Annual Performance Plan

2018/19 – 2020/21

National Department of Health

Annual Performance Plans

2018/19 – 2020/21

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FOREWORD BY THE MINISTER OF HEALTH

If nobility is defined as having qualities or showing acts such as social justice, social solidarity, caring, honesty, generosity and courage to strive for what is good, then National Health Insurance (NHI) is not only a noble concept but a wise public investment for public good. In this year's State of the National Address, the President informed the nation and the world that with effect from 1 April 2018, the country will initiate the implementation of NHI, focussing on the vulnerable groups of our population. Implemented correctly and in an equitable manner, NHI will have far more returns to our national prosperity than it will cost the national fiscus.

As the world grows interdependent, universal health coverage is the only financial mechanism that ensures not only better-educated but healthier citizens. It is thus a key means to reduce inequalities within societies as it stimulates economic growth, facilitates educational gains and reduces poverty associated with health costs.

This Annual Performance Plan outlines, amongst others, the implementation of priority public health interventions as envisaged in the NHI White Paper and NHI Bill that is expected to be passed into law by parliament this year. With effect from 1 April 2018, the following vulnerable groups will be prioritised:

Learners will receive health services to improve their oral health, sight, hearing and speech problems; maternal and woman's health care (antenatal care, contraceptives and family planning, as well as screening and treatment for breast and cervical cancer). Interventions in this area will assist us in reducing maternal and infant mortality. The health of our senior citizens will also be prioritised. We will improve coverage of cataract surgery by contracting private providers to offer the service.

Life Esidimeni has made it imperative to review the mental health services. This Annual Performance Plan intends to scale up mental health services for the benefit of the whole population. Research evidence shows that there is a high prevalence of mental disorders linked to social determinants such as poverty, unemployment, violence, substance abuse and other adversities that increase vulnerability of South Africans to mental disorders; high co-morbidity between mental and other diseases; and that there is a substantial gap between demand and supply of mental health services. We will therefore focus on mental health (screening, referral and care) to ensure that tragic events such as Life Esidimeni never again visits our shores.

These initial steps in the implementation of NHI will enable us to address the historical injustices and transform our health system to benefit all South Africans. Progressively, we will ensure that illness and the need for health care should not be leading

causes of personal bankruptcy and poverty. NHI stands out as an extraordinary opportunity to do that which is good and just for our country, and build the social solidarity that will have widespread benefits for the South African population.

We will also heighten our public communication and health promotion to make our people understand that sickness and unhealthy lifestyles are costly, shrinks the workforce and reduces productivity. Good health expands the workforce and makes it more productive. While progress has been made, managing the dual burden of infectious diseases and Non-Communicable Disease, more needs to be done. The largest gap is in prevention of Non-Communicable Diseases. Tackling the obesity epidemic and wrestling with the issues around curbing smoking and alcohol abuse are rightly high on the Non-Communicable Diseases prevention agenda to ensure the sustainability of NHI.

There are a few noble professions in this world. Practicing medicine is one of them, and nursing is perhaps the noblest of health professions. These are citizens who have chosen to be on the front-lines to ensure that progress towards the overall health goal is achieved. These are citizens who have chosen to be at the bedside, evaluating the patient for severity, placing them on monitors, drawing blood, placing Foley catheters and administering medications when we are ill or injured. Nurses are also the ones who bear the brunt of the patient's anger, or clean them up when they can't help themselves. They act as a surrogate family to patients and often get to know details of a patient's life simply because they are the ones spending most amount of time at the patient's bedside. However, we will have to address the current negative sentiments regarding nurses and address the issue confronting the profession for NHI to succeed.

For NHI to be seen and be felt, we need to bring back to our health system a strong culture of caring. Without that culture of caring and the marked improvement of public health infrastructure, NHI will be but a pipedream.

DR PA MOTSOALEDI
MINISTER OF HEALTH

STATEMENT BY THE DIRECTOR-GENERAL

South Africa is in the midst of an epidemiological health transition that is characterised by the twin epidemics communicable diseases and non-communicable diseases, in a population facing a heavy burden of perinatal and maternal disorders, injury, and violence. The major NCDs (cardiovascular disease, cancer, diabetes and chronic respiratory disease) share common behavioural risk factors (tobacco, unhealthy diet, physical inactivity and the harmful use of alcohol) and provide common pathways for prevention.

As directed by the President in this year's State of the Nation Address: "In the next three months we will launch a huge cancer campaign similar to the HIV counselling and testing campaign. This will also involve the private sector as we need to mobilise all resources to fight this disease". The National Cancer Strategic Framework 2017-2022, the Cervical Cancer Prevention and Control Policy, and the Breast Cancer Control Policy, will strengthen the cancer service delivery platform with more equitable access to effective care for our population.

The implementation of the framework and policies will ensure that services are better organized, and strengthen the referral pathways between levels of services to offer appropriate packages of care for patients and families affected by cancer.

The National Mental Health Policy Framework and Strategic Plan 2013-2020 sets out key objectives and milestones that must be realised to transform mental health services in this country. The priorities are (i) improving detection rates and management of mental disorders especially in primary health care settings; (ii) improving mental health infrastructure capacity especially at community level; and (iii) improving the supply of and access to mental health professionals. The coming year will focus on implementation of these priorities across all Provincial DoH, and monitoring thereof. The mental health NGO and CBO sectors will also be subjected to rigorous quality assurance.

South Africa continues to be home to the world's largest number of people living with HIV. The total number of persons living with HIV in South Africa increased from an estimated 4,72 million in 2002 to 7.03 million in 2016. However, there has been a decline in the number of AIDS-related deaths consistently since 2006 due to access to antiretroviral treatment. This year, we intend scaling up our testing and treating campaign to initiate an additional two million people on antiretroviral treatment by December 2020.

South Africa has entered phase two of the NHI implementation having drawn lessons from pilots and engagements with stakeholders. NHI is designed to improve access to service and quality of care to all South Africans. The establishment of the NHI Fund is a key pillar of the NHI Policy. The fund will require supporting legislation, systems and processes. For the interim, several structures will be established during the preparation period. These include, ministerial advisory committee on health care benefits for national health insurance; national health service pricing advisory committee; national advisory committee on consolidation of financing arrangements and; ministerial advisory committee on health technology assessment for national health insurance.

Priority will also be given to educating the public on the rationale of the NHI and its benefits. The cornerstone of, and sustainability of NHI rest on the prevention of illness and promotion of health.

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH

OFFICIAL SIGN OFF

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

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

Accurately reflects the performance targets which the National Department of Health will endeavour to achieve given the resources made available in the budget for 2018/19 financial year.

MR I VAN DER MERWE
CHIEF FINANCIAL OFFICER
DATE: 2018/2/26

DR G V ANDREWS
CHIEF OPERATIONS OFFICER
DATE: 26/02/18

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH

DR PA MOTSOALEDI
MINISTER OF HEALTH

ACRONYMS

AGSA	Auditor-General of South Africa
AIDS	Acquired Immune Deficiency Syndrome
AMC	Academic Medical Centre
ANC	Ante-natal Care
ANSUR	Ante-natal HIV Surveillance
APP	Annual Performance Plan
ART	Antiretroviral Treatment
BCP	Business Continuity Plan
BoD	Burden of Disease
CARMMA	Campaign on Reduction of Maternal Mortality in Africa
CCOD	Compensation Commission for Occupational Diseases
CDC	Communicable Diseases
CEMDC	Confidential Enquiry of institutional Maternal Deaths Committee
CHC	Community Health Centre
CHW	Community Health Worker
CMR	Child Mortality Rate
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
DCST	District Clinical Specialist Teams
DHIS	District Health Information System
DORA	Division of Revenue Act
DR-TB	Drug Resistant Tuberculosis
DS-TB	Drug Sensitive Tuberculosis
EDMS	Electronic Document Management System
EDR	Electronic Drug Resistant register (EDR.Web)
EML	Essential Medicines List
EMS	Emergency Medical Services
EDP	Emerging Dangerous Pathogens
EPI	Expanded Programme for Immunization
ESMOE	Essential Steps in Managing Obstetric Emergencies
EMTCT	Elimination of Mother -o-Child Transmission
ETR	Electronic TB Register (ETR.Net)
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
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICT	Information Communication Technology
ICSM	Integrated Clinical Services Management
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
LBW	Low Birth Weight
LE	Life Expectancy
MBOD	Medical Bureau for Occupational Diseases
MDG	Millennium Development Goal
MDR	Multi Drug Resistance Tuberculosis
MISP	Master Information Systems Plan
iMMR	Institutional Maternal Mortality Ratio
MRC	Medical Research Council
MTCT	Mother-to-child Transmission
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NAPHISA	National Public Health Institutes of South Africa
NCD	Non-Communicable Diseases
NDP	National Development Plan
NMR	Neo-Natal Mortality rate

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
NTP	National TB Programme
OHSC	Office of Health Standards Compliance
OPV	Oral Polio Vaccine
OSD	Occupation Specific Dispensation
PHC	Primary Health Care
PMR	Peri-natal Mortality Rate
PMTCT	Prevention of Mother to Child Transmission
PPIP	Peri-natal Problem Identification Programme
PPP	Public Private Partnership
QIP	Quality Improvement Plan
RDP	Reconstruction and Development Programme
SAFELTP	South African Field Epidemiology Programme
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
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
StatsSA	Statistics South Africa
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
TB	Tuberculosis
THP	Traditional Health Practitioners
U5MR	Under Five Mortality Rate
UN	United Nations
UNAIDS	United Nations Joint Programmes for AIDs
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WBOT	Ward Based Outreach Teams
WHA	World Health Assembly
WHO	World Health Organisation
YFS	Youth Friendly Services

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 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:

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

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

National Health Act, 2003 (Act No. 61 of 2003)

Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The 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 foundation of the health care system, and understood alongside other laws and policies which relate to health in South Africa.

Medicines and Related Substances Act, 1965 (Act No. 101 of 1965)

Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

Hazardous Substances Act, 1973 (Act No. 15 of 1973)

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

Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973)

Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

Pharmacy Act, 1974 (Act No. 53 of 1974)

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

Health Professions Act, 1974 (Act No. 56 of 1974)

Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

Dental Technicians Act, 1979 (Act No.19 of 1979)

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

Allied Health Professions Act, 1982 (Act No. 63 of 1982)

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

SA Medical Research Council Act, 1991 (Act No. 58 of 1991)

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

Academic Health Centres Act, 86 of 1993

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

Choice on Termination of Pregnancy Act, 196 (Act No. 92 of 1996)

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

Sterilisation Act, 1998 (Act No. 44 of 1998)

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

Medical Schemes Act, 1998 (Act No.131 of 1998)

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

Council for Medical Schemes Levy Act, 2000 (Act 58 of 2000)

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

Tobacco Products Control Amendment Act, 1999 (Act No 12 of 1999)

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

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.

National Health Laboratory Service Act, 2000 (Act No. 37 of 2000)

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

Nursing Act, 2005 (Act No. 33 of 2005)

Provides for the regulation of the nursing profession.

Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007)

Provides for the establishment of the Interim Traditional Health Practitioners Council, and registration, training and practices of traditional health practitioners in the Republic.

Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972)

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

3.4. Other legislation applicable to the Department

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 212 4(a) and 212 8(a).

Provides for establishing the cause of non-natural deaths.

Children's Act, 2005 (Act No. 38 of 2005)

The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court.

Occupational Health and Safety Act, 1993 (Act No.85 of 1993)

Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993)

Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

National Roads Traffic Act, 1996 (Act No.93 of 1996)

Provides for the testing and analysis of drunk drivers.

Employment Equity Act, 1998 (Act No.55 of 1998)

Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

State Information Technology Act, 1998 (Act No.88 of 1998)

Provides for the creation and administration of an institution responsible for the state's information technology system.

Skills Development Act, 1998 (Act No 97of 1998)

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

Public Finance Management Act, 1999 (Act No. 1 of 1999)

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

Promotion of Access to Information Act, 2000 (Act No.2 of 2000)

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

Promotion of Administrative Justice Act, 2000 (Act No.3 of 2000)

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

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000)

Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

Division of Revenue Act

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

Broad-based Black Economic Empowerment Act, 2003 (Act No.53 of 2003)

Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

Labour Relations Act, 1995 (Act No. 66 of 1995)

Establishes a framework to regulate key aspects of relationship between employer and employee at individual and collective level.

Basic Conditions of Employment Act, 1997 (Act No.75 of 1997)

Prescribes the basic or minimum conditions of employment that an employer must provide for employees covered by the Act.

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 realise universal health coverage. The phased implementation of NHI is intended to ensure integrated health 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, 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, universal health coverage has been shown to contribute to improvements in key indicators such as 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 any country's progress towards universal health coverage.

Phase 1: 2012-2017

As part of the initial 5-year preparatory work to improve health systems performance, interventions to improve service delivery and provision have been 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) implementing improved and integrated health information systems and technology; (v) rationalising of laboratory services; (vi) effective and integrated procurement of Health Commodities; (vii) the implementation of and compliance with National Quality Standards for Health; (viii) Re-engineering of Primary Health Care; (ix) the contracting of health practitioners to strategically enhance the quality of Primary Health Care; (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.

The Minister of Health published the White Paper on National Health Insurance on 10 December 2015 for public comments. The Department received more than 160 written comments from various stakeholders. In addition, the National Department of Health had setup 6 NHI work streams. These were:

1. Establishment of the NHI Fund
2. Design and Implementation of NHI health service benefits package
3. Preparation for the purchaser-provider split and accreditation of providers
4. Role of medical schemes in an NHI environment
5. Completion of the NHI Policy for publication
6. Strengthening of the District Health System

The public comments and recommendations from the NHI workstreams contributed to the development of the NHI policy. During June 2017, the National Health Insurance Policy of South Africa was gazetted as the official Policy on NHI.

An evaluation of the first phase of National Health Insurance is currently underway, and the report will be finalised in 2018/19 financial year.

Phase 2: 2017-2022

The second phase will entail development of systems and processes to ensure effective functioning and administration of the NHI Fund. These reforms are categorised into four items: (a) Financing, (b) Health service provision, (c) Governance, and (d) Regulatory, as described below:

Financing	Provision
Public Sector - Restructuring Equitable share - Hospitals (i) Establish cost-based budget for hospitals, (ii) Introduce case-mix based budget - PHC (i) Establish Clinic Budget, (ii) Introduce capitation contracting **Private Sector** - High price for health services - Price regulation for the all services included in the NHI comprehensive benefit framework - Removal of Differential pricing of services based on diagnosis - Co-Payments and Balanced billing	**Public Sector** - School Health, Maternal and woman's health - Mental Illness, Elderly, Disability and Rehabilitation - Expansion of Service Benefits, and Implementation PHC services through 1st 1000 clinics **Private Sector** - Introduction of Single Service Benefits Framework - Reduce the number of options per scheme - Reform of PMBs and alignment to NHI services benefits, including common protocols/care pathways
Governance	**Regulatory**
Public Sector - Established Central Hospital as Semi-autonomous structure - Strengthen Governance and delegations of Hospitals - Strengthen Governance and delegations of Districts **Private Sector** - Governance and non-health care - Reserves and solvency **Interim Institutional Structures** - Establishment of NHI Transitional Structures - Establishment of Health System Reform Structures - Interim NHI Fund	**Public Sector** - Legislation to create NHI Fund - the NHI Bill introduced - Legislation Amendments: (i) National Health Act; (ii) The Health Professions Act and (iii) General Health Legislation Amendment **Private Sector** - Medical Schemes Act and regulations Reform - Consolidation: (i) Consolidate GEMS and other state medical schemes into single structure; (ii) Reduce the number of Medical Schemes and (iii) Reduce the number of options in Medical Schemes - Licensing of health establishments

The NHI implementation will require governance structures and interim committees[1]. These are:

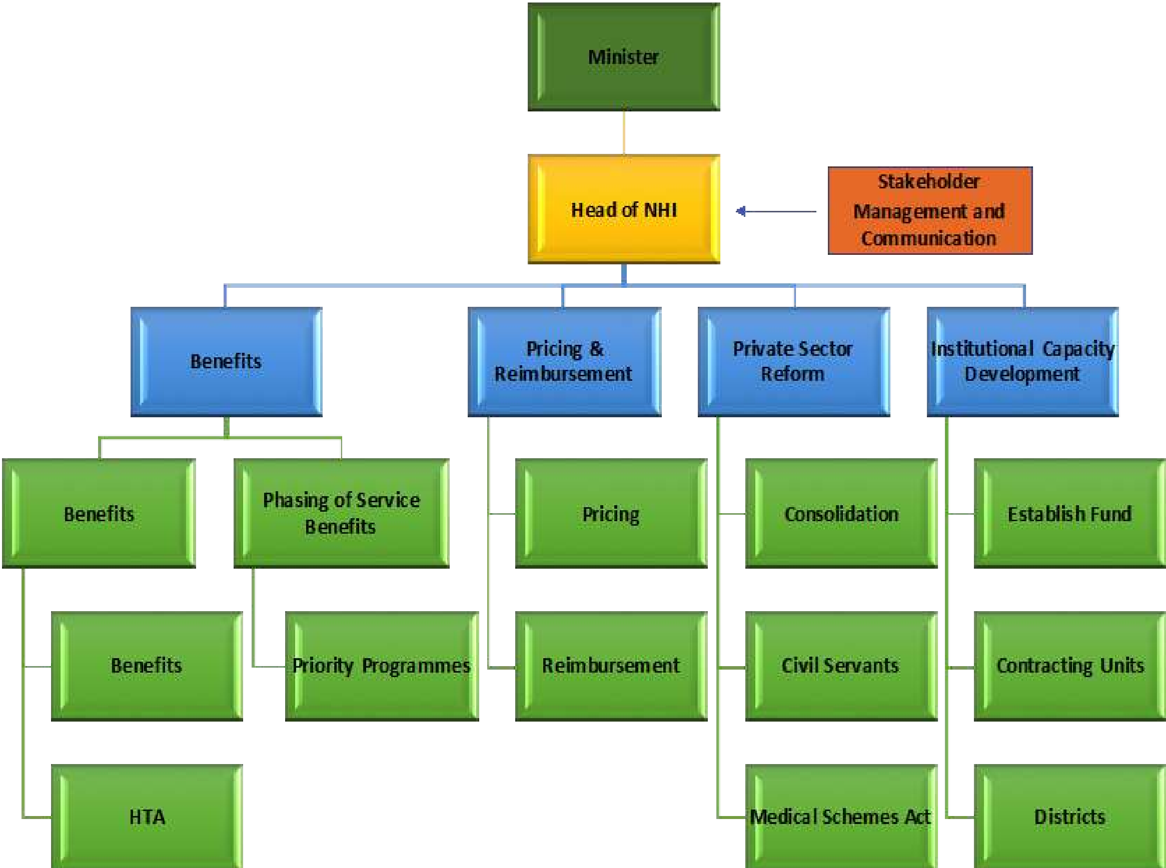
1. Establishment of National Tertiary Health Services Committee – It will be responsible for developing the framework governing the Tertiary services platform including overseeing the establishment of Central Hospitals as semi-autonomous entities
2. Establishment of National Governing Body on Training and Development - be responsible for advising on the vision for health workforce matters and for recommending policy related to health sciences student education and training to the Minister of Health, including human resources for health development plan. It will coordinate and align strategy, policy and financing of health sciences education.
3. Establishment of Contracting Unit for Primary Healthcare Services - The Contracting Unit for PHC (CUP) will be established at the District level, and structured in a cooperative management arrangement with the district hospital linked to a number of PHC facilities
4. Establishment of the NHI Fund -It will be established through legislation and will require the development of systems and processes to ensure its effective functioning and administration.

During the MTEF commencing 2018/19 financial year, efforts will focus on establishing an NHI Fund. The NHI fund will pool revenue and purchase health services, through contracting health services providers accredited by the Office of Health Standards Compliance. The establishment of the National Health Insurance Fund is a key pillar of the NHI Policy. However, the NHI fund will require supporting legislation, systems and processes. Therefore, for the interim, several structures will be established during the preparation period. These include:

a. Ministerial Advisory Committee on Health Care Benefits for National Health Insurance
b. National Health Service Pricing Advisory Committee
c. National Advisory Committee on Consolidation of Financing Arrangements
d. Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance

In addition, an "NHI implementation team will be established as a government component reporting to the Minister of Health. The team will act as transitional structure responsible for implementation of the service benefits, pricing and reimbursement framework, purchasing of healthcare services for vulnerable groups in the population"[2]. The proposed NHI implementation team is provided below.

1 National Health Insurance Policy (chapter 9), 2017
2 National Health Insurance Policy, 2017



3.5.2. South Africa Health Products Regulatory Authority (SAHPRA)

The South African Health Products Regulatory Authority (SAHPRA) is established as a schedule 3A public entity from 2017/18 financial year. It is responsible for the regulation of medicines, medical devices and radiation control. These functions were performed by the Medicines Control Council (MCC), which is managed by a unit within the department. The Medicines Regulatory Authority (MRA) is being transitioned to SAHPRA. The transition will allow the authority to operate more independently and retain the revenue collected from the pharmaceutical industry. The key focus areas of SAHPRA over the medium term will be to evaluate and register pharmaceuticals and medical devices, manage and coordinate the registration process, ensuring access to safe medicines and continue to enforce regulatory compliance. The sole mandate of the MCC was to regulate medicine. However, the mandate of SAHPRA is to expand the core mandate of the MCC to include the regulation of medical devices.

3.5.3. Operation Phakisa and Ideal Clinic Initiative

The Ideal Clinic Realisation and Maintenance process started in 2013 An Ideal Clinic is a Primary Health Care (PHC) facility with good infrastructure adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community. An Ideal Clinic co-operates with other government departments as well as with the private sector practitioners and non-governmental organisations to address the social determinants of health. PHC facilities must be maintained to function optimally and remain in a condition that can be described as the “Ideal Clinic”. Integrated clinical services management (ICSM) is a key focus within an Ideal Clinic. ICSM is a health system strengthening model that builds on the strengths of the HIV programme to deliver integrated care to patients with chronic and/or acute diseases or who came for preventative services by taking a patient-centric view that encompasses the full value chain of continuum of care and support.

4. SITUATIONAL ANALYSIS

4.1. Strategic Challenges Facing the Department

The Health Sector's Negotiated Service Delivery Agreement (NSDA) for 2010-2014 served as the strategic framework for addressing the Burden of Diseases (BoD) during previous 5 years. The NSDA is a charter outlining consensus between different stakeholders on key interventions to ensure achievement of the set goals, as well as their respective roles in this process. In 2010 the NSDA presented four key outputs that the health sector must endeavour to achieve namely:

- Increasing Life Expectancy;
- Decreasing Maternal and Child Mortality;
- Combating HIV and AIDS and Tuberculosis; and
- Strengthening Health Systems Effectiveness.

These outputs were consistent with government's outcome-based approach to improving service delivery; enhancing accountability to the public and enhancing performance management. An increased life expectancy for all South Africans is the highest impact that the country seeks to attain. It lies at the summit of the 4 outputs that the health sector seeks to deliver on.

Strengthening the effectiveness of the health system is the foundation on which successful interventions to improve health outcomes must be built. International experience points to the fact that only a strengthened health system, further fortified by effective inter-sectoral collaboration to address social determinants of health, can improve South African citizens' health outcomes.

4.2. Demographic Profile of South Africa

For 2016, Statistics South Africa (StatsSA) estimates the mid-year population as 55.9 million. [3]Table 1 displays the percentage distribution of the projected provincial share of the total population according to the 2016 midyear estimates. Gauteng continues to comprise the largest share of the South African population with approximately a quarter of South Africa's population (13.5 million people). KwaZulu-Natal has the second largest population, with 10.9 million people (19.9%) living in this province. Northern Cape remains the province with the smallest share of the South African population with approximately 1.2 million people (2.2% of the total South African population).

The 2016 mid-year population estimates reflect that 30.1% of the population in South Africa is aged younger than 15 years, and 8% is 60 years and older. The proportion of those aged 60 and older is increasing over time. The largest share (23%) of the younger population (<15 years) reside in KwaZulu-Natal, followed by 20.4% in Gauteng.

