect the community and environment.	2014/15 R5 057 290	2017/18
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, 58 of 1991 . The Intellectual Property, Rights from Publicly Financed Research and Development Act (2008) also informs the council's mandate. The council's strategic focus is determined in the context of the priorities of the Department o Health and government. The council's research therefore plays a key role in responding to government's key outcome 2 (a long and healthy life for all South Africans).	• administer health research effectively and efficiently in South Africa • lead the generation of new knowledge and facilitate its translation into policies and practices to improve health • support innovation and technology development to improve health • build capacity for the long term sustainability of the country's health research.	2014/15 R808 694	2016/17

Name of Public Entity	Mandate	Outputs	Current Annual Budget (R thousand)	Date of next evaluation
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, 78 of 1973. In terms of the act, the commissioner is mandated to compensate workers and ex-workers in controlled mines and works for occupational diseases of the cardiorespiratory organs and reimbursement for loss of earnings incurred during tuberculosis treatment. In the case where the ex-worker is deceased, it compensates the beneficiaries of deceased worker.	• consolidate the overlapping administrative activities of the Medical Bureau for Occupational Diseases and the Mines and Works Compensation Fund • improve the overall management and sustainability of the compensation fund • provide decentralised services for ex-workers from controlled mines and works • collect and verify the levies from controlled mines and works.	2014/15 R255 116	2018/19

3. PUBLIC PRIVATE PARTNERSHIPS (PPP)

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.

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