Migration patterns between the provinces has largely remained consistent over the past few years with Gauteng and Western Cape received highest number of migrants. The largest outflows were from Eastern Cape, Free State, and Limpopo, while Mpumalanga and North-west saw a positive net migration.

Table 1 - Percentage of the total population per province, South Africa's Mid-year Population Estimates for 2016

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Eastern Cape	13.3	13.3	13.3	13.2	13.2	13.1	13.0	13.0	12.9	12.9	12.8	12.8	12.7	12.7
Free State	5.9	5.8	5.8	5.7	5.7	5.6	5.5	5.5	5.4	5.4	5.3	5.3	5.2	5.2
Gauteng	22.6	22.4	22.5	22.6	22.8	22.9	23.1	23.2	23.3	23.4	23.6	23.7	23.8	23.9
KwaZulu-Natal	20.0	20.0	20.0	19.9	19.9	19.9	19.9	19.9	19.9	19.9	19.9	19.8	19.8	19.8
Limpopo	10.7	10.7	10.6	10.6	10.6	10.5	10.5	10.5	10.5	10.5	10.4	10.4	10.4	10.4
Mpumalanga	7.7	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8	7.8
Northern Cape	2.3	2.3	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	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.8	6.8	6.8	6.8
Western Cape	10.9	11.1	11.1	11.1	11.1	11.1	11.1	11.2	11.2	11.2	11.2	11.2	11.2	11.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

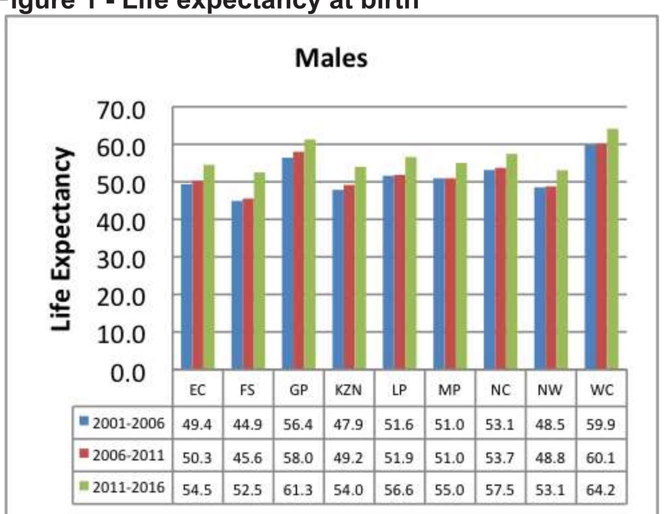
Source: Mid-year population estimates 2016, StatsSA, August 2016[3]

4.3. Life Expectancy

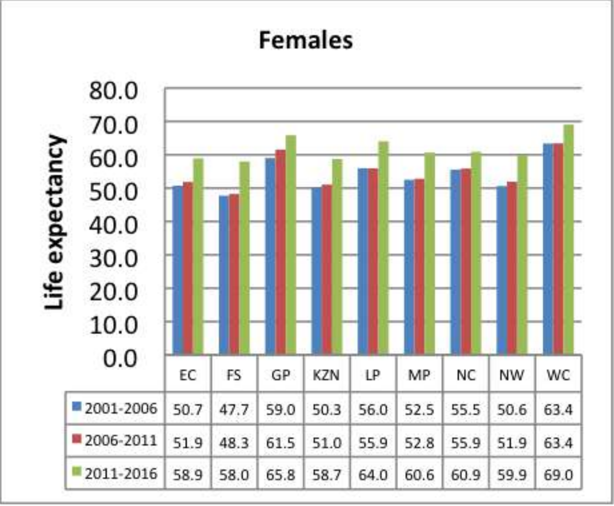
A five-year periodic comparison of life expectancy between 2011 – 2016 show that the average life expectancy for socio-economically males is highest in the Western cape at 64 years in 2016 than in 2000 where the average life expectancy was 60 years

3 The National DoH and Provincial DoH review their population estimates in two year cycles for their denominators. The Department will be using 2016 projections for its plans and reports of 2018/19 financial year.

Figure 1 - Life expectancy at birth



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	49.4	44.9	56.4	47.9	51.6	51.0	53.1	48.5	59.9
2006-2011	50.3	45.6	58.0	49.2	51.9	51.0	53.7	48.8	60.1
2011-2016	54.5	52.5	61.3	54.0	56.6	55.0	57.5	53.1	64.2



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	50.7	47.7	59.0	50.3	56.0	52.5	55.5	50.6	63.4
2006-2011	51.9	48.3	61.5	51.0	55.9	52.8	55.9	51.9	63.4
2011-2016	58.9	58.0	65.8	58.7	64.0	60.6	60.9	59.9	69.0

Source: Mid-year Population estimates 2016, StatsSA

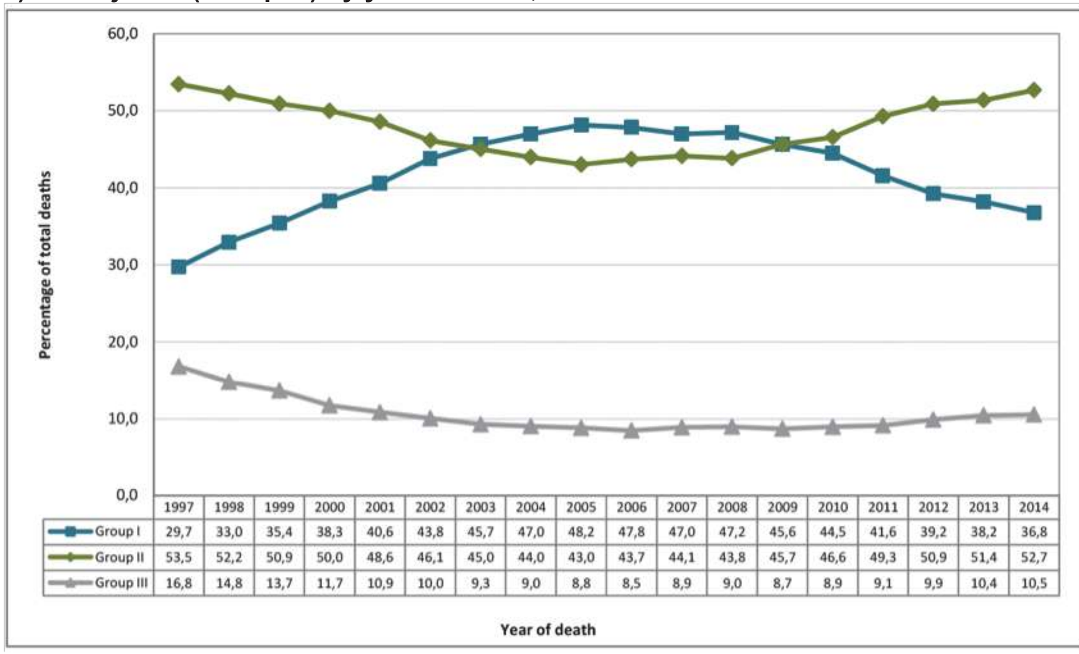
These trends are consistent with the empirical evidence generated by the Medical Research Council. It shows that life expectancy had improved to 62.9 years (in 2014), an increase of nearly 9 years since 2005, with females expected to live to an average of 65.8 as opposed to males at 60.0 years.[4]

4.4. Mortality

The ten leading causes of death according to Stats SA Mortality and causes of death report for the period 2012–2014 is shown in Figure 10. Over the three-year period, tuberculosis remained the leading cause of death, although the proportions declined over time. Apart from deaths due to Tuberculoses being ranked 1 in both genders, Influenza - pneumonia and HIV, are the main causes of death in males; while Diabetes mellitus and Cerebrovascular diseases are the amongst the top three main causes of death in females.

StatsSA has reported that deaths due to non-communicable diseases peaked at age groups 35-33 years while for females peaked at 25 – 34 years. The report further suggests that since 2010 the number of deaths due to non - communicable diseases is higher than deaths due to communicable diseases, and that deaths caused by Non-communicable diseases are increasing, (Figure 6). For males, deaths due to non-communicable diseases were the highest at age groups 35-44 years, while for females, deaths attributed to non-communicable diseases peaked at groups 25-34 years.

Figure 2 - Percentage of deaths due to communicable diseases (Group I), non-communicable diseases(Group II) and injuries (Group III) by year of death, 1997–2014*



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Group I	29,7	33,0	35,4	38,3	40,6	43,8	45,7	47,0	48,2	47,8	47,0	47,2	45,6	44,5	41,6	39,2	38,2	36,8
Group II	53,5	52,2	50,9	50,0	48,6	46,1	45,0	44,0	43,0	43,7	44,1	43,8	45,7	46,6	49,3	50,9	51,4	52,7
Group III	16,8	14,8	13,7	11,7	10,9	10,0	9,3	9,0	8,8	8,5	8,9	9,0	8,7	8,9	9,1	9,9	10,4	10,5

Source: StatsSA Mortality and causes of death in South Africa, 2014 (2015)

Group I: Communicable diseases (e.g. Tuberculosis, pneumonia, diarrhoea, malaria, measles); Maternal and perinatal causes (e.g. maternal hemorrhage, birth trauma); and Nutritional conditions (e.g. protein-energy malnutrition)
Group II: Non-communicable diseases (e.g. cancer, diabetes, heart disease and asthma)
Group III: External causes of mortality (e.g. accidents, homicide and suicide).

4 MRC Rapid Mortality Surveillance Report 2014 (2015)

Figure 3 - Trends of leading causes of death for males and females 2011–2014

Ten Causes of Death in South Africa 2011 to 2014

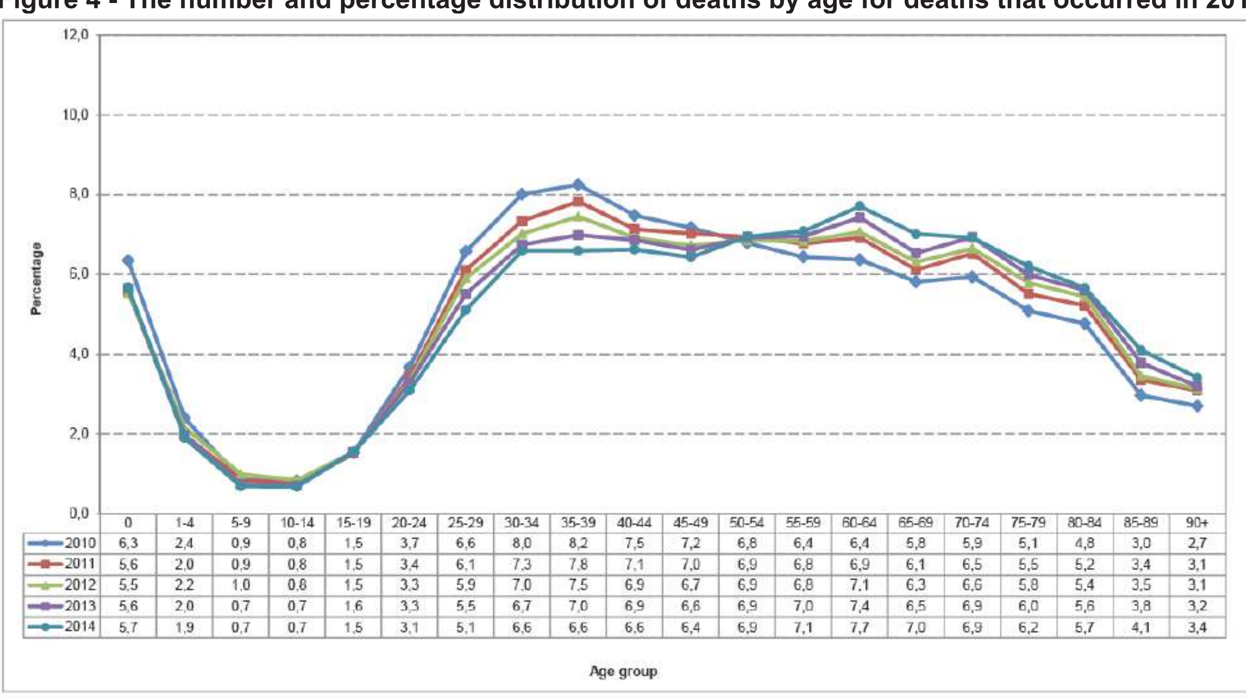
Number of Crude Deaths ('000)

	Tuberculosis	Influenza and Pneumonia	Cerebrovascular diseases	Cardiovascular Diseases	Diabetes	Intestinal infectious diseases	HIV	Hypertensive diseases	Other viral diseases	Chronic lower respiratory diseases
2011	55,101	33,842	26,104	23,916	21,147	19,647	17,338	15,784	14,805	13,277
2012	48,506	26,940	24,498	22,383	21,840	15,260	19,173	16,522	15,343	12,792
2013	41,751	24,250	23,089	22,125	23,070	16,114	23,753	17,071	14,020	12,343
2014	37,878	22,036	23,088	21,339	22,747	14,471	21,938	17,770	13,996	12,096

Source: Adapted from Mortality and Causes of Deaths, StatsSA 2014

The Death notification report results show that the age group with the highest proportion of deaths was age group 55–64 years (7,7%), closely followed by age group 35–39 years, which accounted for 7,0% of all deaths. The lowest percentages were amongst those aged 5–9 years and 10–14 years (each comprising 0,7% of all deaths). About 5,7% of all registered deaths in 2014 occurred amongst infants (aged below 1 year).

Figure 4 - The number and percentage distribution of deaths by age for deaths that occurred in 2010-2014



	0	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
2010	6,3	2,4	0,9	0,8	1,5	3,7	6,6	8,0	8,2	7,5	7,2	6,8	6,4	6,4	5,8	5,9	5,1	4,8	3,0	2,7
2011	5,6	2,0	0,9	0,8	1,5	3,4	6,1	7,3	7,8	7,1	7,0	6,9	6,8	6,9	6,1	6,5	5,5	5,2	3,4	3,1
2012	5,5	2,2	1,0	0,8	1,5	3,3	5,9	7,0	7,5	6,9	6,7	6,9	6,8	7,1	6,3	6,6	5,8	5,4	3,5	3,1
2013	5,6	2,0	0,7	0,7	1,6	3,3	5,5	6,7	7,0	6,9	6,6	6,9	7,0	7,4	6,5	6,9	6,0	5,6	3,8	3,2
2014	5,7	1,9	0,7	0,7	1,5	3,1	5,1	6,6	6,6	6,6	6,4	6,9	7,1	7,7	7,0	6,9	6,2	5,7	4,1	3,4

*(1) Excluding deaths with unspecified age.
(2) Data for 2010–2013 have been updated with late registrations/delayed death notification forms processed in 2014/2015.

4.4.1. Maternal, Infant and Child Mortality

In line with MDG targets the South African health system aimed to reduce its child mortality by two-thirds between 1990 and 2015. Although the HIV epidemic and the resultant mother to child transmission of HIV initially saw a deterioration in the child health indicators more recently South Africa has made remarkable progress in the health outcome indicators of maternal, child and infant mortality. Table 4 describes the progress on the Targets of the South African health system.

Table 2 - Institutional Maternal Mortality Ratio

Province	2009	2010	2011	2012	2013	2014	2015	2016
Eastern Cape	215.2	197	164.7	153.7	172.7	174.15	133.35	144.11
Free State	350.9	263.5	246.8	149.3	185.1	203.26	162.81	172.65
Gauteng	160.2	159.2	136.4	163.7	115	136.26	138.97	125.09
KZN	194.2	208.7	197.6	170.2	146.5	140.85	125.66	124.56
Limpopo	160.4	166.7	196.4	192.9	201.2	169.75	168.11	170.72
Mpumalanga	159.4	218.6	199.7	177.4	150.3	119.54	136.5	148.51
North West	279.5	256.1	173	164.8	168.5	200.86	167.95	151.99
Northern Cape	251.8	267.4	193.6	166.5	158.3	120.68	160.52	114.48
Western Cape	113.1	88	62.6	81.8	83.9	66.5	70.59	75.78
South Africa	**188.9**	**186.2**	**166.97**	**160.22**	**147.69**	**144.58**	**135.53**	**135.27**

Source: National Committee of Confidential Enquiry into Maternal Deaths

The data provides evidence that there have been declining trends of mortality amongst infants and children in South Africa over the past 6 years. One of the contributing factors is the prevention of mother-to-child transmission of HIV (PMTCT) programme in South Africa.

The programme PMTCT programme began 15 years ago. In 2015 the national policy introduced lifelong triple antiretroviral therapy (ART) for all HIV positive pregnant and lactating women (PMTCT Option B+), and three-monthly HIV testing of HIV-negative pregnant and lactating women. Consequently the risk of early (six weeks postpartum) mother-to-child transmission of HIV (MTCT), dropped from approximately 25-30% prior to 2001 to an estimated 1.4% in2016[5]

Table 3 - Infant Mortality Rate (IMR) and Under 5 Mortality Rate in South Africa

	Statistics South Africa. Mid-year population estimates, 2016			Medical Research Council, Rapid Mortality Surveillance Report, 2015 (2016)		
Year	Infant mortality rate(IMR)	Under 5 mortality rate	Crude death rate	Infant mortality rate (IMR)	Under 5 mortality rate	Neonatal Mortality Rate
2009	43.6	66.4	10.5	39.0	56.0	14.0
2010	41.0	59.5	10.5	35.0	52.0	13.0
2011	39.7	56.4	10.7	28.0	40.0	13.0
2012	39.0	54.0	10.6	27.0	41.0	11.0
2013	36.4	48.8	10.2	28.0	41.0	11.0
2014	35.3	46.5	10.0	28.0	39.0	12.0
2015	34.4	45.1	9.8	27.0	37.0	12.0
2016	33.7	44.4	9.7			

The Rapid Mortality Surveillance Report 2015 (2016) reflects that:

- The Under-5 mortality rate (U5MR) significantly decreased from 56 deaths per 1,000 live births in 2009, to 37 deaths per 1,000 live births in 2015. The health system is targeting a further of child mortality with a target of 33 per 1000 live births by 2019.
- The infant mortality rate (IMR) decreased from 39 deaths per 1,000 live births in 2009, to 27 deaths per 1,000 live births in 2014.
- The Neonatal Mortality Rate (NMR) also declined from 14 deaths per 1,000 live births in 2009 to 12 per 1,000 live births in 2015. It has remained stable between 11-12 per 1,000 live births for the past 3 years.

A child born in the Eastern Cape, the Free State, KwaZulu-Natal or Mpumalanga faced IMR of over 40 per 1,000 and U5MR almost 60 per 1,000 or above as per the second burden of diseases study conducted in 2010. (see Figure 16)

The two highest final cause of early neonatal deaths were due to immaturity (>500g group) and intrapartum asphyxia (>1000g group). Infection was the most common final cause of late neonatal death in both the Child PIP and PPIP programmes. The weight category 1000g – 1999g has the highest perinatal indices (PNMR, SBR, NMR) in district hospitals and reflects the poorer care at this level.

5 Eliminating mother-to-child transmission of HIV in South Africa, 2002–2016: progress, challenges and the Last mile Plan, Goga et. al., HST SAHR 2017 Web version.

The three highest primary obstetric causes for perinatal deaths in babies >1000g remains unchanged: unexplained IUD, Spontaneous preterm labour and intrapartum asphyxia. The unexplained IUD's are mostly macerated SBs and DOA. Fresh Stillbirths were mostly intrapartum asphyxia and APH related.

4.4.2. External causes of death

According to StatsSA, the proportion of deaths due to injuries (i.e. external causes of death) including accidents and violence, was generally highest among the youth and specifically the male population.[9]

Deaths due to injuries took a downward trend from 16,8% in 1997 to 8,5% in 2006, and thereafter remained more or less constant from 2007 up to 2009. Between 2010 and 2014, a consistent increase in the proportions of deaths due to injuries was noted from 8,9% in 2010 to 10,5% in 2014.

Nearly half of deaths recorded as injury-related are due to violence. South Africa's injury death rate of 158 per 100,000[23] is double the global average and higher than the average in Africa of 139.5 per 100,000. [10]Though the overall contribution of injury-related deaths to the total number of deaths in South Africa has decreased slightly since 1997, it remains a concern.

The types of injury-related deaths also differ according to age group. Interpersonal violence in 2010 accounted for 7.0% of deaths among 15-44 year olds (the second leading cause of death), 2.0% of deaths among 5-14 year olds, and 2.1% of deaths among 45-59 year olds. Road injuries were the second leading cause of death among 5-14 year olds (11.7% of all deaths in that age group), and the third leading cause among 15-44 year olds (5.5% of all deaths). 2.0% of deaths among 5-14 year olds, and 2.1% of deaths among 45-59 year olds. Road injuries were the second leading cause of death among 5-14 year olds (11.7% of all deaths in that age group), and the third leading cause among 15-44 year olds (5.5% of all deaths).

4.5. Burden of Disease

South Africans seem not to have derived all the benefits from progressive health-care policies, such as free primary health care, that were introduced by the first democratically elected government in 1994, partly because of a low quality of health care, but also due to an uneven access to services. Secondly, and perhaps more significantly, it is also because the upstream determinants of ill-health lie beyond the reach of the health sector, such as poverty, lack of access to safe water and sanitation and insufficient quality education.

The National Department of Health commissioned a Joint Review of the HIV, TB and PMTCT Programmes in 2013. The Joint Review found that the country had made impressive strides in the implementation of HIV, TB and PMTCT programmes 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 HIV infections in children. HIV and TB mortality is declining, with a corresponding overall decline in all natural cause mortality.

4.5.1. HIV and AIDS

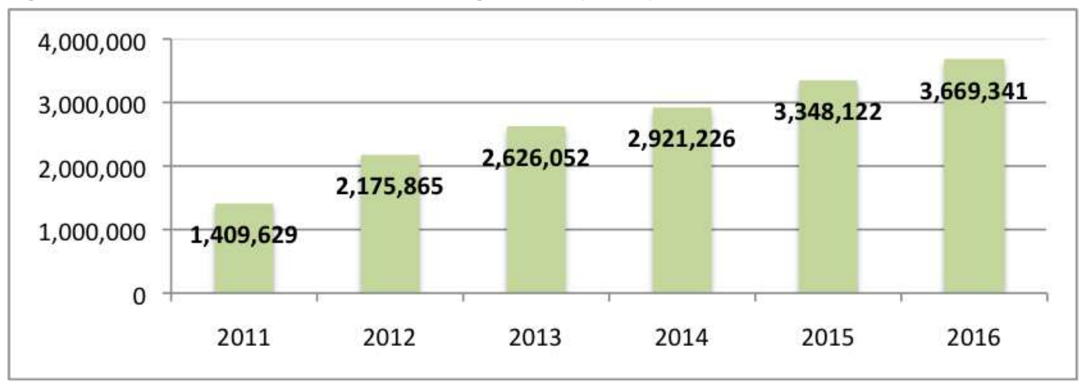
South Africa is experiencing generalised HIV and TB epidemics. It continues to be home to the world's largest number of people living with HIV. The total number of persons living with HIV in South Africa increased from an estimated 4,72 million in 2002 to 7.03 in 2016 For adults aged 15–49 years, an estimated 18,9% of the population is HIV positive in 2016 compared to an estimated 12,7% of the total population being HIV positive in 2015. The estimated overall HIV prevalence rate is approximately 12,7% of the total South African population with HIV prevalence among the youth aged 15-24 declining over time from 7,6% in 2002 to 5,6 in 2016.The number of AIDS-related deaths also declined consistently since 2006 from 325 241 to 150 759 AIDS related deaths in 2016, due to access to antiretroviral treatment.

Table 4 - HIV mortality, incidence estimates and the number of people living with HIV,2002-2016

Year	Number of Births	Number of deaths	Number of AIDS related deaths s	Percentage of AIDS deaths
2002	1 065 149	587 001	232 581	39.6
2003	1 089 307	623 061	268 496	43.1
2004	1 112 009	654 512	299 504	45.8
2005	1 133 578	675 642	320 473	47.4
2006	1 157 720	681 434	325 241	47.7
2007	1 186 149	675 287	315 059	46.7
2008	1 213 007	649 556	284 312	43.8
2009	1 221 737	636 926	266 591	41.9
2010	1 216 150	628 915	256 625	40.8
2011	1 207 511	600 085	225 901	37.6
2012	1 210 987	562 184	185 558	33.0
2013	1 212 947	541 413	161 986	29.9
2014	1 213 213	537 579	155 063	28.8
2015	1 212 055	537 313	151 748	28.2
2016	1 198 861	539 714	150 759	27.9

Source: Statistics South Africa. Mid-year population estimates, 2016

Figure 5 - Total number of clients remaining on ART (TROA) 2011--2016

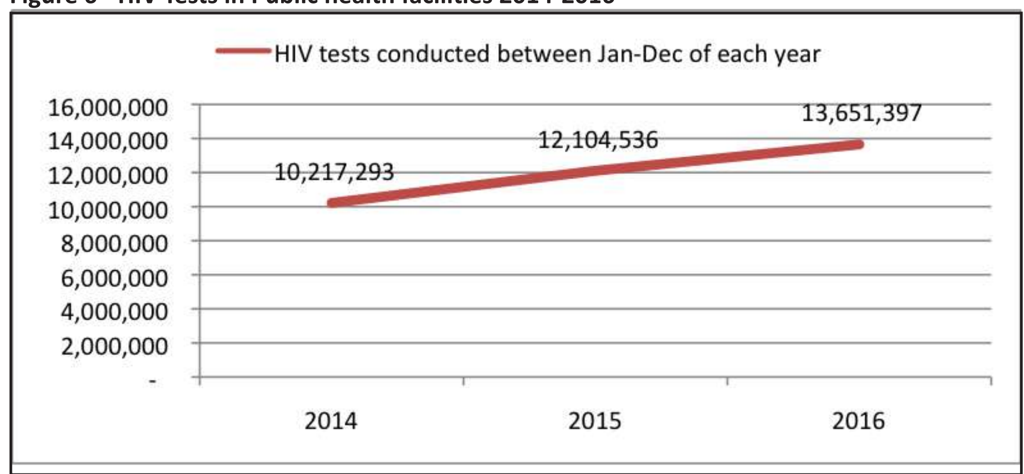


Source: Tier.net (2017)

The rapid scale up of ART services resulting in significant increases in the number of people receiving ART between 2011 and 2016.

The HIV prevention intervention programmes has resulted in a steady decline in the HIV incidence. Since the HIV Counselling and Testing (HCT) campaign was introduced in 2010, over 35 million people have been tested. The number of HIV tests conducted in public health facilities increased from just over 10m in 2014 to 13.65m in 2016.

Figure 6 - HIV Tests in Public health facilities 2014-2016



Source: District Health Information System (2017)

4.5.2. TB

The 2015 Global WHO TB report indicates that South Africa's TB incidence rate has decreased from 1,000 cases per 100,000 in 2012, to 834 cases per 100 000 in 2014. There are still many missed opportunities to identify and treat existing cases to curb transmission at community level. On the positive side, South Africa has remained the leading country in providing Isoniazid Preventive Therapy (IPT) to all HIV positive patients and South Africa accounts for 59% of patients receiving IPT globally.

A review of drug-resistant TB was also conducted in 2015. The review observed great progress, including the introduction of new drugs, ahead of any other country in the world, and good relationships with partner organisations in response to drug resistant TB. Challenges included inadequacy in human resource provision and poor supervision and monitoring of patients on treatment, resulting in an increase in defaulter rate.

There were 244.053 registered TB cases reported in 2016, compared to 283.085 registered tuberculosis cases reported in 2015. A declining trend can be observed since 2009 in terms of all TB cases initiated on treatment. The treatment success rate of new smear-positive TB patients increased from 63% in 2000 to 86% in 2016, similarly there has been an upward trend in TB Cure rate from just 54% in 2000 to 79% in 2016. This performance is commensurate with the downward trend of the loss to follow up rate (formerly known as defaulter rate) from 13% in 2000 to 6.1% in 2016. The number of TB case notifications peaked to 406 082 (2009) with 39.9% reduction (244,053 cases) from this all-time high.

Table 5 - TB Indicators

Period	TB case notification	Successful treatment rate	Cure rate	Loss to Follow Up 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	80	73	6,1
2012	349,582	81	76	6.2
2013	328,896	82	77	5.8
2014	318,896	83	77	6.1
2015	283,085	84	78	5.6
2016	244,053	86	79	6.1

Source: ETR.net,2017

4.5.3. Diseases Outbreaks

Listeriosis

Listeriosis is a serious, but treatable and preventable disease caused by the bacterium***, Listeria monocytogenes***, that exists widely in nature and can be found in soil, water and vegetation. Animal products and fresh produce such as fruits and vegetables can be contaminated from these sources.

Listeria monocytogenes is a disease that occurs every year and is seen in our hospitals. Typically 60 to 80 cases are detected and treated annually in South Africa. Tracing from 1 January 2017, as of 6 February 2018, a total of 852 laboratory-confirmed listeriosis cases have been reported from all provinces. The National Institute for Communicable Diseases (NICD) has confirmed that it is the largest documented listeriosis outbreak South Africa has ever experienced.

Infection with listeria may result in either of the following three conditions:

- flu like illness with diarrhoea including fever, general body pains, vomiting and weakness
- infection of the blood stream which is called septicaemia
- meningoencephalitis (infection of the brain).

The vulnerable populations are the elderly, pregnant women, persons with weak immunity such as HIV, cancer, diabetes, chronic liver or kidney disease. The most affected age groups are neonates, (babies up to the first 28 days of life) accounted for 37% of the cases and the age group between 15 to 49 years, 33%, totalling 70% of all cases.
It is believed that the cause of the recent listeriosis outbreaks is contamination of farms and food processing plants. It is advisable that people living in South Africa follow below mentioned food safely guidelines:

- Keep clean by washing hands before and after food preparation
- Separate raw from cooked food as not to touch both
- Cook food thoroughly
- Keep food at safe temperatures
- Use safe water for cooking; washing and drinking.

Listeriosis was declared notifiable by the Minister of Health and the Regulations relating to surveillance and control of notifiable medical conditions was published on 15 December 2017.

Malaria

Malaria remains an acute public health problem, particularly in sub-Saharan Africa. According to the WHO report , there were 212 million new cases of malaria and 429 000 deaths worldwide in 2015. Children under five years of age are particularly vulnerable, accounting for an estimated 70% of all malaria deaths.

Malaria transmission in South Africa occurs mainly along the low-lying areas of the country bordering: Mozambique, Swaziland and Zimbabwe. Approximately 10% of the population in South Africa live in the malaria endemic areas and are at risk of contracting malaria. Malaria transmission in South Africa follows a seasonal pattern, where transmission increases from September and wanes towards May, the following year. South Africa has set the goal of eliminating the disease (zero local transmission) by the year 2018. According to the WHO report, there was an estimated decrease between 20-40% in malaria incidence, however there was and increase of >20% in estimated mortality rate due to malaria in April 2017. Of which 72% of these cases were imported from neighbouring malaria endemic countries, making it difficult for South Africa to achieve its goal of eliminating malaria by 2018.

The key strategies for elimination of the disease will be to strengthen malaria surveillance, malaria notification system in all spheres of the health sector, health promotion, case management and vector control and vector surveillance. South Africa will also be working closely with its neighbouring countries: Mozambique, Swaziland and Zimbabwe in regional malaria initiatives as this will contribute to the elimination commitment for the country.

4.5.4. Non Communicable Diseases

Non-communicable diseases of public health importance in SA include, amongst others, cancer, diabetes, mental health, asthma and heart diseases. The World Health Organisation reports that more than 38 million people died globally from NCDs in 2012. This constituted 68% of all deaths globally. Almost three quarters of non-communicable disease deaths (28 million) occurred in low- and middle-income countries with about 48% of deaths occurring before the age of 70 in these 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. In 2014, the probability of dying in South Africa between ages 30 and 70 years from the 4 main NCDs (cancer, diabetes, chronic respiratory diseases and cardiovascular diseases) is 27%

Mental Health:

Mental Health disorders are associated with the growing burden of NCDs. The most prevalent disorders are anxiety disorders, substance abuse disorders and mood disorders. The Department 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 National Mental Health Policy Framework and Strategic Plan 2013-2020 adopted in July 2013 sets out key objectives and milestones that must be realised to transform mental health services in this country. The priorities are (i) improving detection rates and management of mental disorders especially in primary health care settings; (ii) improving mental health infrastructure capacity especially at community level; and (iii) improving the supply of and access to mental health professionals. To achieve mental well being also requires that multidimensional interventions be implemented with other sectors to address the socio-economic determinants of mental disorders.

Risk Factors

Common risk factors for NCDs include tobacco use; lack of exercise; unhealthy diets, and excessive use of alcohol etc. 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.

Tobacco use is the single most preventable cause of disease, disability, and death in the world. Each year, 6 million people globally die from illnesses such as lung cancer, chronic respiratory disease, and heart disease caused by tobacco use; and the number of tobacco deaths is projected to increase to 8 million by 2030.

The South African Demographic and Health Survey (SADHS) 2016 reported that overall 7% of women and 37% of men, age 15 and older, currently smoke tobacco products, mostly cigarettes. The percentage of women and men age 15 and older who smoke tobacco has decreased since 1998; 11% of women and 42% of men smoked tobacco in 1998 compared with 7% of women and 37% of men in 2016 (Figure 7).Total taxes on cigarettes (including excise and sales taxes) increased from 32 % to 52 % of retail price between 1993 and 2009. In that same period, cigarette sales declined 30 % and the rate of smoking among adults dropped by 25 %. Meanwhile, government revenue from tobacco taxes increased by 800 %. Taxes like this are effective for young people whose purchasing is particularly sensitive to price increases.

Figure 7 - Comparison of tobacco smoking in 1998 and2016, by frequency of smoking

Percentage of women and men age 15+ who smoke tobacco

		SADHS 1998	SADHS 2016
Women	Any smoking	11	7
Women	Daily smoker	9	6
Women	Occasional smoker	1	2
Men	Any smoking	42	37
Men	Daily smoker	37	30
Men	Occasional smoker	6	7

Alcohol consumption

According to the WHO Status report on alcohol consumption, globally in 2010, the consumption of alcohol was equal to 6.2 litres of pure alcohol consumed per person aged 15 years or older, which translates into 13.5 grams of pure alcohol per day

Alcohol consumption has been identified as a component cause for more than 200 diseases, injuries and other health conditions with ICD-10 codes including neuropsychiatric conditions such as depression or anxiety disorders (Kessler, 2004; Boden and Fergusson, 2011) ; Foetal alcohol syndrome (FAS) and preterm birth complications amongst others. According to research, people with lower socioeconomic status (SES) appear to be more vulnerable to tangible problems and consequences of alcohol consumption (Grittner et al., 2012) [18]. In South Africa, risky alcohol consumption – drinking 5 or more standard measures of alcohol on a single occasion in the past 30 days was most common in women in the 20-24 year age group (9%) with over one-quarter of men (28%) in the same age group, exhibit risky drinking behaviour. One in six men (16%) reported signs of problem drinking using the CAGE test. Stats SA Quarterly Labour Force Survey, 2017[20] indicate that on a quarter-to-quarter basis, the official unemployment rate remained unchanged at 27,7%, and increased by 1,1 percentage points year-on-year. Addressing socio-ecomomic factors like increasing jobs especially amongst the youth may reduce alcohol consumption due to socioeconomic stress factors.

In March 2013, the Minister of Health in South Africa signed ground breaking legislation to mandate salt reductions in the food industry. Maximum sodium content limits will gradually decrease in two waves with deadlines in 2016 and 2019. Broad-based legislation such as this can significantly reduce sodium consumption among young people who tend to eat convenient, processed foods high in salt, such as snack chips, cereals, and breads.

Research shows that there is a high prevalence of mental disorders linked to social determinants such as poverty, unemployment, violence, substance abuse and other adversities that increase vulnerability of South Africans to mental disorders; high co-morbidity between mental and other diseases; and that there is a substantial gap between demand and supply of mental health services.

Nutrition

The prevalence of overweight and obesity in South Africa has increased since 1998. According to the SADHS 2016 key indicator report, 68% of women are overweight or obese (overweight 27%, obesity 41%). Of major concern is the high prevalence of severe obesity among South Africa women; one in five women has a BMI ≥ 35.0, placing her in the severely obese category. Severely obese persons have an elevated risk for heart disease, diabetes, and other conditions relative to those who are overweight or obese. Thirty-one percent of men are overweight or obese (overweight 20%, obesity 11%) with only 3% falling in the severe obesity category.

In South Africa, 31% of women and 17% of men age 15 and older are anaemic. The proportion of women with anaemia is slightly higher in the reproductive age group than in older women; specifically, 33% of women age 15-49 are anaemic compared with 25% of women age 55 older.

The South African Demographic and Health Survey of 2016 confirms that “stunting remains a national concern”. In South Africa, 27% of children under 5 years are stunted, while 6% are underweight, and 3% are wasted. On the positive front, the survey revealed that, 32% of children up to the age of 6 months were exclusively breastfed.

4.6. Social Determinants of Health

Addressing the social determinants of health is a key constitutional activity and significantly contributes to the epidemiological profile of the country. The government provides the following basic services: no-fee paying schools, social grants, housing, safe water supplies, electricity, sanitation and sewage, and free primary health care

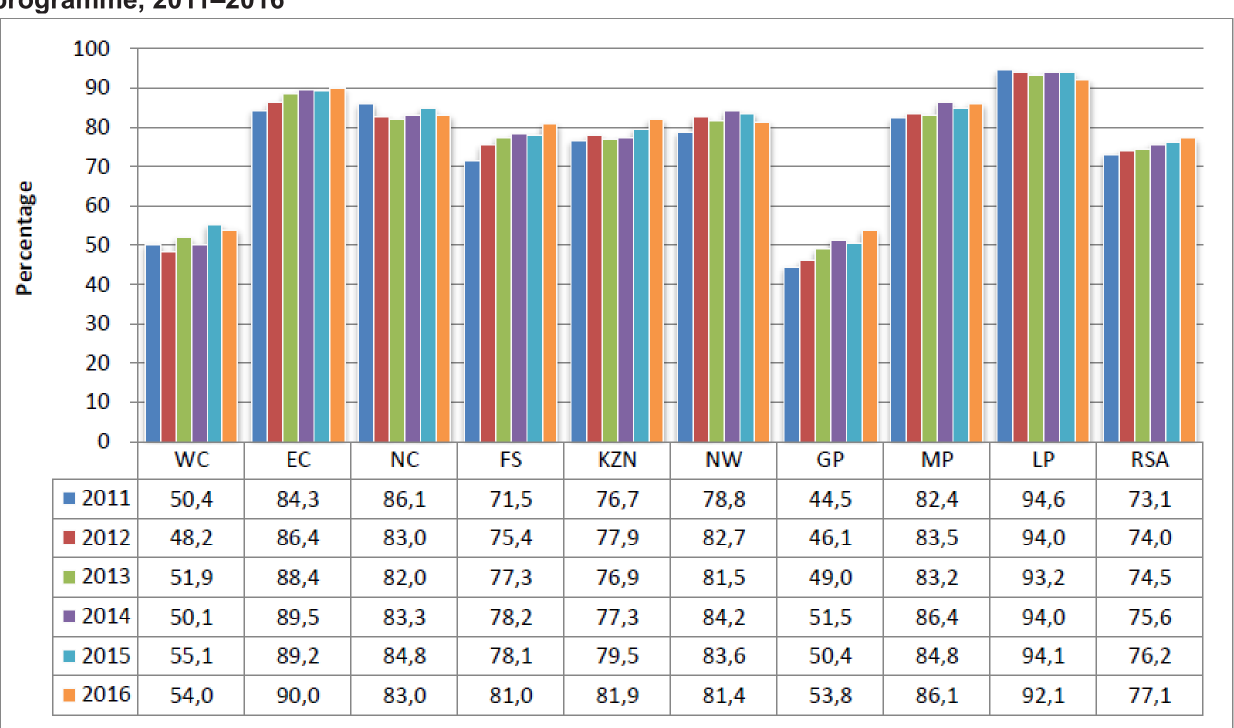
Education:

The Community Survey of 2016 observed that across the population groups there is an increase in the persons attending an educational institution over the past 2 decades. Overall 17m individuals were attending an educational institution in 2016. The percentage of the population with no schooling dropped from 19.3% in 1996 to 6.5%[21]however functional literacy declined from 27.3% in 2002 to 28.4% in 2016.

The General Household Survey (GHS) by Stats SA, 2016[22] estimates that 766 812 students were enrolled at higher education institutions (universities and universities of technology) in 2016. More than two-thirds (66,4%) of these students were black African, while 18,7% were white; 7,8% were Indian/Asian and 7,1% were coloured. However, proportionally black Africans are still under-represented. Furthermore, the percentage of individuals with tertiary qualifications improved from 9,3% to 14,0%.

There were approximately 14 million learners at school in 2016. Figure 8 presents the percentage of individuals attending public schools and who benefited from a school nutrition programme. More than three-quarters (77.1%) of learners who attended public schools benefited from school feeding schemes in 2016, compared to 73.1% in 2011.The proportion of learners who benefitted from feeding schemes increased most in Free State (9,5%) and Gauteng (9,3%) while it decreased in Northern Cape (- 3,1 %) and Limpopo (-2,5 %).

Figure 8 - Percentage of learners attending public schools who benefited from the school nutrition programme, 2011–2016



	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
2011	50,4	84,3	86,1	71,5	76,7	78,8	44,5	82,4	94,6	73,1
2012	48,2	86,4	83,0	75,4	77,9	82,7	46,1	83,5	94,0	74,0
2013	51,9	88,4	82,0	77,3	76,9	81,5	49,0	83,2	93,2	74,5
2014	50,1	89,5	83,3	78,2	77,3	84,2	51,5	86,4	94,0	75,6
2015	55,1	89,2	84,8	78,1	79,5	83,6	50,4	84,8	94,1	76,2
2016	54,0	90,0	83,0	81,0	81,9	81,4	53,8	86,1	92,1	77,1

Access to Medical Insurance

Between 2002 and 2016, individuals who were covered by a medical aid scheme increased from 7,3 million to 9,5 million persons (15,9% to 17,4%). Nearly a quarter (23,2%) of South African households had at least one member who belonged to a medical aid scheme.

The uninsured population (i.e. population without medical aid) has also grown substantially over time. Between 2008 and 2016, the uninsured population grew at an average rate of 1.52% per year with about seven in every ten (71,4%) households reported that they went to public clinics and hospitals as their first point of access when household members fell ill or got injured[24].

Household assets and income sources:

Nationally, salaries (65,4%) and grants (45,7%) are the main sources of income. Provincially, Western Cape (76,7%) and Gauteng (74,8%) households are sustained by salaries as a source of income while in Eastern Cape (59,1%) and Limpopo (58,0%) social grants are the main source of income. The percentage of individuals that benefited from social grants consistently increased from 12,7% in 2003 to 29,7% in 2016. Simultaneously, the percentage of households that received at least one grant increased from 29,9% in 2003 to 44,8% in 2016.

Housing*:*

According to the results of the General Household Survey, 2016, more than three-quarters (79.3%) of South African households lived in formal dwellings with the highest concentration of households living in formal dwellings in Limpopo (91.9%), followed by Mpumalanga (86.5%). The highest percentage of informal dwellings was found in the North West (20.8%) and Gauteng (19.8%). The percentage of South Africans living in state-subsidised houses increased from 5% in 2002 to 13,5% in 2016,

Progress is being made towards providing basic services that impact on social determinants of health:

- Nationally 88.8% of South African households have access to piped water, while the Eastern Cape (75.7%) and Limpopo (75.7%) provinces are below the national average. Satisfaction with service delivery of users who rated the service to be “good” has steadily decreased from 76.4% in 2005” to 63.0% in 2016.
- The percentage of households with access to improved sanitation increased in South Africa from 62,3% in 2002 to 80,9% in 2016. The majority of households in Western Cape (94,3%) and Gauteng (90,7%) have access to adequate sanitation, while in Limpopo (57,1%) and (67,4%) of households in Mpumalanga have adequate sanitation.
- Nationally, the percentage of households connected to the electricity has slightly increased from 77,1% in 2002 to 84.2% in 2016 with 76.8% of households using electricity for cooking (an increase of nearly 20% from 2002).
- The percentage of households for which refuse were removed at least once per week increased modestly from 56,7% in 2002 to 64,9% in 2016.

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 including:

(a) a complex, quadruple burden of diseases;
(b) 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 Organisation (WHO) converge around the fact that a well-functioning and effective health system is the 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 (Tech-NHC) functions as the Technical Implementation Forum. The Tech NHC consists of the Director-General of the National Department of Health (NDoH) and the Provincial Heads of Department (HoDs) of Health in the 9 Provinces, and NDoH Deputy Director-Generals.

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

5.3. Sustainable Development Goals 2030

The Sustainable Development Goals 2030 built on Millennium Development Goals 2015 were adopted as the Global Goals by the world leaders on 25 September 2015. There are 17 Sustainable Development Goals (SDGs) to end poverty, fight in equality and tackle climate change by 2030. The following targets have been adopted for Goal 3 “Ensure healthy lives and promote well-being for all at all ages”.

An alignment exists between the National Development Plan 2030 adopted by the Government of South Africa in 2013, and the Sustainable Development Goals adopted by United Nations during September 2015. The Department is expecting the finalised set of indicators to measure progress against SGDs during 2016/17 financial year.

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- By 2020, halve the number of global deaths and injuries from road traffic accidents

- By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- Strengthen the implementation of the World Health Organisation Framework Convention on Tobacco Control in all countries, as appropriate
- Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

5.4. Priorities to achieve Vision 2030

The NDP 2030 states 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:

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

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.

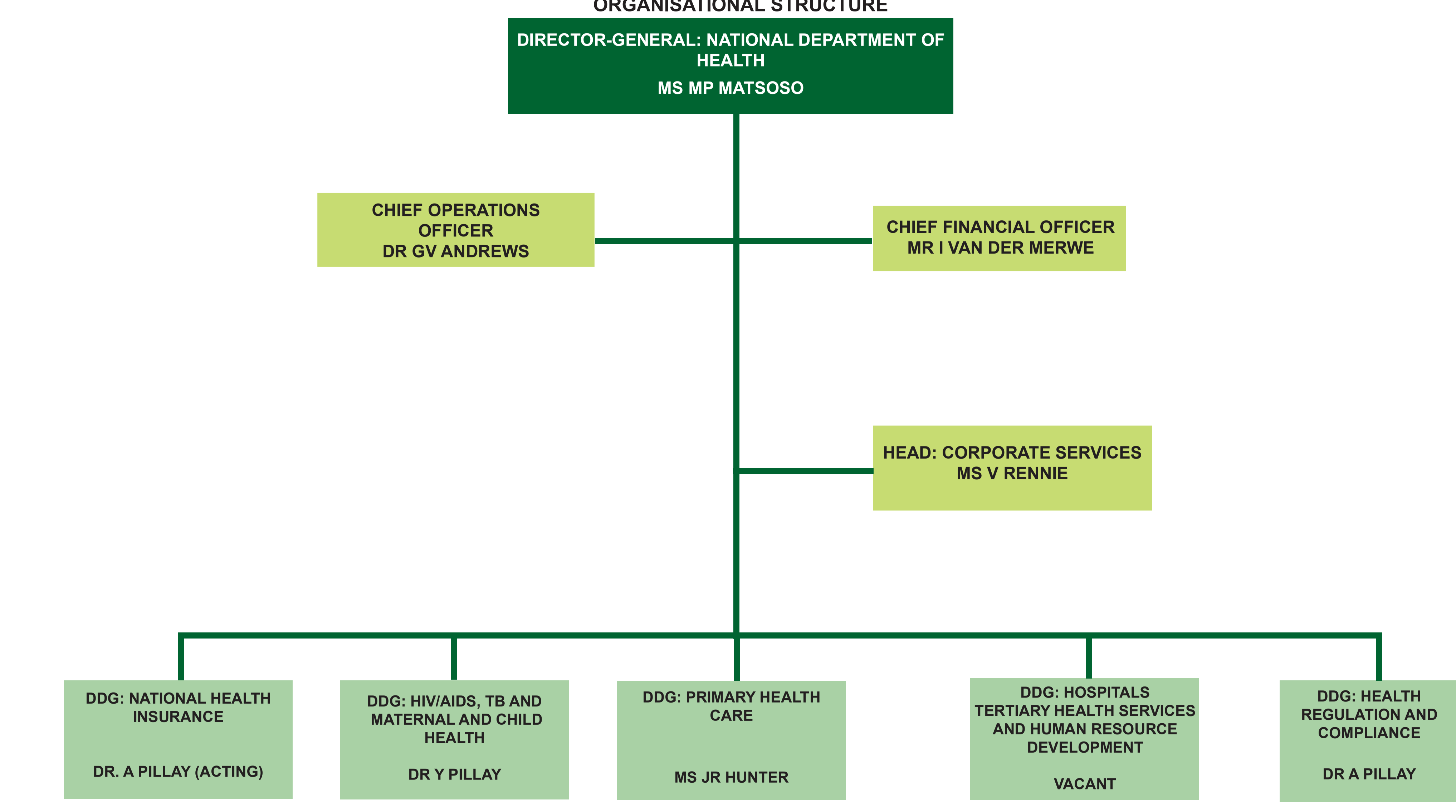
Table12: Alignment between Sustainable Development Goal 3, National Development Plan 2030, Medium Term Strategic Framework 2014-2019 and National Department of Health Strategic Goals 2014-2019

Sustainable Development Goal 3	National Development Plan (NDP) Goals 2030 (Chapter 10)	National Development Plan (NDP) Priorities 2030 (Chapter 10)	Medium Term Strategic Framework (MTSF) 2014-2019	National Department of Health Strategic Goals 2015- 2020
Life expectancy is affected by the advanced made towards 13 targets under the health SDG (provided below).	Average male and female life expectancy at birth increased to 70 years	a) Address the social determinants that affect health and diseases b) Prevent and reduce the disease burden and promote health	Sub-outcome 3. Implement the re-engineering of Primary Health Care Strategic Action: Improve inter-sectoral collaboration with a focus on population wide interventions (to promote healthy lifestyles in the whole population) and community based interventions (to promote healthy lifestyles in communities) and addressing social and economic determinants of Non-Communicable Diseases	Prevent disease and reduce its burden, and promote health through a multi stakeholder National Health Commission
By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Tuberculosis (TB) prevention and cure progressively improved;		Sub-outcome 8: HIV & AIDS and Tuberculosis prevented and successfully managed	
• By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births • By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	Maternal, infant and child mortality reduced		Sub-outcome 9: Maternal, infant and child mortality reduced	
• By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being • Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol • Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	Prevalence of Non-Communicable Diseases reduced		Sub-outcome 3. Implement the re-engineering of Primary Health Care Strategic Action: Improve inter-sectoral collaboration with a focus on population wide interventions (to promote healthy lifestyles in the whole population) and community based interventions (to promote healthy lifestyles in communities) and addressing social and economic determinants of Non-Communicable Diseases	
By 2020, halve the number of global deaths and injuries from road traffic accidents	Injury, accidents and violence reduced by 50% from 2010 levels			

Sustainable Development Goal 3	National Development Plan (NDP) Goals 2030 (Chapter 10)	National Development Plan (NDP) Priorities 2030 (Chapter 10)	Medium Term Strategic Framework (MTSF) 2014-2019	National Department of Health Strategic Goals 2015- 2020
• Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. • Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines • Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Health systems reforms completed	c) Strengthen the health system	Sub-outcome 7: Improved health facility planning and infrastructure delivery	Improve health facility planning by implementing norms and standards;
				Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms;
		d) Improve health information systems	Sub-outcome 10: Efficient Health Management Information System developed and implemented for improved decision making	Develop an efficient health management information system for improved decision making;
		e) Improve quality by using evidence	Sub-outcome 2: Improved quality of health care	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
By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	Primary health care teams deployed to provide care to families and communities		Sub-outcome 3. Implement the re-engineering of Primary Health Care	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;
Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Universal health coverage achieved	f) Financing universal healthcare coverage	Sub-outcome 1: Universal Health coverage progressively achieved through implementation of National Health Insurance Sub-outcome 4: Reduced health care costs	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;
Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	Posts filled with skilled, committed and competent individuals	g) Improve human resources in the health sector h) Review management positions and appointments and strengthen accountability mechanisms	Sub-outcome 5: Improved human resources for health Sub-outcome 6: Improved health management and leadership	Improve human resources for health by ensuring appropriate appointments, adequate training and accountability measures.

6. ORGANISATIONAL ENVIRONMENT

The organisational structure is currently under review in light of the National Health Insurance policy adopted by the Government of South Africa. The success of the implementation thereof is highly dependent on the institutional arrangements and alignment with the available budget. The revised organisational structure will be implemented during 2018/19 financial year.



7. OVERVIEW OF 2018/19 BUDGETS AND MTEF ESTIMATE

7.1. PERSONNEL INFORMATION

Personnel numbers and cost by salary level and programme[1]

Programmes

1. Administration
2. National Health Insurance, Health Planning and Systems Enablement
3. HIV and AIDS, Tuberculosis, and Maternal and Child Health
4. Primary Health Care Services
5. Hospitals, Tertiary Health Services and Human Resource Development
6. Health Regulation and Compliance Management

	Number of posts estimated for 31 March 2018		Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Average: Salary level/Total (%)
			2016/17			2017/18			2018/19			2019/20			2020/21			2017/18 - 2020/21	
Health			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	1 739	–	**1 694**	**837.3**	**0.5**	**1 688**	**873.4**	**0.5**	**1 498**	**828.8**	**0.6**	**1 489**	**894.3**	**0.6**	**1 479**	**961.4**	**0.7**	-4.3%	100.0%
1 – 6	602	–	586	138.0	0.2	582	148.3	0.3	503	140.9	0.3	500	154.4	0.3	497	166.6	0.3	-5.1%	33.8%
7 – 10	747	–	754	361.6	0.5	753	385.4	0.5	731	422.3	0.6	729	458.9	0.6	724	498.2	0.7	-1.3%	47.7%
11 – 12	268	–	214	205.8	1.0	214	202.4	0.9	129	123.1	1.0	126	128.8	1.0	126	137.9	1.1	-16.2%	9.7%
13 – 16	122	–	140	131.9	0.9	139	137.2	1.0	135	142.5	1.1	134	152.2	1.1	132	158.7	1.2	-1.7%	8.8%
Programme	1 739	–	**1 694**	**837.3**	**0.5**	**1 688**	**873.4**	**0.5**	**1 498**	**828.8**	**0.6**	**1 489**	**894.3**	**0.6**	**1 479**	**961.4**	**0.7**	-4.3%	100.0%
Programme 1	437	–	443	187.6	0.4	439	197.2	0.4	435	209.2	0.5	433	231.6	0.5	431	244.7	0.6	-0.6%	28.2%
Programme 2	159	–	153	109.5	0.7	153	114.7	0.7	152	116.7	0.8	150	124.3	0.8	148	131.2	0.9	-1.1%	9.8%
Programme 3	120	–	124	75.6	0.6	124	79.4	0.6	121	84.4	0.7	121	89.6	0.7	118	94.6	0.8	-1.6%	7.9%
Programme 4	410	–	414	177.9	0.4	414	185.6	0.4	413	209.1	0.5	410	220.9	0.5	409	233.2	0.6	-0.4%	26.7%
Programme 5	266	–	274	138.0	0.5	273	128.5	0.5	272	145.2	0.5	270	157.7	0.6	270	183.3	0.7	-0.4%	17.6%
Programme 6	347	–	286	148.7	0.5	285	168.0	0.6	105	64.3	0.6	105	70.2	0.7	103	74.5	0.7	-28.8%	9.7%

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

7.2. EXPENDITURE TRENDS AND ESTIMATES

Expenditure estimates by programme and economic classification

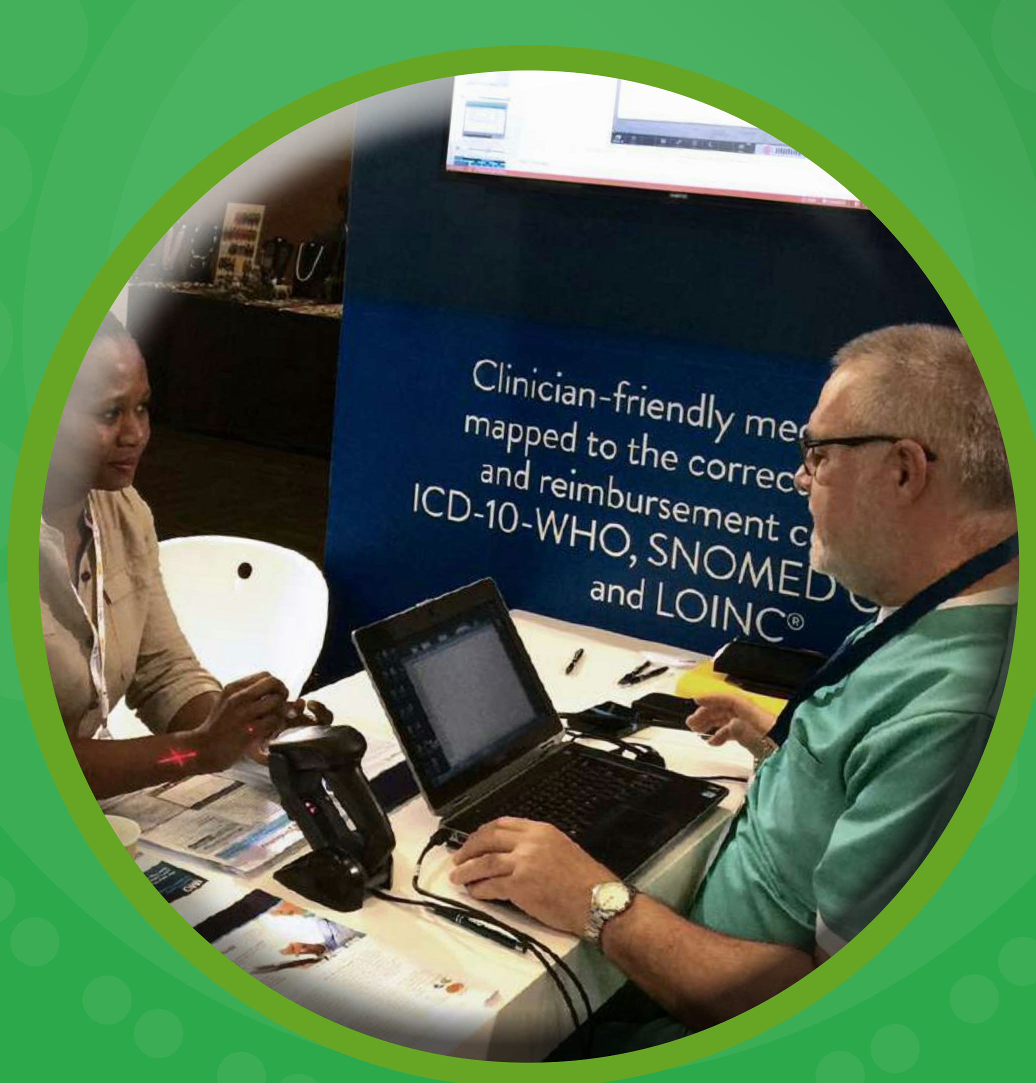
Programmes

1. Administration
2. National Health Insurance, Health Planning and Systems Enablement
3. HIV and AIDS, Tuberculosis, and Maternal and Child Health
4. Primary Health Care Services
5. Hospitals, Tertiary Health Services and Human Resource Development
6. Health Regulation and Compliance Management

Programme R million	Revised estimate 2017/18	Average growth rate (%)	Average: Expenditure/Total (%)	Medium-term expenditure estimate 2018/19	2019/20	2020/21	Average growth rate (%)	Average: Expenditure/Total (%)
		2014/15 - 2017/18					2017/18 - 2020/21	
Programme 1	514.8	9.7%	1.2%	550.8	592.5	627.1	6.8%	1.2%
Programme 2	914.7	11.6%	1.6%	1 671.6	2 380.3	3 081.7	49.9%	4.1%
Programme 3	18 267.8	12.5%	40.7%	20 719.1	22 873.3	25 317.7	11.5%	44.1%
Programme 4	263.9	6.9%	0.6%	301.7	366.6	431.4	17.8%	0.7%
Programme 5	20 907.8	3.6%	51.7%	22 124.2	23 364.2	24 831.1	5.9%	46.2%
Programme 6	1 726.6	7.2%	4.2%	1 775.5	1 876.5	1 980.4	4.7%	3.7%
Total	**42 595.6**	7.5%	100.0%	**47 142.9**	**51 453.4**	**56 269.3**	9.7%	100.0%
Change to 2017 Budget estimate				475.9	1 068.4	1 749.9		
Economic classification								
Current payments	**2 560.6**	**4.5%**	**5.6%**	**3 088.4**	**4 019.4**	**4 806.5**	**23.4%**	**7.3%**
Compensation of employees	873.4	10.0%	2.1%	828.8	894.3	961.4	3.3%	1.8%
Goods and services	1 687.3	2.0%	3.5%	2 259.6	3 125.0	3 845.1	31.6%	5.5%
Transfers and subsidies	**39 282.1**	**7.5%**	**92.9%**	**43 017.0**	**46 423.6**	**50 322.4**	**8.6%**	**90.7%**
Provinces and municipalities	37 570.2	7.6%	88.7%	41 122.6	44 423.1	48 211.9	8.7%	86.8%
Departmental agencies and accounts	1 516.1	7.7%	3.7%	1 698.5	1 793.7	1 892.3	7.7%	3.5%
Non-profit institutions	193.7	-2.4%	0.5%	195.9	206.8	218.2	4.0%	0.4%
Households	2.0	408.5%	0.0%	–	–	–	-100.0%	0.0%
Payments for capital assets	**752.8**	**15.5%**	**1.4%**	**1 037.5**	**1 010.4**	**1 140.4**	**14.9%**	**2.0%**
Buildings and other fixed structures	644.0	19.4%	1.2%	748.1	792.1	876.5	10.8%	1.6%
Machinery and equipment	103.8	1.0%	0.2%	289.4	218.3	263.9	36.5%	0.4%
Software and other intangible assets	5.0	-20.0%	0.0%	–	–	–	-100.0%	0.0%
Payments for financial assets	**0.1**	–	**0.0%**	–	–	–	**-100.0%**	**0.0%**
Total	42 595.6	7.5%	100.0%	47 142.9	51 453.4	56 269.3	9.7%	100.0%

PART B

PROGRAMME SUB-PROGRAMME PLANS



PROGRAMME 1: ADMINISTRATION

1.1. STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Ensure effective financial management and accountability by improving audit outcomes	Audit opinion from Auditor General	Unqualified Audit Opinion	unqualified Audit opinion	Unqualified Audit opinion	Unqualified audit opinion with no significant matters for 2016/17	Clean Audit opinion for the NDOH for 2017/18	Clean Audit Opinion for the NDOH for 2018/19	Clean Audit Opinion for the NDOH for 2019/20
	Number of Provincial DoH that demonstrate improvements in Audit Outcomes or Opinions	3 Unqualified Audit Opinion	3 Unqualified Audit Opinions	4 Provincial DoH that demonstrate improvements in Audit	4 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2016/17	5 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2017/18	5 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2018/19	6 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2019/20

1.2. QUARTERLY TARGETS FOR 2018/19

Performance indicator	Reporting period	Annual target 2018/19	Quarterly targets			
			1st	2nd	3rd	4th
Audit opinion from Auditor General	Annual	Clean Audit opinion for the NDOH for 2017/18	N/A	Clean Audit opinion for the NDOH for 2017/18	N/A	N/A
Number of Provincial DoH that demonstrate improvements in Audit Outcomes or Opinions	Annual	5 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2017/18	N/A	5 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2017/18	N/A	N/A

1.3. RECONCILING PERFORMANCE TARGETS WITH THE BUDGETS AND THE MTEF

Administration expenditure trends and estimates by subprogramme

Sub-programme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Ministry	28 851	29 952	29 041	31 840	3.3%	6.7%	31 217	34 483	37 081	5.2%	5.9%
Management	20 885	19 846	22 121	19 566	-2.2%	4.6%	25 666	28 225	29 856	15.1%	4.5%
Corporate Services	178 331	199 693	199 225	235 501	9.7%	45.6%	244 998	261 753	276 572	5.5%	44.6%
Office Accommodation	110 449	147 624	142 962	165 179	14.4%	31.8%	174 912	185 995	196 225	5.9%	31.6%
Financial Management	47 960	41 386	49 528	62 752	9.4%	11.3%	73 999	82 037	87 357	11.7%	13.4%
Total	**386 476**	**438 501**	**442 877**	**514 838**	**10.0%**	**100.0%**	**550 792**	**592 493**	**627 091**	**6.8%**	**100.0%**
Change to 2017				2 000			3 322	10 017	7 932		

Administration expenditure trends and estimates by economic classification

Economic classification	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Current payments	**381 821**	**426 936**	**432 768**	**507 550**	**10.0%**	**98.1%**	**537 331**	**581 720**	**615 307**	**6.6%**	**98.1%**
Compensation of employees	167 468	177 729	187 591	197 170	5.6%	40.9%	209 195	231 617	244 681	7.5%	38.6%
Goods and services[1]	214 353	249 207	245 177	310 380	13.1%	57.2%	328 136	350 103	370 626	6.1%	59.5%
of which:											
Audit costs: External	*27 921*	*20 110*	*21 818*	*35 255*	*8.1%*	*5.9%*	*29 956*	*32 127*	*33 177*	*-2.0%*	*5.7%*
Communication	*8 895*	*9 815*	*9 442*	*16 432*	*22.7%*	*2.5%*	*17 024*	*18 577*	*16 967*	*1.1%*	*3.0%*
Operating leases	*90 241*	*128 104*	*131 085*	*147 579*	*17.8%*	*27.9%*	*155 654*	*174 899*	*184 518*	*7.7%*	*29.0%*
Property payments	*22 311*	*23 330*	*16 634*	*20 000*	*-3.6%*	*4.6%*	*20 827*	*18 217*	*19 219*	*-1.3%*	*3.4%*
Travel and subsistence	*15 664*	*15 565*	*14 284*	*20 257*	*8.9%*	*3.7%*	*21 634*	*24 467*	*27 662*	*10.9%*	*4.1%*
Training and development	*4 591*	*3 851*	*4 584*	*8 445*	*22.5%*	*1.2%*	*15 936*	*18 909*	*20 399*	*34.2%*	*2.8%*
Transfers and subsidies[1]	**2 150**	**3 413**	**3 136**	**2 677**	**7.6%**	**0.6%**	**2 455**	**2 612**	**2 756**	**1.0%**	**0.5%**
Departmental agencies and accounts	1 366	2 439	2 808	2 252	18.1%	0.5%	2 455	2 612	2 756	7.0%	0.4%
Households	784	974	328	425	-18.5%	0.1%	–	–	–	-100.0%	–
Payments for capital assets	**2 322**	**7 942**	**6 826**	**4 597**	**25.6%**	**1.2%**	**11 006**	**8 161**	**9 028**	**25.2%**	**1.4%**
Machinery and equipment	2 322	7 942	4 647	4 597	25.6%	1.1%	11 006	8 161	9 028	25.2%	1.4%
Software and other intangible assets	–	–	2 179	–	–	0.1%	–	–	–	–	–
Payments for financial assets	**183**	**210**	**147**	**14**	**-57.5%**	**–**	**–**	**–**	**–**	**-100.0%**	**–**
Total	**386 476**	**438 501**	**442 877**	**514 838**	**10.0%**	**100.0%**	**550 792**	**592 493**	**627 091**	**6.8%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**1.2%**	**1.2%**	**1.2%**	**1.2%**	**–**	**–**	**1.2%**	**1.2%**	**1.1%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits											
Current	**784**	**974**	**328**	**425**	**-18.5%**	**0.1%**	**–**	**–**	**–**	**-100.0%**	**–**
Employee social benefits	784	974	328	425	-18.5%	0.1%	–	–	–	-100.0%	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**1 366**	**2 439**	**2 808**	**2 252**	**18.1%**	**0.5%**	**2 455**	**2 612**	**2 756**	**7.0%**	**0.4%**
Health and Welfare Sector Education and Training Authority	1 276	2 439	2 808	2 252	20.8%	0.5%	2 455	2 612	2 756	7.0%	0.4%
Public Service Sector Education and Training Authority	90	–	–	–	-100.0%	–	–	–	–	–	–

1.4. Personnel information

Administration personnel numbers and cost by salary level[1]

Number of posts estimated for 31 March 2018			Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Average: Salary level/Total (%)
			2016/17			2017/18			2018/19			2019/20			2020/21			2017/18 - 2020/21	
Administration			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**437**	**–**	**443**	**187.6**	**0.4**	**439**	**197.2**	**0.4**	**435**	**209.2**	**0.5**	**433**	**231.6**	**0.5**	**431**	**244.7**	**0.6**	**-0.6%**	**100.0%**
1 – 6	230	–	233	51.0	0.2	229	53.0	0.2	226	56.1	0.2	225	63.1	0.3	224	67.0	0.3	-0.7%	52.0%
7 – 10	126	–	129	60.8	0.5	129	64.0	0.5	128	68.3	0.5	128	77.0	0.6	127	81.5	0.6	-0.5%	29.5%
11 – 12	46	–	47	37.6	0.8	47	40.2	0.9	47	42.2	0.9	46	44.8	1.0	46	48.4	1.1	-0.7%	10.7%
13 – 16	35	–	34	38.2	1.1	34	39.9	1.2	34	42.5	1.3	34	46.8	1.4	34	47.8	1.4	–	7.8%

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

2. Rand million.

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 health coverage, health financing reform, integrated health systems planning, monitoring and evaluation, and research.

Technical Policy and Planning provides advisory and strategic technical assistance on policy and planning, and supports policy analysis and implementation and commissions health financing research. *Quality Assurance* co-ordinates the development of policies and quality improvement strategies for the health sector.

Health Information Management, Monitoring and Evaluation develops and maintains a national health information system, commissions and coordinates research, and monitors and evaluates strategic health programmes.

The eHealth Strategy for South Africa 2012-2016 was reviewed in 2017 to assess progress made, identify best practices, key challenges and make recommendations for the development of the new strategy. It highlighted key achievements such as the establishment of the Ministerial Advisory Committee to strengthen eHealth governance and the development of the National Health Normative Standards Framework (HNSF) for Interoperability in eHealth in South Africa. Furthermore, it identified strategic focus areas to accelerate eHealth implementation such as reliable and affordable facility internet connectivity

The assessments of PHC Patient Information Systems and Hospital Patient Information Systems using the HNSF conducted by Council for Industrial and Scientific Research (CSIR) identified gaps in capacity of acquired information systems and costs. Furthermore, the Health Patient Registration System (HPRS) Project was started in PHC facilities in the NHI districts in 2014, which is currently being rolled-out to PHC facilities nationally. The HPRS has developed and implemented a Patient Master Index that uses the National Identity Number as a unique identifier; and a basic enterprise architecture for HPRS has also been designed.

There were also interventions geared towards improving service delivery such as the Stock Visibility System (SVS) using to monitor real time medicine availability at facility level and Ideal Clinic Software used to monitor health care quality and adherence to standards. The review highlighted strategic challenges that will need to be addressed such as availability of reliable and affordable internet connectivity in primary health care facilities, the need for strong IT infrastructure and cybersecurity, as well as prioritization of budget allocation to eHealth

The National Health Research Committee and the National Health Research Ethics Council are the two statutory bodies that support the Ministry of Health in the advancement and strengthening of research systems in South Africa as mandated in the National Health Act, 61 of 2003.

The 2016 South Africa Demographic and Health Survey (SADHS) was conducted in 2016. A nationally representative sample of over 15000 household units were selected. Trained teams of interviewers collected data in face-to-face interviews with adults from over 11000 households, from among approximately 13000 occupied households. In a subset of households, nurses took measurements including blood pressure, height and weight, and tested for anaemia. Dried blood spots (DBSs) were prepared for anonymous testing for HIV and HbA1c (a test for diabetes). For the first time, SADHS data collection was undertaken using tablet computers rather than paper-based questionnaires. The SADHS Key Indicator Report was released on 15 May 2017, and the main report will be published in 2018/19 financial year.

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, and licensing of persons and premises that deliver pharmaceutical services and related policies.

Sector-wide procurement has implemented a number of reforms aimed at improving medicine access and availability. These interventions have primarily focused on addressing improved selection of medicines, improved contract management, improved replenishment management, and improved distribution models.

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; commissions ongoing research into sustainability of the health financing option that has been adopted for the South African environment for achieving universal health coverage; develops policy for the medical schemes industry and provide technical oversight over the Council for Medical Schemes; and provides technical and implementation oversight for the indirect national health insurance conditional grant. The sub-programme also implements the single exit price regulations, including policy development and implementation initiatives in terms of dispensing and logistical fees.

The final policy on NHI was approved by Cabinet and published on the 30 June 2017. The process of developing policy and legislation for National Health Insurance (NHI) is ongoing. The NHI Bill has been processed by the social protection community, and Human Development Cluster for Cabinet approval.

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), European Union (EU) United Nations (UN) agencies, as well as other developed and developing countries and emerging economic groupings such as Brazil-Russia-India-China-South Africa (BRICS) and IBSA (India, Brail South Africa) to strengthen the health system and coordinates international development support.

Over the medium term, and in line with NDP 2030, the cluster will mobilise resources for national, continental and regional health activities; establish strategic bilateral cooperation, especially with BRICS countries as well as other countries on the continent, thereby meeting our obligations in NEPAD to engage in post conflict reconstruction and diseases and emergencies in Africa; facilitate participation in various multilateral and other global engagements such as AU, SADC, WHO, EU, UN and BRICS; implement cross border initiatives to manage cross border care and enhance harmonisation 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 inter-sectoral issues such as climate change, trade and foreign policy.

2.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Achieve Universal Health Coverage through the phased implementation of National Health Insurance	Legislation for NHI	Draft White Paper for the NHI Bill revised and prepared for submission to Cabinet	The draft White Paper for the NHI Bill has been revised and prepared for submission to cabinet	NHI Bill conceptualised	Draft NHI Bill gazetted for public comments	NHI Bill submitted to Parliament	NHI Bill approved by the National Assembly and National Council of Provinces.	NHI Bill assented to by the President
	Private Health providers contracted to expand coverage of care	New Indicator	New Indicator	New Indicator	New Indicator	Private health providers contracted to purchase health services on behalf of population	Additional Private health providers contracted to purchase health services on behalf of population	Additional Private health providers contracted to purchase health services on behalf of population
Implement eHealth Strategy of South Africa through the development of patient information systems	eHealth Strategy 2019-2023 published	New Indicator	New Indicator	New Indicator	eHealth Strategy 2012-2016 implementation reviewed	eHealth Strategy 2019-2023 published	eHealth Strategy 2019 – 2023 implantation commenced, and monitored	eHealth Strategy 2019 – 2023 implementation monitored
Develop and implement a system for the creation of a NHI Beneficiary Registry	Number of health facilities implementing health patient registration system (HPRS)	50 PHC Facilities implementing improved health patient registration system (HPRS)	657 PHC facilities are implementing the health patient registration system (HPRS)	1854 PHC Facilities implementing the health patient registration system (HPRS)	3000 PHC Facilities implementing the health patient registration system (HPRS)	3000 PHC Facilities maintained; Additional 470 PHC facilities and 22 Hospitals implementing the health patient registration system (HPRS)	3470 PHC facilities and 22 Hospitals maintained; Additional 38 hospitals implementing the health patient registration system (HPRS)	3470 PHC facilities and 60 Hospitals maintained; Additional 260 hospitals implementing the health patient registration system (HPRS)
	Number of individuals from the population registered on the NHI Patient Beneficiary Registry	New Indicator	New Indicator	New Indicator	15 million	35 million	50 million	57 million
Establish a national stock management surveillance centre to improve medicine availability	Total number of health facilities reporting stock availability at national surveillance centre	600 of health facilities reporting stock availability at national surveillance centre	1 859 of health facilities reporting stock availability at national surveillance centre	3349 of health facilities reporting stock availability at national surveillance centre	3450 of health facilities reporting stock availability at national surveillance centre (cumulative)	3625 of health facilities reporting stock availability at national surveillance centre (cumulative)	3800 of health facilities reporting stock availability at national surveillance centre (cumulative)	3942 health facilities reporting stock availability at national surveillance centre (cumulative)

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Improve contracting and supply of medicines through innovative service delivery models	Number of patients enrolled for receiving medicines through the centralised chronic medicine dispensing & distribution (CCMDD) programme	200,000 patients enrolled for receiving medicines through the CCMDD programme	396 567 patients enrolled for receiving medicines through the CCMDD programme	1,100,000 patients enrolled for receiving medicines through the CCMDD programme	1,900,000 patients enrolled for receiving medicines through the CCMDD programme (cumulative)	2,500, 000 patients enrolled for receiving medicines through the CCMDD programme (cumulative)	2,800,000 patients enrolled for receiving medicines through the CCMDD programme (cumulative)	3,000,000 patients enrolled for receiving medicines through the CCMDD programme (cumulative)
Improve the use of anti-biotics in South Africa by implementing the Antimicrobial Resistance Strategy	Surveillance system implemented for monitoring resistance	Approved National antimicrobial resistance Strategy	Appointment of the Ministerial Advisory Committee	Antimicrobial stewardship guideline as identified in the antimicrobial resistance strategy developed	Surveillance system for monitoring resistance developed.	Surveillance system for monitoring resistance accessible to 3 provincial DoH	Surveillance system for monitoring resistance accessible to 6 provincial DoH	Surveillance system for monitoring resistance accessible to 9 provincial DoH
Regulate Traditional Health Practitioners in South Africa	Traditional Health Practitioners Amendment Bill drafted and published for comment	New Indicator	New Indicator	New Indicator	Traditional Health Practitioners Amendment Bill drafted	Traditional Health Practitioners Amendment Bill published for comment	Amendment Bill promulgated	NA
Regulation of the price on medicines through the transparent pricing system	Single Exit Price Adjustments Published and Implemented Annually	Implemented 2014/2015 Annual Single Exit Price Adjustment	The SEPA gazette was published for implementation of 4.8% increase on 13 January 2016.	2016/17 Annual Price Adjustments implemented	2017/18 Annual Price Adjustments gazetted and published	2018/19 Annual Price Adjustments gazetted and implemented	2019/20 Annual Price Adjustments gazetted and implemented	2020/21 Annual Price Adjustments gazetted and implemented
Improve the acceptability, quality and safety of health services by increasing user and community feedback and involvement	Number of PHC health facilities conducting Patient Experience of Care Survey	Patient Experience of care survey protocol and tool developed	Patient Experience of care survey tool tested and piloted	Patient Experience of care survey guidelines re-tabled at Tech NHC for approval	9 Provincial Health Departments trained on use of PEC Guideline	1500 PHC facilities conducting Patient Experience of care surveys annually	2000 PHC facilities conducting Patient Experience of care surveys	3000 PHC facilities conducting Patient Experience of care surveys
Implement an integrated monitoring and evaluation plan aligned to health outcomes and outputs contained in the Health Sector Strategy	NHI Phase 1 Evaluation Conducted	New Indicator	New Indicator	New Indicator	NHI Phase 1 evaluation conducted	NHI Phase 1 evaluation report published	NHI Phase 1 evaluation report disseminated and used to inform further planning for NHI	Comprehensive NHI indicator list developed

2.3. QUARTERLY TARGETS FOR 2018/19

Performance indicator	Reporting period	Annual target 2018/19	Quarterly targets			
			1st	2nd	3rd	4th
Legislation for NHI	Quarterly	Draft NHI Bill published for comments	Comments reviewed and revised draft NHI Bill submitted to Cabinet	NHI Bill approved by Cabinet	NHI Bill submitted to Parliament	Draft NHI Bill published for comments
Private Health providers contracted to expand coverage of care	Quarterly	Private health providers contracted to purchase health services on behalf of population	Service providers mapped and contracts drafted	Service providers contracted for school health services, cataract surgery, and oncology	Service providers rendering services to the population	Service providers rendering services to the population
eHealth Strategy 2019-2023 published	Quarterly	eHealth Strategy 2019-2023 published	Consultative meetings with 4/9 provinces	Consultative meetings with 5/9 provinces	Consultations held with key eHealth stakeholders	eHealth Strategy 2019-2023 Published
Number of health facilities implementing health patient registration system (HPRS)	Quarterly	3000 PHC Facilities maintained; Additional 470 PHC facilities and 22 Hospitals implementing the health patient registration system (HPRS)	3000 PHC Facilities maintained; Additional 470 PHC facilities implementing the web based patient registration system	3470 PHC facilities maintained and 7 Hospitals implementing the web based patient registration system	3470 PHC facilities maintained and 14 Hospitals implementing the web based patient registration system	3470 PHC facilities maintained and 22 Hospitals implementing the web based patient registration system
Number of individuals from the population registered on the NHI Patient Beneficiary Registry	Quarterly	35 million	17 million (cumulative)	23 million (cumulative)	31 million (cumulative)	35 million (cumulative)
Total number of health facilities reporting stock availability at national surveillance centre	Quarterly	3625 of health facilities reporting stock availability at national surveillance centre (cumulative)	3500 of health facilities reporting stock availability at national surveillance centre	3550 of health facilities reporting stock availability at national surveillance centre	3590 of health facilities reporting stock availability at national surveillance centre	3625 of health facilities reporting stock availability at national surveillance centre
Number of patients enrolled for receiving medicines through the centralised chronic medicine dispensing & distribution (CCMDD) programme	Quarterly	2,500, 000 patients enrolled for receiving medicines through the CCMDD programme (cumulative)	2,050 000 patients enrolled for receiving medicines through the CCMDD programme	2,200 000 patients enrolled for receiving medicines through the CCMDD programme	2,350 000 patients enrolled for receiving medicines through the CCMDD programme	2,500 000 patients enrolled for receiving medicines through the CCMDD programme
Surveillance system implemented for monitoring resistance	Quarterly	Surveillance system for monitoring resistance accessible to 3 provincial DoH	MoUs with NHLS and NICD drafted to access resistance surveillance data	MoUs with NHLS and NICD concluded and users registered on the surveillance system	Resistance surveillance reports produced by 3 Provincial DoH and analysed	Analysis of drug resistance (surveillance reports) presented to Ministerial Advisory Committee
Traditional Health Practitioners Amendment Bill published for comment	Quarterly	Traditional Health Practitioners Amendment Bill published for comment	Refer the draft Bill to state law advisor to obtain preliminary opinion	Consultation with state law advisor on preliminary opinion completed	Obtain Cabinet approval for publishing for public comment	Publish for public comment
Single Exit Price Adjustments Published and Implemented Annually	Annual	2018/19 Annual Price Adjustments gazetted and implemented	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Number of PHC health facilities conducting Patient Experience of Care Survey	Quarterly	1500 PHC facilities conducting Patient Experience of care surveys annually	Support for conducting the PEC survey provided to 4 Provincial DoH	Support for conducting the PEC survey provided to 9 Provincial DoH	750 PHC facilities conducting Patient Experience of care surveys annually	1500 PHC facilities conducting Patient Experience of care surveys annually (cumulative)
NHI Phase 1 Evaluation Conducted	Quarterly	NHI Phase 1 evaluation report published	Field Work and Data Collection Completed	Data Analysis completed, and Draft report produced	Final evaluation report approved	Final evaluation report disseminated

2.5 Reconciling Performance targets with the Budget and MTEF

National Health Insurance, Health Planning and Systems Enablement expenditure trends and estimates by sub-programme and economic classification

Sub programme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Programme Management	331	597	3 628	3 952	128.6%	0.3%	4 649	4 711	4 986	8.1%	0.2%
Technical Policy and Planning	9 979	14 028	18 123	97 761	114.0%	5.6%	21 377	22 411	24 103	-37.3%	2.1%
Health Information Management, Monitoring and Evaluation	51 800	57 421	81 632	67 133	9.0%	10.3%	62 048	65 066	68 640	0.7%	3.3%
Sector-Wide Procurement	24 347	26 282	26 567	139 445	78.9%	8.6%	46 279	46 839	49 239	-29.3%	3.5%
Health Financing and National Health Insurance	177 446	367 663	476 785	546 709	45.5%	62.6%	1 451 193	2 151 160	2 839 828	73.2%	86.6%
International Health and Development	74 296	87 062	72 435	79 687	2.4%	12.5%	86 007	90 124	94 869	6.0%	4.3%
Total	**338 199**	**553 053**	**679 170**	**934 687**	**40.3%**	**100.0%**	**1 671 553**	**2 380 311**	**3 081 665**	**48.8%**	**100.0%**
Change to 2017 Budget estimate				199 600			678 731	1 332 960	1 974 008		
Economic classification											
Current payments	**233 458**	**467 496**	**558 188**	**822 445**	**52.2%**	**83.1%**	**1 462 027**	**2 243 112**	**2 941 091**	**52.9%**	**92.6%**
Compensation of employees	91 491	98 433	109 525	114 740	7.8%	16.5%	116 693	124 255	131 216	4.6%	6.0%
Goods and services[1]	141 967	369 063	448 663	707 705	70.8%	66.6%	1 345 334	2 118 857	2 809 875	58.3%	86.5%
of which:											
Minor assets	*111*	*220*	*176*	*503*	*65.5%*	*–*	*9 724*	*12 252*	*14 794*	*208.7%*	*0.5%*
Consultants: Business and advisory services	*9 698*	*12 564*	*33 783*	*14 129*	*13.4%*	*2.8%*	*291 355*	*1 098 918*	*1 708 998*	*394.5%*	*38.6%*
Contractors	*75 735*	*278 074*	*357 963*	*524 251*	*90.6%*	*49.3%*	*658 500*	*711 712*	*767 175*	*13.5%*	*33.0%*
Agency and support/outsourced services	*239*	*6 536*	*–*	*84 680*	*607.6%*	*3.7%*	*287 646*	*187 023*	*199 244*	*33.0%*	*9.4%*
Travel and subsistence	*24 925*	*28 260*	*21 869*	*20 625*	*-6.1%*	*3.8%*	*23 675*	*29 852*	*32 860*	*16.8%*	*1.3%*
Operating payments	*24 054*	*31 634*	*25 926*	*33 828*	*12.0%*	*4.6%*	*43 500*	*44 408*	*47 269*	*11.8%*	*2.1%*
Transfers and subsidies[1]	**103 745**	**84 667**	**119 878**	**28 716**	**-34.8%**	**13.5%**	**30 048**	**31 731**	**33 476**	**5.2%**	**1.5%**
Provinces and municipalities	76 956	61 077	94 227	–	-100.0%	9.3%	–	–	–	–	–
Non-profit institutions	26 537	23 470	25 364	28 401	2.3%	4.1%	30 048	31 731	33 476	5.6%	1.5%
Households	252	120	287	315	7.7%	–	–	–	–	-100.0%	–
Payments for capital assets	**940**	**828**	**1 080**	**83 526**	**346.2%**	**3.4%**	**179 478**	**105 468**	**107 098**	**8.6%**	**5.9%**
Machinery and equipment	765	828	1 080	78 526	368.2%	3.2%	179 478	105 468	107 098	10.9%	5.8%
Software and other intangible assets	175	–	–	5 000	205.7%	0.2%	–	–	–	-100.0%	0.1%
Payments for financial assets	**56**	**62**	**24**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Total	**338 199**	**553 053**	**679 170**	**934 687**	**40.3%**	**100.0%**	**1 671 553**	**2 380 311**	**3 081 665**	**48.8%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**1.0%**	**1.5%**	**1.8%**	**2.2%**	**–**	**–**	**3.5%**	**4.6%**	**5.5%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits											
Current	**252**	**68**	**287**	**315**	**7.7%**	**–**	**–**	**–**	**–**	**-100.0%**	**–**
Employee social benefits	252	68	287	315	7.7%	–	–	–	–	-100.0%	–
Non-profit institutions											
Current	**26 537**	**23 470**	**25 364**	**28 401**	**2.3%**	**4.1%**	**30 048**	**31 731**	**33 476**	**5.6%**	**1.5%**
Wits University Foundation	–	–	650	–	–	–	–	–	–	–	–
Non-profit institutions	13 670	–	–	–	-100.0%	0.5%	–	–	–	–	–
Health information systems programme	–	12 103	12 745	13 382	–	1.5%	14 158	14 951	15 773	5.6%	0.7%
Health Systems Trust	12 867	11 367	11 969	15 019	5.3%	2.0%	15 890	16 780	17 703	5.6%	0.8%
Households											
Other transfers to households											
Current	**–**	**52**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Other transferes to households	–	52	–	–	–	–	–	–	–	–	–
Provinces and municipalities											
Provinces											
Provincial revenue funds											
Current	**76 956**	**61 077**	**94 227**	**–**	**-100.0%**	**9.3%**	**–**	**–**	**–**	**–**	**–**
National health insurance grant	76 956	61 077	94 227	–	-100.0%	9.3%	–	–	–	–	–

2.5 Personnel information

National Health Insurance, Health Planning and Systems Enablement personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2018		Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Average: Salary level/Total (%)
			2016/17			2017/18			2018/19			2019/20			2020/21			2017/18 - 2020/21	
National Health Insurance, Health Planning and Systems Enablement			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**159**	–	**153**	**109.5**	**0.7**	**153**	**114.7**	**0.7**	**152**	**116.7**	**0.8**	**150**	**124.3**	**0.8**	**148**	**131.2**	**0.9**	**-1.1%**	**100.0%**
1 – 6	35	–	35	10.3	0.3	35	10.8	0.3	35	11.2	0.3	34	11.8	0.3	33	12.3	0.4	-1.9%	22.7%
7 – 10	67	–	67	38.1	0.6	67	39.8	0.6	66	40.9	0.6	66	44.5	0.7	65	47.1	0.7	-1.0%	43.8%
11 – 12	32	–	31	30.9	1.0	31	32.8	1.1	31	33.1	1.1	30	34.4	1.1	30	36.6	1.2	-1.1%	20.2%
13 – 16	25	–	20	30.2	1.5	20	31.4	1.6	20	31.5	1.6	20	33.5	1.7	20	35.3	1.8	–	13.3%

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

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

3.1 Programme Purpose

The programme, through its sub-programmes (described below), develops and supports the implementation of national policies, guidelines, norms and standards, and achievement of targets for the national response needed to decrease morbidity and mortality associated with the burden of HIV and Tuberculosis epidemics and poor health of children, adolescents and women.

The **Women, Maternal, Neonatal and Reproductive Health** sub-programme supports provinces to implement of key to improve women, maternal, neonatal and reproductive health outcomes. It serves as the secretariat to the NCCEMD and NaPeMCO Ministerial Committees.

The focus areas to decrease maternal and neonatal death includes strengthening of BANC plus which increased the number of ANC visits from four to eight which should reduce maternal mortality due to hypertension. The sub-programme will also introduce the use of the anti-shock garment as well as strengthen the quality of caesarean section services which should both contribute to the reduction of mortality due to obstetric haemorrhage.. The focus on improving health care professionals' skills and knowledge will include strengthening of postpartum and post abortion contraceptive services, cervical cancer screening and clinical breast examinations.

Child, Youth and School Health sub-programme supports provincial units responsible for implementation of policies and guidelines. The sub-programme shall focus on recommendations made by the Ministerial Committee on morbidity and mortality in children as follows: (a) reducing under five mortality by focusing on the major causes of childhood mortality; (b) increasing the number of HIV+ children on treatment; (c) strengthening the EPI programme (d) strengthening youth health services, including ensuring that health services are youth friendly; and (e) strengthening school health services.

HIV and AIDS sub-programme manages and provides oversight on the conditional grant that now supports both HIV&AIDS and TB interventions. The sub-programme has made scored significant successes including the reduction of mother-to-child HIV transmission, which has resulted in lower maternal and 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 HIV infections; and retaining those on treatment over time.

TB Control and Management sub-programme is responsible for coordination and management of the national response to the TB epidemic that incorporates strategies needed to prevent, diagnose and treat both drug sensitive TB (DS-TB) and drug resistant TB (DR-TB). The sub-programme also monitors the implementation of the National Strategic Plan on HIV, STIs and TB and supports the strategic objectives decided by the World Health Organisation (WHO) and the United Nation's Sustainable Development Goals (SDS) to end TB.

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3.2 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
To implement combination of prevention and treatment interventions to reduce burden of HIV, STI and TB infections	Total number of clients remaining on ART (TROA)	3 103 902	3 407 336	3 831 730	4 200 000	5 000 000	5 800 000	6 100 000
	Number of people reached in the National Health Screening and Testing campaign annually	New Indicator	New Indicator	New Indicator	New Indicator	14 000 000	14 000 000	14 000 000
	Medical Male Circumcisions performed	508 404	465 526	413 880	500 000	600 000	550 000	500 000
	Number of undiagnosed TB infected persons (new cases) found	New Indicator	New Indicator	New Indicator	New Indicator	80 000	110 000	120 000
To reduce under 5 mortality rate to less than 33 per 1 000 live births	EPI coverage survey conducted	New Indicator	New Indicator	New Indicator	EPI coverage survey protocol developed.	Survey protocol developed and field work completed	Survey report completed and used to strengthen EPI programme	Targeted Interventions identified and implemented to strengthen EPI Programme
	EPI surveillance and coverage external review recommendations implemented	New Indicator	New Indicator	New Indicator	New Indicator	Implementation plans developed in partnership with Provincial DoH;and Three (3) pro-vincial trainings conducted	Six (6) provincial trainings conducted	Implementation plans monitored

3.3 QUARTERLY TARGETS FOR PROGRAMME PERFORMANCE INDICATORS

Performance indicator	Reporting period	Annual target 2018/19	Quarterly targets			
			1st	2nd	3rd	4th
Total number of clients remaining on ART (TROA)	Quarterly	5 000 000	4 400 000 (cumulative)	4 600 000 (cumulative)	4 800 000 (cumulative)	5 000 000 (cumulative)
Number of people reached in the National Health Screening and Testing campaign annually	Quarterly	14 000 000	3 000 000	4 000 000	3 000 000	4 000 000
Medical Male Circumcisions performed	Quarterly	600 000	150,000	250,000	100,000	100,000
Number of undiagnosed TB infected persons (new cases) found	Quarterly	80 000	15 000	60 000 (cumulative)	70 000 (cumulative)	80 000 (cumulative)
EPI coverage survey conducted	Quarterly	Survey protocol developed and field work completed	Protocol Developed	Preparations for fieldwork completed	Fieldwork initiated	Fieldwork completed
EPI surveillance and coverage external review recommendations implemented	Quarterly	Implementation plans developed in partnership with Provincial DoH; and Three (3) provincial trainings conducted	Implementation plan drafted	Implementation plans approved	one provincial training conducted	two provincial trainings conducted

3.4 RECONCILING PERFORMANCE TARGETS WITH THE BUDGETS AND THE MTEF

HIV and AIDS, Tuberculosis, and Maternal and Child Health expenditure trends and estimates by sub-programme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Programme Management	4 225	5 388	4 446	6 458	15.2%	–	5 409	5 480	5 848	-3.3%	–
HIV and AIDS	12 572 819	13 962 474	15 712 480	18 024 381	12.8%	98.4%	20 441 530	22 582 308	25 008 240	11.5%	98.7%
Tuberculosis	21 783	20 094	24 326	26 298	6.5%	0.2%	27 240	27 708	30 619	5.2%	0.1%
Women's Maternal and Reproductive Health	12 422	13 717	11 569	18 190	13.6%	0.1%	19 907	20 259	22 329	7.1%	0.1%
Child, Youth and School Health	207 447	177 328	212 361	222 451	2.4%	1.3%	224 971	237 558	250 625	4.1%	1.1%
Total	**12 818 696**	**14 179 001**	**15 965 182**	**18 297 778**	**12.6%**	**100.0%**	**20 719 057**	**22 873 313**	**25 317 661**	**11.4%**	**100.0%**
Change to 2017 Budget estimate				19 434			(26 538)	(36 118)	(40 989)		
Economic classification											
Current payments	**515 858**	**358 495**	**508 243**	**523 685**	**0.5%**	**3.1%**	**417 155**	**433 035**	**455 837**	**-4.5%**	**2.1%**
Compensation of employees	65 285	71 345	75 573	79 420	6.8%	0.5%	84 413	89 621	94 580	6.0%	0.4%
Goods and services[1]	450 573	287 150	432 670	444 265	-0.5%	2.6%	332 742	343 414	361 257	-6.7%	1.7%
of which:											
Consultants: Business and advisory services	*10 901*	*19 647*	*69 169*	*88 936*	*101.3%*	*0.3%*	*94 723*	*97 428*	*102 771*	*4.9%*	*0.4%*
Fleet services (including government motor transport)	*11 418*	*34 036*	*22 787*	*11 577*	*0.5%*	*0.1%*	*11 137*	*11 861*	*12 508*	*2.6%*	*0.1%*
Inventory: Medical supplies	*209 221*	*76 540*	*131 352*	*118 909*	*-17.2%*	*0.9%*	*145 801*	*150 994*	*155 871*	*9.4%*	*0.7%*
Consumables: Stationery, printing and office supplies	*2 447*	*2 744*	*5 467*	*9 300*	*56.1%*	–	*15 117*	*16 163*	*17 341*	*23.1%*	*0.1%*
Travel and subsistence	*11 892*	*15 120*	*18 395*	*15 279*	*8.7%*	*0.1%*	*16 671*	*16 680*	*17 639*	*4.9%*	*0.1%*
Operating payments	*9 657*	*9 098*	*30 787*	*(8 791)*	*-196.9%*	*0.1%*	*17 975*	*18 065*	*19 502*	*-230.4%*	*0.1%*

HIV and AIDS, Tuberculosis, and Maternal and Child Health expenditure trends and estimates by subprogramme and economic classification

R thousand	Audited outcome 2014/15	2015/16	2016/17	Adjusted appropriation 2017/18	Average growth rate (%) 2014/15 - 2017/18	Average: Expen-diture/ Total (%) 2014/15 - 2017/18	Medium-term expenditure estimate 2018/19	2019/20	2020/21	Average growth rate (%) 2017/18 - 2020/21	Average: Expen-diture/ Total (%) 2017/18 - 2020/21
Transfers and subsidies[1]	**12 301 747**	**13 819 482**	**15 456 399**	**17 757 821**	13.0%	96.9%	**20 301 535**	**22 440 034**	**24 861 567**	11.9%	97.9%
Provinces and municipalities	12 102 108	13 670 730	15 290 603	17 577 737	13.2%	95.7%	20 121 697	22 250 195	24 661 287	11.9%	97.0%
Departmental agencies and accounts	15 000	19 340	16 711	17 547	5.4%	0.1%	17 108	18 066	19 059	2.8%	0.1%
Foreign governments and international organisations	–	–	14 370	–	–	–	–	–	–	–	–
Non-profit institutions	184 346	128 702	134 665	162 376	-4.1%	1.0%	162 730	171 773	181 221	3.7%	0.8%
Households	293	710	50	161	-18.1%	–	–	–	–	-100.0%	–
Payments for capital assets	**531**	**799**	**498**	**16 267**	212.9%	–	**367**	**244**	**257**	-74.9%	–
Machinery and equipment	531	799	498	16 267	212.9%	–	367	244	257	-74.9%	–
Payments for financial assets	**560**	**225**	**42**	**5**	-79.3%	–	–	–	–	-100.0%	–
Total	**12 818 696**	**14 179 001**	**15 965 182**	**18 297 778**	12.6%	100.0%	**20 719 057**	**22 873 313**	**25 317 661**	11.4%	100.0%
Proportion of total programme expenditure to vote expenditure	**38.2%**	**39.4%**	**41.5%**	**42.9%**	–	–	**43.9%**	**44.5%**	**45.0%**	–	–
Details of transfers and subsidies											
Households											
Social benefits											
Current	**293**	**710**	**50**	**161**	-18.1%	–	–	–	–	-100.0%	–
Employee social benefits	293	710	50	161	-18.1%	–	–	–	–	-100.0%	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**15 000**	**19 340**	**16 711**	**17 547**	5.4%	0.1%	**17 108**	**18 066**	**19 059**	2.8%	0.1%
South African National AIDS Council	15 000	19 340	16 711	17 547	5.4%	0.1%	17 108	18 066	19 059	2.8%	0.1%
Non-profit institutions											
Current	**184 346**	**128 702**	**134 665**	**162 376**	-4.1%	1.0%	**162 730**	**171 773**	**181 221**	3.7%	0.8%
Non-governmental organisations: Lifeline	19 023	19 898	20 953	22 000	5.0%	0.1%	23 276	24 579	25 931	5.6%	0.1%
Non-governmental organisations: loveLife	69 843	54 396	57 808	61 200	-4.3%	0.4%	64 750	68 376	72 137	5.6%	0.3%
Non-governmental organisations: Soul City	15 561	16 277	14 465	19 226	7.3%	0.1%	20 270	21 336	22 509	5.4%	0.1%
Non-governmental organisations: HIV and AIDS	79 919	38 131	41 439	51 450	-13.7%	0.3%	54 434	57 482	60 644	5.6%	0.3%
Public Universities South Africa	–	–	–	8 500	–	–	–	–	–	-100.0%	–
Foreign governments and international organisations											
Current	–	–	**14 370**	–	–	–	–	–	–	–	–
International AIDS Society	–	–	14 370	–	–	–	–	–	–	–	–

3.5 Personnel information

HIV and AIDS, Tuberculosis, and Maternal and Child Health personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2018: Number of funded posts	Number of posts additional to the establishment	Number and cost[2] of personnel posts filled / planned for on funded establishment: Actual 2016/17 Number	Cost	Unit cost	Revised estimate 2017/18 Number	Cost	Unit cost	Medium-term expenditure estimate 2018/19 Number	Cost	Unit cost	2019/20 Number	Cost	Unit cost	2020/21 Number	Cost	Unit cost	Number: Average growth rate (%) 2017/18 - 2020/21	Average: Salary level/Total (%) 2017/18 - 2020/21
HIV and AIDS, Tuberculosis, and Maternal and Child Health																			
Salary level	**120**	–	**124**	**75.6**	**0.6**	**124**	**79.4**	**0.6**	**121**	**84.4**	**0.7**	**121**	**89.6**	**0.7**	**118**	**94.6**	**0.8**	**-1.6%**	**100.0%**
1 – 6	19	–	19	5.3	0.3	19	5.5	0.3	19	6.1	0.3	19	6.5	0.3	19	7.1	0.4	–	15.7%
7 – 10	63	–	64	34.0	0.5	64	35.6	0.6	62	38.2	0.6	62	40.8	0.7	60	43.3	0.7	-2.1%	51.2%
11 – 12	23	–	25	21.0	0.8	25	22.4	0.9	24	23.1	1.0	24	24.4	1.0	24	26.4	1.1	-1.4%	20.0%
13 – 16	15	–	16	15.3	1.0	16	16.0	1.0	16	17.0	1.1	16	17.9	1.1	15	17.9	1.2	-2.1%	13.0%

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

2. Rand million.

PROGRAMME 4: PRIMARY HEALTH CARE SERVICES (PHC)

4.1 Programme Purpose

Develop and oversee the implementation of legislation, policies, systems, and norms and standards for a uniform well functioning district health system, environmental health services, communicable disease control, non-communicable disease control as well as health promotion and nutrition.

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 organisation and delivery of services within the DHS. The health system needs functional district health management offices to 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 indicator targets. 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 organisations to ensure that weaknesses within the DHS are addressed.

Environmental and Port Health services sub-programme is responsible for strengthening the provision of environmental and port health services in the country and to ensure rendering of the service is in line with the National Environmental Health Policy and the Norms and Standards for Environmental Health. Municipal Health Services are delivered by district and metropolitan municipalities but the Department of Health must continue to provide oversight and support through policy development, support and implementation monitoring. Going forward, the sub-program will also strengthen the provision of Port Health Services as required by the International Health Regulations of 2005, by controlling and monitoring trans-boundary movement of goods and people in order to prevent importation of communicable diseases and any events of international concern into the country.

Health Promotion, Nutrition and Oral Health sub-programme's main focus is to develop and oversee the implementation of legislation, policies, systems, and norms and standards. The Health Promotion component of this sub-programme will implement the approved health promotion strategy to reduce risk factors for disease. The nutrition sub-programme will focus on the health related causes of under-nutrition, over-nutrition and micronutrient deficiencies using a multi-sectoral, multi-dimensional and life-course approach. Oral Health services will work towards expanding access to services at PHC level and in schools.

Non-Communicable Disease Control sub-programme provides direction with regard to various non-communicable diseases as well as mental health, forensic mental health, rehabilitation and eye health services. With a large global and national increase in the prevalence of Non-Communicable Diseases (NCDs) the Department will strengthen implementation of a continuum of Care starting with primary prevention, screening, early detection, treatment and control at all levels of care. Effective palliative care is also an important component of this sub-programme. This includes the development of guidelines and strategies for non-communicable diseases as well as the management of disabilities and the establishment and strengthening of rehabilitation services.

Communicable Disease Control sub-programme addresses major causes of morbidity and mortality related to communicable diseases. This sub-programme will focus on strengthening disease detection through improved surveillance, strengthening preparedness and core response capacities for public health emergencies in line with International Health Regulations. This sub-programme also facilitates the implementation of Influenza prevention and control, Neglected Tropical Disease prevention and control programmes as well as the Malaria Elimination Programme.

4.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS

This section provides key strategic objectives, indicators and three-year targets for the various budget sub-programmes funded from the Primary Health Care Services (PHC) Programme of NDoH.

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Eliminate Malaria in South Africa	The National Malaria elimination Strategic Plan for South Africa Published	New Indicator	New Indicator	New Indicator	New Indicator	Malaria Elimination Strategic Plan for South Africa published	M&E report produced on the key indicators for Malaria Elimination	M&E report produced on the key indicators for Malaria Elimination
Implement the International Health Regulations Joint External Evaluation recommendations	Joint External Evaluation (JEE) Recommendations implemented	New Indicator	New Indicator	New Indicator	Joint External Evaluation on International Health Regulations conducted	Work plan for JEE recommendations developed	JEE recommendation implemented	All JEE recommendation implemented
Strengthen district governance and improve management and leadership of the district health system	Number of Districts compliant with the minimum requirements of the District Health Management Office structure guidelines	WISN process and normative guidelines for PHC facilities have been completed.	The draft District Health Management Office structure and job profiles finalised.	Guidelines for uniform structure for District Health Management developed	National Guidelines for District Health Management Structures approved	Plans developed for 10 districts structures to meet the minimum requirements of the guidelines	Plans developed for 30 districts structures to meet the minimum requirements of the guidelines	Plans developed for 52 districts structures to meet the minimum requirements of the guidelines
	Number of PHC facility committees assessed to determine functionality	Implementation plan approved and Monitoring and evaluation system developed	1588 PHC facility committees assessed to determine its functionality.	3211PHC facility committees assessed to determine its functionality	3400 PHC facility committees assessed to determine its functionality	3400 PHC facility committees assessed to determine its functionality; Report on findings with recommendations completed	3400 PHC facility committees assessed to determine its functionality; Report on findings with recommendations completed	3400 PHC facility committees assessed to determine its functionality; Report on findings with recommendations completed
Improve quality of services at primary health care facilities through the Ideal Clinic Initiative	Number of primary health Care facilities in the 52 districts that qualify as Ideal Clinics	New Indicator	322 facilities qualifying as Ideal clinics.	Additional 786 primary health Care facilities in the 52 districts qualify as Ideal Clinics	1000 primary health Care facilities in the 52 districts qualify as Ideal Clinics	1400 primary health Care facilities in the 52 districts qualify as Ideal Clinics	1800 primary health care facilities in the 52 districts qualify as Ideal Clinics	2500 primary health care facilities in the 52 districts qualify as Ideal Clinics
Improve accessibility of Primary Health Services to people with disabilities	Proportion of PHC facilities accessible to people with disabilities	New Indicator	New Indicator	New Indicator	34% of PHC facilities accessible to people with disabilities	40% of 3400 PHC facilities accessible to people with disabilities	50% of 3400 of PHC facilities accessible to people with disabilities	60% of 3400 of PHC facilities accessible to people with disabilities
Improve quality of services at District Hospitals through the Ideal District Hospitals Programme	Ideal District Hospital Framework implemented	New Indicator	New Indicator	New Indicator	Ideal District hospital framework drafted and presented to NDHSC	Status of all district hospitals determined against the Ideal District hospital framework version 1	80% of district hospitals score at least 60% against the Ideal District hospital framework	80% of district hospitals score at least 70% against the Ideal District hospital framework

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Improve environmental health services in all 52 districts and metropolitan municipalities in the country	Number of public health facilities assessed for adherence to Health Care Risk Waste (HCRW) Norms and Standards	Health Care Risk waste management regulations finalised.	Health care risk waste regulations finalised and tools for audit implementation developed	9 Provincial Implementation Plans developed	50 public health facilities assessed for adherence to Health Care Risk Waste (HCRW) Norms and Standards	78 Major Health Care Risk Waste (HCRW) generating public health facilities (hospitals that generate more than 25kg per day) assessed for adherence to HCRW Norms and Standards	78 Major Health Care Risk Waste (HCRW) generating public health facilities (hospitals that generate more than 25kg per day) assessed for adherence to HCRW Norms and Standards	78 Major Health Care Risk Waste (HCRW) generating public health facilities (hospitals that generate more than 25kg per day) assessed for adherence to HCRW Norms and Standards
	Number of municipalities that are randomly selected and audited against environmental health norms and standards in executing their environmental health functions	Environmental Health strategy developed	20 Municipalities met environmental health norms and standards in executing their environmental health functions.	35 municipalities are randomly selected and audited against environmental health norms and standards in executing their environmental health functions	20 municipalities are randomly selected and audited against environmental health norms and standards in executing their environmental health functions	21 municipalities randomly selected and audited against environmental health norms and standards	Municipalities that achieved less than 65% compliance during 2018/19 audited against environmental health norms and standards	Municipalities that achieved less than 65% compliance during 2020/21 audited against environmental health norms and standards
Strengthen district mental health services	Number of Districts with Mental Health Teams established	New Indicator	Strategy for establishment of specialist mental health teams was approved by TECH-NHC	8 District mental health teams established	10 District mental health teams established	15 District mental health teams established	20 District mental health teams established	25 District mental health teams established
Expand provision of rehabilitation services, and accessibility of Primary Health Services to people with physical disabilities	Number of multi-disciplinary rehabilitation teams (physiotherapist, optometrist, audiologist, occupational therapist) established	New Indicator	New Indicator	New Indicator	Survey conducted to determine the number of Districts with an multi-disciplinary rehabilitation team	2 multi-disciplinary rehabilitation teams established	5 multi-disciplinary rehabilitation teams established	9 multi-disciplinary rehabilitation teams established

4.3 QUARTERLY TARGETS FOR STRATEGIC OBJECTIVE INDICATORS

4.4 RECONCILING THE PERFORMANCE TARGETS FOR THE BUDGET AND MTEF

Primary Health Care Services expenditure trends and estimates by subprogramme and economic classification

Sub-programme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Programme Management	2 834	3 245	3 336	3 136	3.4%	1.4%	3 976	4 157	4 465	12.5%	1.2%
District Health Services	25 790	9 784	19 550	46 266	21.5%	11.2%	10 606	11 242	11 689	-36.8%	5.9%
Communicable Diseases	23 366	21 133	17 589	21 723	-2.4%	9.2%	22 727	24 048	25 390	5.3%	6.9%
Non-Communicable Diseases	25 282	20 562	19 425	22 491	-3.8%	9.7%	74 183	125 682	177 134	99.0%	29.3%
Health Promotion and Nutrition	18 353	22 107	19 135	26 256	12.7%	9.4%	24 682	25 770	27 651	1.7%	7.7%
Environmental and Port Health Services	110 697	135 740	146 696	144 027	9.2%	59.1%	165 562	175 719	185 110	8.7%	49.2%
Total	**206 322**	**212 571**	**225 731**	**263 899**	**8.6%**	**100.0%**	**301 736**	**366 618**	**431 439**	**17.8%**	**100.0%**
Change to 2017 Budget estimate				(400)			8 647	51 547	94 675		
Economic classification											
Current payments	**195 103**	**207 024**	**221 809**	**255 618**	**9.4%**	**96.8%**	**298 386**	**363 084**	**427 667**	**18.7%**	**98.6%**
Compensation of employees	151 285	167 726	177 860	185 583	7.0%	75.1%	209 054	220 937	233 187	7.9%	62.2%
Goods and services[1]	43 818	39 298	43 949	70 035	16.9%	21.7%	89 332	142 147	194 480	40.6%	36.4%
of which:											
Contractors	*312*	*301*	*293*	*179*	*-16.9%*	*0.1%*	*25 200*	*50 312*	*75 240*	*649.1%*	*11.1%*
Agency and support/outsourced services	*–*	*–*	*–*	*1 000*	*–*	*0.1%*	*25 758*	*50 366*	*75 408*	*322.5%*	*11.2%*
Fleet services (including government motor transport)	*1 283*	*10 623*	*13 566*	*8 343*	*86.7%*	*3.7%*	*7 571*	*7 301*	*7 707*	*-2.6%*	*2.3%*
Travel and subsistence	*7 325*	*9 879*	*12 116*	*13 082*	*21.3%*	*4.7%*	*8 892*	*10 038*	*9 162*	*-11.2%*	*3.0%*
Operating payments	*10 182*	*2 115*	*2 977*	*4 900*	*-21.6%*	*2.2%*	*4 679*	*5 201*	*4 432*	*-3.3%*	*1.4%*
Venues and facilities	*1 307*	*3 238*	*5 129*	*1 973*	*14.7%*	*1.3%*	*2 524*	*3 149*	*2 561*	*9.1%*	*0.7%*

Primary Health Care Services expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Transfers and subsidies[1]	**7 169**	**3 417**	**2 894**	**3 015**	**-25.1%**	**1.8%**	**3 131**	**3 307**	**3 490**	**5.0%**	**0.9%**
Foreign governments and international organisations	2 622	–	–	–	-100.0%	0.3%	–	–	–	–	–
Non-profit institutions	4 400	2 901	1 641	2 960	-12.4%	1.3%	3 131	3 307	3 490	5.6%	0.9%
Households	147	516	1 253	55	-27.9%	0.2%	–	–	–	-100.0%	–
Payments for capital assets	**4 015**	**2 098**	**1 000**	**5 255**	**9.4%**	**1.4%**	**219**	**227**	**282**	**-62.3%**	**0.4%**
Machinery and equipment	4 015	2 098	1 000	5 255	9.4%	1.4%	219	227	282	-62.3%	0.4%
Payments for financial assets	**35**	**32**	**28**	**11**	**-32.0%**	**–**	**–**	**–**	**–**	**-100.0%**	**–**
Total	**206 322**	**212 571**	**225 731**	**263 899**	**8.6%**	**100.0%**	**301 736**	**366 618**	**431 439**	**17.8%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**0.6%**	**0.6%**	**0.6%**	**0.6%**	**–**	**–**	**0.6%**	**0.7%**	**0.8%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits											
Current	**47**	**516**	**1 253**	**55**	**5.4%**	**0.2%**	**–**	**–**	**–**	**-100.0%**	**–**
Employee social benefits	47	516	1 253	55	5.4%	0.2%	–	–	–	-100.0%	–
Non-profit institutions											
Current	**4 400**	**2 901**	**1 641**	**2 960**	**-12.4%**	**1.3%**	**3 131**	**3 307**	**3 490**	**5.6%**	**0.9%**
South African Medical Research Council	512	471	496	520	0.5%	0.2%	550	581	613	5.6%	0.2%
South African Federation for Mental Health	320	335	353	371	5.1%	0.2%	393	415	438	5.7%	0.1%
South African National Council for the Blind	718	752	792	832	5.0%	0.3%	880	929	980	5.6%	0.3%
Non-governmental organisations: Mental health	82	–	–	–	-100.0%	–	–	–	–	–	–
National Council Against Smoking	768	803	–	887	4.9%	0.3%	938	991	1 046	5.6%	0.3%
National Kidney Foundation of South Africa	–	350	–	350	–	0.1%	370	391	413	5.7%	0.1%
Health Systems Global: South Africa	2 000	–	–	–	-100.0%	0.2%	–	–	–	–	–
Mental Health and Substance Abuse	–	190	–	–	–	–	–	–	–	–	–
Households											
Other transfers to households											
Current	**100**	**–**	**–**	**–**	**-100.0%**	**–**	**–**	**–**	**–**	**–**	**–**
Donation for conference on paediatric cardiology and cardiac surgery	100	–	–	–	-100.0%	–	–	–	–	–	–
Foreign governments and international organisations											
Current	**2 622**	**–**	**–**	**–**	**-100.0%**	**0.3%**	**–**	**–**	**–**	**–**	**–**
World Health Organisation	2 622	–	–	–	-100.0%	0.3%	–	–	–	–	–

Primary Health Care Services personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2018		Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Average: Salary level/Total (%)
			2016/17			2017/18			2018/19			2019/20			2020/21			2017/18 - 2020/21	
Primary Health Care Services			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**410**	**–**	**414**	**177.9**	**0.4**	**414**	**185.6**	**0.4**	**413**	**209.1**	**0.5**	**410**	**220.9**	**0.5**	**409**	**233.2**	**0.6**	**-0.4%**	**100.0%**
1 – 6	93	–	94	19.2	0.2	94	20.1	0.2	94	22.9	0.2	94	24.5	0.3	94	26.0	0.3	–	22.8%
7 – 10	274	–	277	121.4	0.4	277	126.6	0.5	276	143.3	0.5	274	152.1	0.6	273	160.7	0.6	-0.5%	66.8%
11 – 12	27	–	27	21.1	0.8	27	22.3	0.8	27	24.7	0.9	26	25.2	1.0	26	26.6	1.0	-1.3%	6.4%
13 – 16	16	–	16	16.2	1.0	16	16.7	1.0	16	18.2	1.1	16	19.1	1.2	16	19.9	1.2	–	3.9%

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

2. Rand million.

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

5.1 Programme Purpose

The purpose of the programme is to develop policies, delivery models and clinical protocols for hospitals and emergency medical services. It is also to ensure alignment of academic medical centres with health workforce programmes, training of health professionals and to ensure the planning of health infrastructure meet the health needs of the country. This programme will also assist the government to achieve the population health goals of the country through nursing and midwifery, by the provision of expert policy and technical advice and recommendations on the role of nurses in attainment of desired health outputs.

Hospitals And Tertiary Health Services is responsible for tertiary services planning, policies that guides the management of and service standards in hospitals as well as to ensure the production of appropriate numbers, staff mix and appropriately qualified health professionals

Trauma, Violence and EMS is responsible for improving the governance, management and functioning of Emergency Medical Services (EMS) in the 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, EMS must have in place comprehensive enabling legislation which governs the provision of EMS. The key components of this legislation include authority for national coordination, standardised treatment, transport, communication and evaluation, including licensing of ambulances and designation of emergency care centres. The Cluster has developed National Regulations governing the provision of EMS and these were promulgated in December 2017.

Forensic Chemistry Laboratory sub-programme is responsible for ensuring the effective and efficient rendering of Forensic Chemistry Laboratory services in instances of unnatural deaths (toxicology analysis) and drunken driving matters (ante-mortem and post-mortem blood alcohol analysis) to support the Criminal Justice System. They are also responsible for food testing in terms of the Foodstuffs Act. The ultimate goal is to reduce the burden of disease and unnatural causes of death. The Cluster is also responsible for policies that guide the management of and service standards of Forensic Pathology Services.

Nursing Services sub-programme is responsible to develop and monitor policies, guidelines, norms, standards and practice models to ensure that the nursing and midwifery workforce are competent and responsive to the burden of disease and population health needs. During the coming MTEF period, key initiatives by the sub-programme will be implemented in line with the recommendations of the National Strategic Plan for Nurse Education Training and Practice by coordinating the three cores areas of nursing including education, stakeholder engagement and practice.

Health Facilities Infrastructure Planning 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, the infrastructure component of the national health grant. These Grants are funding Infrastructure projects ranging from New and Replaced facilities; Upgrades and Additions; Refurbishment, Rehabilitation and Renovations; to Maintenance and Repairs. The Infrastructure Unit also provide guidance on the common objective of optimising the acquisition and management of South Africa's public health Care infrastructure through the infrastructure lifecycle through the establishment of 46 new national norms, standards, guidelines and performance benchmarks for health infrastructure that were developed and implemented. In addition, further system development and configuration was done on the project management information system which primary function is to provide a centralised database of all current health related capital cost project work in the country to enable effective infrastructure programme review and management.

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

5.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Strengthen local decision making and accountability of central hospitals to facilitate semi-autonomy	Number of central hospital organisational structures aligned with Guidelines on Organisational Structures for Central Hospitals	New Indicator	An assessment on the current capacity of the central hospital was conducted. Draft organisational structure for central hospitals presented at NHC for approval	Organisational structure for Central Hospitals developed and submitted to NHC for approval	Draft Guidelines on Organisational Structures for Central Hospitals Developed	Guidelines on Organisational Structures for Central Hospitals approved by TechNHC	Costed implementation plans for improvement of 10 Central hospitals organisational structures completed	Implementation plans monitored
Ensure quality health Care by improving compliance with National Core Standards at all Central, Tertiary, Regional and Specialised Hospitals	Number of Hospitals that achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	1/10 targeted Central hospital fully complied with the National Core Standards namely: Steve Biko at 96%.	2 hospitals obtained overall scores of 91% and 80% but did not meet 100% compliance on extreme measures and more than 90% compliance on vital measures.	18 Hospitals (3 Central 8 Tertiary, 11 Regional)	43 Hospitals (8 Central, 15 Tertiary, 20Regional Hospitals)	10 Central Hospitals achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	50% of Hospitals assessed, and achieved an overall performance of 75% (or more) compliance with NCS	70% of Hospitals assessed, and achieved an overall performance of 75% (or more) compliance with NCS
	Oncology services improvement plan developed	New Indicator	New Indicator	New Indicator	New Indicator	Oncology service improvement plan developed for public hospitals	Implementation monitored	Implementation monitored
	Obstetric services improvement plans developed	New Indicator	New Indicator	New Indicator	New Indicator	Obstetric service improvement plan developed for public hospitals	Implementation monitored	Implementation monitored
Ensure access to and efficient effective delivery of quality Emergency Medical Services (EMS) Ensure access to and efficient effective delivery of quality Emergency Medical Services (EMS)	Number of provinces that are monitored for compliance with the EMS regulations	Regulations governing the provision of emergency medical services published for public comment	EMS Regulations were published on 9 May 2015. The regulations were revised to incorporate all the stakeholder inputs and the missing Annexures.	EMS Regulations revised, and a compliance checklist drafted and presented to National Committee Emergency Medical services (NCEMSEMS)	Compliance checklist finalised and presented to Tech NHC for approval. 9 Provincial DoH baseline assessments conducted and reports produced to determine compliance levels	9 provincial department of health monitored for compliance with the EMS regulations using the approved checklist 9 x EMS Improvement plans revised accordingly	9 provincial DoH monitored for compliance with the EMS regulations using the approved checklist annually and 9 x EMS Improvement plans revised accordingly	9 provincial DoH monitored for compliance with the EMS regulations using the approved checklist 9 x EMS Improvement plans revised accordingly

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
To build new and improve quality of health infra-structure in South Africa	Number of facilities that comply with gazetted infrastructure Norms & Standards.	100% from date of gazetting	78 Doctor Consulting Rooms that comply	65 new facilities	Specifications of 50 facilities compliant with Infrastructure norms and standards	400 facilities compliant with Infrastructure norms and standards	800 facilities compliant with Infra-structure norms and standards	1500 facilities compliant with Infra-structure norms and standards
	Number of clinics and Community Health Centres constructed or revitalised	72 clinics and community health centres constructed	49 clinics and CHC's constructed and revitalised	22 clinics and Community Health Centres constructed or revitalised	20 clinics and Community Health Centres constructed or revitalised	20 clinics and Community Health Centres constructed or revitalised	20 clinics and Community Health Centres constructed or revitalised	20 clinics and Community Health Centres constructed or revitalised
	Number of hospitals constructed or revitalised	7 hospitals constructed or revitalised	1 Hospitals completed.	3 hospitals constructed or revitalised	1 hospitals constructed or revitalised	2 hospitals constructed or revitalised	2 hospitals constructed or revitalised	2 hospitals constructed or revitalised
	Number of facilities maintained, repaired and/or refurbished in NHI Districts	94 maintenance projects for health facilities in NHI Districts	198 facilities completed of which 117 facilities maintained, repaired and/or refurbished; and 81 facilities upgraded as part of maintenance programme	67 facilities maintained, repaired and/or refurbished in NHI Districts	150 facilities, repaired and/or refurbished in NHI Districts	125 facilities maintainted, repaired and/or refurbished in NHI Districts	120 facilities maintained, repaired and/or refurbished in NHI Districts	Not Applicable (By the end of 2019/20, all health facilities in national health insurance pilot districts will have been maintained, repaired and/or refurbished)
	Number of facilities maintained, repaired and/or refurbished outside NHI Districts	249 maintenance projects for health facilities outside NHI pilot Districts	217 facilities maintained, repaired and/or refurbished	37 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts
Improve management of PERSAL data to track implementation of staffing norms and facilitate HRH planning	HR Regulations developed and promulgated to ensure WISN based HRH planning in PHC facilities	New Indicator	New Indicator	New Indicator	New Indicator	Draft HR Regulations submitted to NHC for consideration	Draft HR Regulations for WISN implementation promulgated	Monitor implementation and compliance with HR Regulations for WISN implementation
Improve the Human resource planning by strengthening the placement process for medical interns and community service personel	Percentage South African Medical Interns and Community service personel allocated in health facilities that studied at South African universities	New Indicator	New Indicator	New Indicator	98% (1510/1529) Medical Interns Placed and 91% (6878/7527) Community service personel placed	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Develop and support implementation of health workforce staffing norms and standards	National Human Resources for Health (HRH) Strategy 2019-2024 drafted	New indicator	New indicator	New indicator	A review of the HRH strategic plan 2012/2013-2016/2017 conducted	HRH Strategic plan 2019- 2024 drafted	HRH Strategic plan 2019- 2024 published and implementation commenced	HRH Strategic plan 2019- 2024 monitored
Increase production of Human Resources for Health to strengthen capacity in the health system through the implementation of the Nelson Mandela Fidel Castro Medical Programme	Number of medical students returning to South Africa from the expanded Nelson Mandela Fidel Castro Medical Programme placed in local medical schools	New indicator	New indicator	Consultation with key stakeholders and provinces on planning for the returning South African medical students.	Expanded academic integration programme finalized for final year training in South Africa	All students returning from Cuba during 2018/19 placed for final clinical training in the local medical schools	All students returning from Cuba placed for final clinical training in the local medical schools	All students returning from Cuba placed for final clinical training in the local medical schools
Improve management of health facilities at all levels of are through the Health Leadership and Management Academy	Number of managers accessing the knowledge hub information system for coaching and mentoring	New indicator	Framework for Knowledge hub developed and approved	2Hospital and 6 PHC managers using the knowledge hub information system for coaching and mentoring	100 Hospital Managers and 300 PHC Managers accessing the knowledge hub information system for coaching and mentoring	150 Hospital and 900 PHC Managers accessing the knowledge hub information system for coaching and mentoring	250 Hospital and 1800 PHC Managers accessing the knowledge hub information system for coaching and mentoring	All hospital and PHC managers accessing the knowledge hub information system for coaching and mentoring
Strengthen Nursing Education Training and Practice through implementation of the objectives of the Nursing Strategy.	New basic Nursing qualification programmes and draft curricula developed	New indicator	A National Policy for Nursing Education and Training was developed and presented to National Health Council.	New basic nursing qualification programmes and draft curricula developed in line with the national nursing education and training policy	New basic nursing qualification programmes finalised 8 colleges with customised draft curricula	9/17 remaining colleges have customised curricula for the new 3yr Diploma in General Nursing New courses commenced in 2019 academic year	New basic nursing qualification programmes implemented and monitored at all 17 public nursing colleges	Progress reports produced on the implementation of the new basic nursing qualification programmes at all 17 public nursing colleges
	Norms and standards for clinical training platform developed	New Indicator	New Indicator	New Indicator	Norms and standards for clinical training platform drafted and consultations held	Norms and standards for clinical training platform approved	Provinces supported in the development of implementation plans of the Norms and Standards for Clinical Training Platforms	Provinces supported in the development of improvement plans of the norms and standards for clinical training platforms
Eliminate the backlog of blood alcohol tests by 2018/19 and toxicology tests by 2020/21	Percentage backlog eliminated for blood alcohol tests	New Indicator	New Indicator	67% Backlog of blood alcohol tests eliminated	Backlog of blood alcohol tests eliminated (0% backlog) in Durban, Cape Town, and Pretoria Laboratories	100% backlog eliminated for blood alcohol tests in Johannesburg laboratory	Not applicable	Not applicable
	Percentage backlog eliminated for toxicology tests	New Indicator	70% backlog eliminated for toxicology tests	Review of all the samples with CAS number completed to determine the extent of backlog	40% backlog eliminated for toxicology tests (cumulative target)	60% backlog eliminated for toxicology tests	70%backlog eliminated for toxicology tests	95% backlog eliminated for toxicology tests

5.3 QUARTERLY TARGETS FOR STRATEGIC OBJECTIVE PERFORMANCE INDICATORS 2018/19

Performance indicator	Reporting period	Annual target 2018/19	Quarterly targets			
			1st	2nd	3rd	4th
Number of central hospital organisational structures aligned with Guidelines on Organisational Structures for Central Hospitals	Quarterly	Guidelines on Organisational Structures for Central Hospitals approved by Tech NHC	Current draft revised in line with Tech NHC directive	Revised guidelines presented to Tech NHC	Guidelines reviewed	Guidelines approved by Tech NHC
Number of Hospitals that achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	Quarterly	10 Central Hospitals achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	8 Central Hospitals	8 Central Hospitals	9 Central Hospitals	10 Central Hospitals (Cumulative)
Oncology services improvement plan developed	Quarterly	Oncology service improvement plan developed for public hospitals	Implementation plan drafted	Implementation plan consulted on and reviewed	Implementation plan consulted on and reviewed	Implementation plan completed
Obstetric services improvement plans developed	Quarterly	Obstetric service improvement plan developed for public hospitals	Implementation plan drafted	Implementation plan consulted on and reviewed	Implementation plan consulted on and reviewed	Implementation plan completed
Number of provinces that are monitored for compliance with the EMS regulations	Quarterly	9 provincial department of health monitored for compliance with the EMS regulations using the approved checklist 9 x EMS Improvement plans revised accordingly	checklist circulated to 9 provincial EMS teams to monitor compliance with EMS regulations	checklists analysed and EMS improvement plans revised	implementation of EMS Regulations monitored and reported	implementation of EMS Regulations monitored and reported
Number of facilities that comply with gazetted infrastructure Norms & Standards.	Quarterly	400 facilities compliant with Infrastructure norms and standards	50 facilities compliant with Infrastructure norms and standards	100 facilities compliant with Infrastructure norms and standards	250 facilities compliant with Infrastructure norms and standards	400 facilities compliant with Infrastructure norms and standards
Number of clinics and Community Health Centres constructed or revitalised	Annual	20 clinics and Community Health Centres constructed or revitalised	20 Clinics and CHCs at various stages of construction	20 Clinics and CHCs at various stages of construction	20 Clinics and CHCs at various stages of construction	20 clinics and Community Health Centres constructed or revitalised
Number of hospitals constructed or revitalised	Annual	2 hospitals constructed or revitalised	2 hospitals at various stages of construction	2 hospitals at various stages of construction	2 hospitals at various stages of construction	2 hospitals constructed or revitalised
Number of facilities maintained, repaired and/or refurbished in NHI Districts	Quarterly	125 facilities maintainted, repaired and/or refurbished in NHI Districts	25 facilities maintainted, repaired and/or refurbished in NHI Districts	60 facilities maintainted, repaired and/or refurbished in NHI Districts	90 facilities maintainted, repaired and/or refurbished in NHI Districts	125 facilities maintainted, repaired and/or refurbished in NHI Districts
Number of facilities maintained, repaired and/or refurbished outside NHI Districts	Quarterly	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	15 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	40 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	70 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts
HR Regulations developed and promulgated to ensure WISN based HRH planning in PHC facilities	Quarterly	Draft HR Regulations submitted to NHC for consideration	Draft HR Regulations developed	stakeholder engagements on Draft HR Regulations	Comments Considered comments and incorporate into Draft HR regulations	Draft HR Regulations submitted to NHC for consideration

Performance indicator	Reporting period	Annual target 2018/19	Quarterly targets			
			1st	2nd	3rd	4th
Percentage South African Medical Interns and Community service personel allocated in health facilities that studied at South African universities	Bi- annual	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively	Guideline reviewed and approved by NHC on placement of medical interns and community service personel and workflow plan for placement and 100% of asynchronous medical interns and community service personel allocated in April	NA	100% Medical Interns and Community service personel allocated for 2019 cycle	NA
National Human Resources for Health (HRH) Strategy 2019-2024 drafted	Quarterly	HRH Strategic plan 2019- 2024 drafted	International benchmarks to inform the review of the HRH strategy	Develop updated HRH Strategy	Task Team established for the peer-review of the draft HRH Strategy	Draft HRH Strategy finalised for presentation to NHC
Number of medical students returning to South Africa from the expanded Nelson Mandela Fidel Castro Medical Programme placed in local medical schools	Quarterly	All students returning from Cuba during 2018/19 placed for final clinical training in the local medical schools	Oversight visits conducted at universities and hospitals to confirm readiness for enrolment of students; Allocation of students to institutions	All students returning from Cuba during 2018/19 enrolled in medical schools for integration	Not Applicable	Not Applicable
Number of managers accessing the knowledge hub information system for coaching and mentoring	Quarterly	150 Hospital and 900 PHC Managers accessing the knowledge hub information system for coaching and mentoring	30 Hospital and 300 PHC Managers (Cumulative) using the knowledge hub information system for coaching and mentoring	80 Hosptial CEOs and 450 PHC Managers using the knowledge hub information system for coaching and mentoring (Cumulative)	120 Hospital CEOs and 600 PHC Managers using the knowledge hub information system for coaching and mentoring (Cumulative)	150 Hospital CEOs and 900 PHC Managers using the knowledge hub information system for coaching and mentoring (Cumulative)
New basic Nursing qualification programmes and draft curricula developed	Quarterly	9/17 remaining colleges have customised curricula for the new 3yr Diploma in General Nursing New courses commenced in 2019 academic year	5/9 remaining Nursing Colleges supported to customize the new basic nursing programmes	9/9 cumulative Nursing Colleges supported to customize the new basic nursing programmes	9/17 remaining colleges supported in the accreditation submission of customized curricula for the new basic nursing programmes	New courses commenced
Norms and standards for clinical training platform approved	Quarterly	Norms and standards for clinical training platform approved	Draft 1 of the norms and standards for clinical platforms developed and tabled at NHRC	Draft 2 Norms and Standards for Clinical training platforms tabled at Tech NHC	Final draft of Norms and Standards for clinical training platform developed and approved	Norms and Standards for clinical training platform disseminated in provinces
Percentage backlog eliminated for blood alcohol tests	Quarterly	100% backlog eliminated for blood alcohol tests in Johannesburg laboratory	25% backlog eliminated for blood alcohol tests in Johannesburg laboratory	50% backlog eliminated for blood alcohol tests in Johannesburg laboratory	75% backlog eliminated for blood alcohol tests in Johannesburg laboratory	100% backlog eliminated for blood alcohol tests in Johannesburg laboratory
Percentage backlog eliminated for toxicology tests	Quarterly	60% backlog eliminated for toxicology tests	30% backlog eliminated for toxicology tests	40% backlog eliminated for toxicology tests	50% backlog eliminated for toxicology tests	60% backlog eliminated for toxicology tests

5.4 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Hospitals, Tertiary Health Services and Human Resource Development expenditure trends and estimates by sub-programme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Programme Management	4 191	3 738	2 614	3 692	-4.1%	–	3 271	3 418	3 623	-0.6%	–
Health Facilities Infrastructure Management	5 807 614	6 092 904	5 973 459	6 423 670	3.4%	31.2%	6 740 585	7 022 896	7 411 977	4.9%	30.3%
Tertiary Health Care Planning and Policy	10 172 223	10 384 336	10 850 183	11 680 763	4.7%	55.4%	12 405 087	13 190 103	14 073 690	6.4%	56.3%
Hospital Management	4 583	4 771	8 108	4 955	2.6%	–	6 498	6 825	7 222	13.4%	–
Human Resources for Health	2 340 618	2 394 258	2 515 297	2 653 788	4.3%	12.7%	2 805 363	2 963 774	3 126 790	5.6%	12.7%
Nursing Services	2 563	4 229	7 289	6 562	36.8%	–	9 077	9 438	10 004	15.1%	–
Forensic Chemistry Laboratories	110 056	112 764	104 446	127 405	5.0%	0.6%	145 804	158 835	188 406	13.9%	0.7%
Violence, Trauma and EMS	6 730	5 315	7 320	6 949	1.1%	–	8 497	8 897	9 386	10.5%	–
Total	**18 448 578**	**19 002 315**	**19 468 716**	**20 907 784**	**4.3%**	**100.0%**	**22 124 182**	**23 364 186**	**24 831 098**	**5.9%**	**100.0%**
Change to 2017 Budget estimate				(200 400)			(176 948)	(276 570)	(271 052)		
Economic classification											
Current payments	**239 485**	**284 070**	**279 872**	**254 651**	**2.1%**	**1.4%**	**279 342**	**295 455**	**257 300**	**0.3%**	**1.2%**
Compensation of employees	104 678	110 874	138 008	128 470	7.1%	0.6%	145 181	157 689	183 272	12.6%	0.7%
Goods and services[1]	134 807	173 196	141 864	126 181	-2.2%	0.7%	134 161	137 766	74 028	-16.3%	0.5%
of which:											
Minor assets	*5 840*	*1 093*	*3 993*	*1 879*	*-31.5%*	–	*4 917*	*5 964*	*7 023*	*55.2%*	–
Consultants: Business and advisory services	*916*	*1 652*	*1 140*	*9 068*	*114.7%*	–	*18 324*	*19 326*	*1 390*	*-46.5%*	*0.1%*
Contractors	*4 976*	*5 318*	*4 852*	*13 069*	*38.0%*	–	*21 490*	*23 317*	*9 983*	*-8.6%*	*0.1%*
Agency and support/outsourced services	*88 115*	*131 620*	*101 976*	*56 219*	*-13.9%*	*0.5%*	*35 113*	*32 902*	*2 976*	*-62.5%*	*0.1%*
Inventory: Other supplies	*10 247*	*11 612*	*9 068*	*13 200*	*8.8%*	*0.1%*	*12 442*	*11 641*	*12 281*	*-2.4%*	*0.1%*
Travel and subsistence	*9 502*	*9 835*	*11 416*	*11 111*	*5.4%*	*0.1%*	*13 920*	*15 011*	*11 938*	*2.4%*	*0.1%*
Transfers and subsidies[1]	**17 992 739**	**18 173 324**	**18 598 040**	**19 993 255**	**3.6%**	**96.1%**	**21 000 893**	**22 172 929**	**23 550 572**	**5.6%**	**95.1%**
Provinces and municipalities	17 992 004	18 172 941	18 596 182	19 992 489	3.6%	96.1%	21 000 893	22 172 929	23 550 572	5.6%	95.1%
Foreign governments and international organisations	–	–	1 661	–	–	–	–	–	–	–	–
Households	735	383	197	766	1.4%	–	–	–	–	-100.0%	–
Payments for capital assets	**216 301**	**544 782**	**590 431**	**659 872**	**45.0%**	**2.6%**	**843 947**	**895 802**	**1 023 226**	**15.7%**	**3.8%**
Buildings and other fixed structures	168 329	470 641	574 044	643 984	56.4%	2.4%	748 073	792 125	876 501	10.8%	3.4%
Machinery and equipment	47 972	74 141	16 387	15 888	-30.8%	0.2%	95 874	103 677	146 725	109.8%	0.4%
Payments for financial assets	**53**	**139**	**373**	**6**	**-51.6%**	–	–	–	–	**-100.0%**	–
Total	**18 448 578**	**19 002 315**	**19 468 716**	**20 907 784**	**4.3%**	**100.0%**	**22 124 182**	**23 364 186**	**24 831 098**	**5.9%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**55.0%**	**52.8%**	**50.6%**	**49.0%**	–	–	**46.9%**	**45.4%**	**44.1%**	–	–
Details of transfers and subsidies											
Households											
Social benefits											
Current	**735**	**383**	**197**	**766**	**1.4%**	–	–	–	–	**-100.0%**	–
Employee social benefits	735	383	197	766	1.4%	–	–	–	–	-100.0%	–
Foreign governments and international organisations											
Current	–	–	**1 661**	–	–	–	–	–	–	–	–
International Hospital Federation	–	–	1 661	–	–	–	–	–	–	–	–
Provinces and municipalities											
Provinces											
Provincial revenue funds											
Current	**12 490 023**	**12 755 896**	**13 323 502**	**14 307 994**	**4.6%**	**67.9%**	**15 185 199**	**16 125 956**	**17 171 015**	**6.3%**	**68.8%**

5.5 Personnel information

Hospitals, Tertiary Health Services and Human Resource Development personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2018		Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Average: Salary level/Total (%)
			2016/17			2017/18			2018/19			2019/20			2020/21			2017/18 - 2020/21	
Hospitals, Tertiary Health Services and Human Resource Development			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**266**	**–**	**274**	**138.0**	**0.5**	**273**	**128.5**	**0.5**	**272**	**145.2**	**0.5**	**270**	**157.7**	**0.6**	**270**	**183.3**	**0.7**	**-0.4%**	**100.0%**
1 – 6	71	–	74	18.5	0.3	74	20.6	0.3	73	23.2	0.3	72	25.1	0.3	72	29.2	0.4	-0.9%	26.8%
7 – 10	153	–	156	78.0	0.5	155	86.1	0.6	155	98.0	0.6	155	107.6	0.7	155	125.4	0.8	–	57.1%
11 – 12	24	–	–	21.7	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
13 – 16	18	–	44	19.8	0.5	44	21.8	0.5	44	24.0	0.5	43	25.0	0.6	43	28.7	0.7	-0.8%	16.0%

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

2. Rand million.

PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT

6.1 PROGRAMME PURPOSE

The purpose of this programme is to ensure accountability and compliance by public entities and statutory health professional councils in accordance with applicable legislative prescripts.

The South African Health Products Regulatory Authority has been established as a Schedule 3A entity from 2017/18 financial year. The SAHPRA Board has been appointed for a three-year term. The Authority is required to table its own strategic and annual performance plan from the 2018/19 period. The Authority was established in terms of section 2C (1) of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965) as amended to provide for the monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, Scheduled substances, clinical trials and medical devices, In Vitro Diagnostics and related matters in the public interest.

Compensation Commissioner for Occupational Diseases and Occupational Health: is responsible for compensation of active and ex-workers in controlled mines and works certified to be suffering from cardio-pulmonary related diseases as a result of work place exposures in the controlled mines or works. Over the medium term, the business processes will be reengineered with regard to revenue collection; reducing the turnaround period for claims, amending the Occupational Diseases in Mines and Works Act(1973); and improving governance, internal controls and relationships with the stakeholders.

Public Entities Management sub-programme supports the Executive Authority's oversight function and provides guidance to health public entities and statutory health professional councils (hereinafter referred to as entities') falling within the mandate of the health legislation with regard to planning, budget procedures, performance and financial reporting, remuneration, governance and accountability. The sub-programme further assists the Minister in accounting to Parliament on activities and performance of the entities.

Governance oversight over entities is conducted through monitoring compliance to legislative requirements based on entities enabling legislation, applicable provisions of the Public Finance Management Act, 1999 (PFMA) (Act No. 1 of 1999) as amended in conjunction with the principles contained in King III report on corporate governance as well as other relevant policies and legislative prescripts. The Cluster oversee the health entities and statutory councils falling within the mandate of the Department of Health:

HEALTH ENTITIES	HEALTH STATUTORY COUNCILS
The National Health Laboratory Service (NHLS)	Allied Health Professions Council of South Africa (AHPCSA)
The South African Medical Research Council (SAMRC)	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)
South African Health Products Regulatory Authority (SAHPRA)	Health Professions Council of South Africa (HPCSA)
	Interim Traditional Health Practitioners Council of South Africa (ITHPCSA)

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

6.2 STRATEGIC OBJECTIVE, PERFORMANCE INDICATORS AND ANNUAL TARGETS

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

Objective Statement	Performance Indicator	Audited/Actual performance			Estimated performance	Medium-term targets		
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
To establish the National Public Health Institutes of South Africa (NAPHISA) for coordinated and integrated disease and injury surveillance.	Legal framework to establish National Public Health Institutes of South Africa (NAPHISA)	Conceptual framework document and business case for NAPHISA developed	Legislation on NAPHISA was gazetted	Comments on draft NAPHISA legislation considered and revised. NAPHISA bill approved by cabinet for tabling in parliament.	NAPHISA Bill tabled for consider-ation to the Parliamentary Portfolio Committee of Health	NAPHISA Act Promulgated into law.	NAPHISA established as a public entity, and NAPHISA board appointed	NAPHISA fully operational and functional
Improve oversight and Corporate Governance practices by establishing effective governance structures, policies and tools.	Governance monitoring system implemented to strengthen oversight and corporate governance	2 health entities fully functional	4 public health Entities' and 6 statutory health professional council's functionality reports compiled to review compliance to good corporate governance practices.	4 health Entities' and 5 statutory health pro-fessional councils	Bi-annual governance progress reports produced of all health entities and councils	Biannual governance progress reports produced of all health entities and councils	Biannual governance progress reports produced of all health entities and councils	Not Applicable
Ensure integrated and coordinated governance and management oversight of public entities and statutory professional councils	Handbook for Board members serving on public health entities and statutory professional councils developed.	New Indicator	New Indicator	New Indicator	New Indicator	Handbook for departmental representatives serving on Entities Boards developed.	Not Applicable	Not Applicable

6.3 QUARTERLY TARGETS FOR STRATEGIC OBJECTIVES PERFORMANCE INDICATORS 2018/19

Performance indicator	Reporting period	Annual target 2018/19	Quarterly targets			
			1st	2nd	3rd	4th
Legal framework to establish National Public Health Institutes of South Africa (NAPHISA)	Annual	NAPHISA Act Promulgated into law.	Not Applicable	Not Applicable	Not Applicable	NAPHISA Act Promulgated into law.
Governance monitoring system implement-ed to strengthen oversight and corporate governance	Bi-Annual	Biannual governance progress reports produced of all health entities and councils	Not Applicable	Governance reports of statutory health profes-sional councils produced	Not Applicable	Governance reports of statutory health professional councils produced
Handbook for Board members serving on public health entities and statutory profession-al councils developed.	Bi-Annual	Handbook for departmental representatives serving on Entities Boards developed.	Not Applicable	Draft Handbook for departmental representa-tives serving on Entities Boards developed.	Not Applicable	Handbook for depart-mental representatives serving on Entities Boards finalised.

6.4 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Sub-programme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R thousand	2014/15	2015/16	2016/17	2017/18	2014/15 - 2017/18		2018/19	2019/20	2020/21	2017/18 - 2020/21	
Programme Management	3 758	3 502	4 114	4 532	6.4%	0.2%	6 021	6 330	6 695	13.9%	0.3%
Food Control	6 871	8 347	8 570	11 528	18.8%	0.6%	10 571	10 991	11 957	1.2%	0.6%
Radiation Control and Health Technology	120 504	138 303	163 843	152 404	8.1%	9.0%	14 218	17 352	18 645	-50.4%	2.8%
Public Entities Management	1 162 942	1 399 104	1 477 814	1 496 434	8.8%	86.8%	1 679 072	1 773 086	1 870 606	7.7%	92.7%
Compensation Commissioner for Occupational Diseases and Occupational Health	46 626	50 164	60 169	61 673	9.8%	3.4%	65 664	68 694	72 472	5.5%	3.6%
Total	**1 340 701**	**1 599 420**	**1 714 510**	**1 726 571**	**8.8%**	**100.0%**	**1 775 546**	**1 876 453**	**1 980 375**	**4.7%**	**100.0%**
Change to 2017 Budget estimate				(400)			(11 320)	(13 409)	(14 718)		
Economic classification											
Current payments	**174 365**	**189 970**	**233 859**	**226 667**	**9.1%**	**12.9%**	**94 144**	**102 960**	**109 339**	**-21.6%**	**7.2%**
Compensation of employees	106 122	123 990	148 712	167 975	16.5%	8.6%	64 278	70 227	74 486	-23.7%	5.1%
Goods and services[1]	68 243	65 980	85 147	58 692	-4.9%	4.4%	29 866	32 733	34 853	-15.9%	2.1%
of which:											
Audit costs: External	–	22	2 640	3 299	–	0.1%	2 503	2 854	3 011	-3.0%	0.2%
Computer services	1 822	4 119	2 120	4 650	36.7%	0.2%	835	3 652	3 723	-7.1%	0.2%
Consumables: Stationery, printing and office supplies	1 944	1 977	1 780	1 990	0.8%	0.1%	3 981	3 427	3 875	24.9%	0.2%
Operating leases	1 307	1 163	1 236	1 747	10.2%	0.1%	2 885	2 776	2 795	17.0%	0.1%
Property payments	257	322	437	1 201	67.2%	–	4 148	3 335	3 519	43.1%	0.2%
Travel and subsistence	13 437	14 089	14 588	8 113	-15.5%	0.8%	3 515	3 327	4 619	-17.1%	0.3%
Transfers and subsidies[1]	**1 163 002**	**1 397 850**	**1 479 643**	**1 496 600**	**8.8%**	**86.8%**	**1 678 961**	**1 772 981**	**1 870 495**	**7.7%**	**92.7%**
Departmental agencies and accounts	1 161 716	1 397 643	1 477 829	1 496 350	8.8%	86.7%	1 678 961	1 772 981	1 870 495	7.7%	92.7%
Households	1 286	207	1 814	250	-42.1%	0.1%	–	–	–	-100.0%	–
Payments for capital assets	**3 288**	**11 368**	**963**	**3 261**	**-0.3%**	**0.3%**	**2 441**	**512**	**541**	**-45.1%**	**0.1%**
Buildings and other fixed structures	536	–	–	–	-100.0%	–	–	–	–	–	–
Machinery and equipment	2 752	7 160	963	3 261	5.8%	0.2%	2 441	512	541	-45.1%	0.1%
Software and other intangible assets	–	4 208	–	–	–	0.1%	–	–	–	–	–
Payments for financial assets	**46**	**232**	**45**	**43**	**-2.2%**	**–**	**–**	**–**	**–**	**-100.0%**	**–**
Total	**1 340 701**	**1 599 420**	**1 714 510**	**1 726 571**	**8.8%**	**100.0%**	**1 775 546**	**1 876 453**	**1 980 375**	**4.7%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**4.0%**	**4.4%**	**4.5%**	**4.0%**	**–**	**–**	**3.8%**	**3.6%**	**3.5%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits											
Current	**1 286**	**207**	**1 554**	**250**	**-42.1%**	**0.1%**	**–**	**–**	**–**	**-100.0%**	**–**
Employee social benefits	1 286	207	1 554	250	-42.1%	0.1%	–	–	–	-100.0%	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	**1 158 501**	**1 394 280**	**1 474 288**	**1 492 632**	**8.8%**	**86.5%**	**1 675 125**	**1 768 931**	**1 866 223**	**7.7%**	**92.4%**
South African Medical Research Council	446 331	623 892	660 270	614 961	11.3%	36.8%	624 829	659 819	696 109	4.2%	35.3%
National Health Laboratory Service	674 052	678 926	711 871	746 464	3.5%	44.1%	789 759	833 986	879 855	5.6%	44.2%
Office of Health Standards Compliance	33 367	88 906	100 535	125 711	55.6%	5.5%	129 678	136 940	144 472	4.7%	7.3%
Council for Medical Schemes	4 751	2 556	1 612	5 496	5.0%	0.2%	5 670	5 987	6 317	4.8%	0.3%
South African Health Product Regulatory Authority	–	–	–	–	–	–	125 189	132 199	139 470	–	5.4%
Households											
Other transfers to households											
Current	–	–	**260**	–	–	–	–	–	–	–	–
Employee social benefits	–	–	260	–	–	–	–	–	–	–	–
Departmental agencies and accounts											
Social security funds											
Current	**3 215**	**3 363**	**3 541**	**3 718**	**5.0%**	**0.2%**	**3 836**	**4 050**	**4 272**	**4.7%**	**0.2%**
Compensation Commissioner	3 215	3 363	3 541	3 718	5.0%	0.2%	3 836	4 050	4 272	4.7%	0.2%

6.5 Personnel information

Health Regulation and Compliance Management personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2018		Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Average: Salary level/Total (%)
			2016/17			2017/18			2018/19			2019/20			2020/21			2017/18 - 2020/21	
Health Regulation and Compliance Management			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**347**	–	**286**	**148.7**	**0.5**	**285**	**168.0**	**0.6**	**105**	**64.3**	**0.6**	**105**	**70.2**	**0.7**	**103**	**74.5**	**0.7**	-28.8%	100.0%
1 – 6	154	–	131	33.6	0.3	131	38.3	0.3	56	21.4	0.4	56	23.4	0.4	55	25.1	0.5	-25.1%	49.8%
7 – 10	64	–	61	29.3	0.5	61	33.4	0.5	44	33.6	0.8	44	36.8	0.8	44	40.3	0.9	-10.3%	32.3%
11 – 12	116	–	84	73.6	0.9	84	84.9	1.0	–	–	–	–	–	–	–	–	–	-100.0%	14.0%
13 – 16	13	–	10	12.2	1.2	9	11.4	1.3	5	9.3	1.9	5	10.0	2.0	4	9.1	2.3	-23.7%	3.8%

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

PART C

Links to other plans

1. CONDITIONAL GRANTS

Health Professions Training and Development Grant

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2018/19
Health Professional Training and Development	Support provinces to fund services costs associated with clinical training and supervision of health science trainees on the public service platform	Number of specialists	370
		Number of registrars	1 335
		Number of medical officers	325
		Number of clinical supervisors/trainers per category in nursing, EMS and allied health and pharmacy	901
		Number of grant administration staff	23

National Tertiary Services Grant

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2018/19
National Tertiary services	To ensure provision of tertiary health services in South Africa	Number of inpatient separations	644 876
		Number of day patient separation	388 399
	To compensate tertiary facilities for the additional costs associated with the provision of these services	Number of outpatient first attendances	1 210 403
		Number of outpatient follow-up attendances	2 945 919
		Number of inpatient days	4 059 840

Comprehensive HIV&AIDS and TB Grant

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2018/19
Comprehensive HIV & AIDS, TB & COS	To enable the health sector to develop and implement an effective response to HIV/AIDS and TB	Number of new patients started on ART	800 000
		Total Number of patients on ART remaining in care	5 000 000
		Number of male condoms distributed	953 152 462
		Number of female condoms distributed	40 000 000
	To fund Community Outreach Services	No of exposed infants HIV positive at 10 weeks PCR test	169 659
		Number of clients tested for HIV (including antenatal)	14 000 000
		Number of Medical Male Circumcision performed	600 000
	Prevention and protection of health workers of exposure to hazards in the work place	No of patients on ART initiated on Isoniazid Preventative Therapy (IPT)	565 494
		Number of missing undiagnosed TB infected persons found	80 000
		Number of clients initiated on new generation MDR and XDR regiment	7 500
		TB symptom clients screened in facility rate	80%
		TB client start on treatment rate	90%
		TB client treatment success rate	86.93%
		TB Rifampicin Resistant confirmed treatment start rate	70%
		TB MDR treatment success rate	60%
		Number of Adherence clubs	30 000
		Number of patients participating in adherence clubs	900 000
		Community health workers trained	34 707

Health Facility Revitalisation Grant

Name conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2018/19
Health Facility Revitalisation Grant	- To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including: health technology (HT), organisational development (OD) systems and quality assurance (QA) - To enhance capacity to deliver health infrastructure - To accelerate the fulfilment of the requirements of Occupational Health and Safety	Number of new facilities completed	25
		Number of facilities maintained	60
		Number of facilities upgraded and renovated	16
		Number of facilities commissioned in terms of Health Technology	26

Human Papillomavirus Component (Hpv) Grant

Name Conditional Grant	Purpose of the Grant	Performance Indicators	Indicator Targets for 2018/19
Human Papillomavirus (HPV)	To enable the health sector to prevent cervical cancer by making available HPV vaccination for grade four school girls in all public and special schools.	percentage of grade four school girls aged 9 and above in vaccinated for HPV	80%
		percentage of schools with grade four girls reached by the HPV vaccination team	80%

National Health Insurance (NHI) Grant: Personal Services Component

Name Conditional Grant	Purpose of the Grant	Performance Indicators	Indicator Targets 2018/19
National Health Insurance (NHI): Personal Services Component	To expand the healthcare service benefits through the strategic purchasing of services from healthcare providers.	Number of health professionals contracted (total and by discipline) Psychiatrists, Clinical Psychologists	10 20
		Number of health professionals contracted through capitation arrangements	10
		Improved identification and management of high risk pregnancies	11 Regional Facilities
		Improved care of women during labour with management of complications (No of O&G, anaesthetist & paediatrician contracted to manage complicated high risk pregnancies	6 (2 per discipline) in each of 11 tertiary institutions
		No of GPs contracted to manage high risk pregnancies	197
		Number of patients screened and treated for mental health problems	22 000
		Percentage reduction in the backlog of forensic mental observations	100%
		Percentage reduction in radiation oncology backlog	5 000 to be treated
		Number of HPV DNA tests rendered	17 500
		Number or percentage of patients confirmed to have cervical cancer that were screened by HPV DNA	1.4% of 17 500
		Number of learners who received interventions for poor eyesight	54 810
		Number of learners that received interventions for hearing difficulty	14 000
		Number of learners who received interventions for oral health	14 000
		Number of patients receiving radiation oncology	5 000
		Number of cataract surgeries performed through contracting private providers	5 000
		Number of people with mental health problems seen by a psychiatrist or a psychologist at district level	22 000

National Health Insurance (NHI) Grant: Non Personal Services Component

Name Conditional Grant	Purpose of the Grant	Performance Indicators	Indicator Targets for 2018/19
National Health Insurance (NHI): Non Personal Services	- To expand the alternative models for the dispensing and distribution of chronic medication - To fund the development of and roll out of new Health Information Systems in Preparation for NHI - Develop a risk-adjusted capitation model for the reimbursement of Primary Health Care (PHC) - To enable the health sector to address the deficiencies in the Primary Health Care facilities systematically to yield fast results	An alternative chronic medicines dispensing and distribution model implemented	2 500 000
		Number of new patients Number of total patients registered in the programme, broken down by the following: - ART - ARV with Co-morbidities - NCDs	1 000 000 1 535 126 866 413 198 873 469 840
		No of Pick-up-Points (PuPs)	3 112 – state 1 261– non state
		Number and percentage of PHC facilities peer reviewed	600 (17%)
		Number and percentage of PHC facilities achieving an ideal status	1 500 (43%)
		Number of facilities implementing the Health Patient Registration System - PHC - Hospitals	 3 470 22
		Number of patients registered on the Health Patient Registration Systems (No of NHI beneficiaries registered)	35 000 000
		Number of primary healthcare facilities implementing an electronic stock replenishment system	3 100
		Number of hospitals implementing an electronic stock replenishment system	308
		A base capitation model for the reimbursement of PHC facilities developed	Risk Capitation Model

National Health Insurance (NHI) Grant: Health Facility Revitalisation Component

Name Conditional Grant	Purpose of the Grant	Performance Indicators	Indicator Targets for 2018/19
National Health Insurance (NHI): Health Facility Revitalisation Component	- To create an alternative track to improve spending, performance as well as monitoring and evaluation on infrastructure in preparation for National Health Insurance (NHI) - To enhance capacity and capability to deliver infrastructure for NHI - To accelerate the fulfilment of the requirements of Occupational Health and Safety	Number of new facilities completed	8
		Number of facilities maintained	40
		Number of facilities upgraded and additions/ renovated and refurbished	4

Comprehensive HIV/AIDS, TB & COS Grant: Community Outreach Services Component

Name of conditional grant	Purpose of the grant	Performance indicators	Indicator targets for 2018/19
Comprehensive HIV/AIDS, TB & COS: Community Outreach Services Component	- To ensure provision of quality community outreach services through WBPHCOTs - To improve efficiencies of the WBOT programme by harmonising and standardising services and strengthening performance monitoring	Number of functional Ward Based Primary Health Care Outreach Teams (WBPHCOT)	2 000
		Number of CHWs receiving stipend	45 270
		Number of Outreach Team Leaders (OTLs) employed	2 000
		Number of TB defaulters traced	1 550
		Number of HIV defaulters traced	70 500

2. Public Entities

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

1. **Council for Medical Schemes**

The Council for Medical Schemes was established in terms of the Medical Schemes Act (1998), as a regulatory authority responsible for overseeing the medical schemes industry in South Africa. Section 7 of the act sets out the functions of the council, which include protecting the interests of beneficiaries, controlling and coordinating the functioning of medical schemes, collecting and disseminating information about private health care, and advising the Minister of Health on any matter concerning medical schemes.

2. **National Health Laboratory Service**

The National Health Laboratory Service was established in 2001 in terms of the National Health Laboratory Service Act (2000). The entity is mandated to support the Department of Health by providing cost effective diagnostic laboratory services to all state clinics and hospitals. It also provides health science training and education, and supports health research. It is the biggest diagnostic pathology service in South Africa, servicing more than 80 per cent of the population, through a national network of 268 laboratories. Its specialised divisions include the National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry and the Anti-Venom Unit. Through the National Institute for Communicable Diseases and the National Institute for Occupational Health, and through its own research programme, the service contributes to research and development and provides a training platform for students of pathology

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

3. **South African Medical Research Council**

The South African Medical Research Council (SAMRC) was established in terms of the South African Medical Research Council Act (1969). The Intellectual Property Rights from Publicly Financed Research and Development Act (2008) also informs the SAMRC's mandate. The SAMRC is mandated to promote the improvement of health and quality of life through research, development and technology transfers. Research and innovation are primarily conducted through funded research units located within the council (intramural units) and in higher education institutions (extramural units) and play a key role in achieving outcome 2 (a long and healthy life for all South Africans) of government's 2014-2019 medium-term strategic framework. The focus of the South African Medical Research Council over the medium term will be on the enhancement of health and medical research; capacity development; and innovation and technology transfer.

The council has launched a three-year R30 million grand challenges South Africa programme on maternal, infant and neonatal health, in collaboration with the Bill and Melinda Gates Foundation, to identify innovations in gestational diabetes, perinatal haemorrhage, pre-eclampsia and neonatal survival. The council also collaborates with a number of other research partners, including the Newton Fund, the British Medical Research Council, GlaxoSmithKline and Canadian Institutes of Health Research.

4. **Compensation Commissioner for Occupational Diseases in Mines and Works**

The Compensation Commissioner for Occupational Diseases in Mines and Works was established in terms of the Occupational Diseases in Mines and Works Act (1973). The act gives the commissioner the mandate to: collect levies from controlled mines and works, to compensate workers and ex-workers in controlled mines and works for occupational diseases of the cardiorespiratory organs, and reimburse workers for loss of earnings incurred during tuberculosis treatment. The commissioner compensates the dependants of deceased workers and also administers pensions for qualifying ex-workers or their dependants.

5. **The Office of Health Standard Compliance**

The Office of Health Standards Compliance was established in terms of the National Health Amendment Act (2013). The office is mandated to: monitor and enforce the compliance of health establishments with the norms and standards prescribed by the Minister of Health in relation to the national health system; and ensure the consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner. The Minister appointed an ombudsman during 2016/17 financial year, that makes it possible for patients to complain about public and private healthcare institutions in South Africa.

6. **South African Health Products Regulatory Authority (SAHPRA)**

SAHPRA is established as a schedule 3A public entity from 2017/18 financial year. This will assist to bring the medical devices industry, cosmetics and foodstuffs as well as pharmaceuticals under the jurisdiction of the SAHPRA. The Medicines Regulatory Authority (MRA) is being transitioned to SAHPRA. The transition will allow the authority to operate more independently and retain the revenue collected from the pharmaceutical industry.

SAHPRA is responsible for the regulation and control of registration, licensing, manufacturing, importation, and all other aspects pertaining to active pharmaceutical ingredients, medicines, medical devices; and for conducting clinical trials in a manner compatible with the national medicines policy.

3.Public Private Partnership

Bio Vac

In 2003, the National Department of Health established the Biological 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. During 2014, the National DoH has transferred its shareholding in BioVac to the Department of Science and Technology.

Infrastructure PPPs

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

ANNEXURE A: Review of the Strategic Plan 2015-2020

PROGRAMME 1: ADMINISTRATION

Strategic Objective Statement	Performance Indicator	Baseline 2016/17	Target 2019/20
Ensure effective financial management and accountability by improving audit outcomes	Audit opinion from Auditor General	Unqualified Audit opinion	Clean Audit Opinion for the NDOH for 2018/19
	Number of Provincial DoH that demonstrate improvements in Audit Outcomes or Opinions	4 Provincial DoH that demonstrate improvements in Audit	5 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2018/19

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

Strategic Objective Statement	Performance Indicator	Baseline 2016/17	Target 2019/20
Achieve Universal Health Coverage through the phased implementation of National Health Insurance	Legislation for NHI	NHI Bill conceptualised	NHI Bill assented to by the President
	Establishment of the National Health Insurance Fund	Funding Modality for the National Health Insurance Fund including budget reallocation for the primary health care updated	Functional NHI fund –purchasing services on behalf of the population from accredited and contracted providers
Implement eHealth Strategy of South Africa through the development of patient information systems	eHealth Strategy 2019-2023 published	eHealth Strategy 2012-2016 implementation reviewed	eHealth Strategy 2019 – 2023 implemention commenced, and monitored
Develop and implement a system for the creation of a NHI Beneficiary Registry	Number of health facilities implementing health patient registration system (HPRS)	1854 PHC Facilities implementing the health patient registration system (HPRS)	3470 PHC facilities and 60 Hospitals implementing the health patient registration system (HPRS)
	Number of individuals from the population registered on the NHI Patient Beneficiary Registry	15 million	50 million
Establish a national stock management surveillance centre to improve medicine availability	Total number of health facilities reporting stock availability at national surveillance centre	3349 of health facilities reporting stock availability at national surveillance centre	3800 of health facilities reporting stock availability at national surveillance centre
Improve contracting and supply of medicines through innovative service delivery models	Number of patients enrolled for receiving medicines through the centralised chronic medicine dispensing & distribution (CCMDD) programme	1,100,000 patients enrolled for receiving medicines through the CCMDD programme	2,800,000 patients enrolled for receiving medicines through the CCMDD programme
Improve the use of antibiotics in South Africa by implementing the Antimicrobial Resistance Strategy	Surveillance system implemented for monitoring resistance	Antimicrobial stewardship guideline as identified in the antimicrobial resistance strategy developed	Surveillance system for monitoring resistance accessible to 9 provincial DoH
Regulate Traditional Health Practitioners in South Africa	Traditional Health Practitioners Amendment Bill drafted and published for comment	Traditional Health Practitioners Amendment Bill drafted	Amendment Bill promulgated
Regulation of the price on medicines through the transparent pricing system	Single Exit Price Adjustments Published and Implemented Annually	2016/17 Annual Price Adjustments implemented	2019/20 Annual Price Adjustments gazetted and implemented
Improve the acceptability, quality and safety of health services by increasing user and community feedback and involvement	Number of PHC health facilities conducting Patient Experience of Care Survey	Patient Experience of care survey guidelines re-tabled at Tech NHC for approval	2000 PHC facilities conducting Patient Experience of care surveys
Implement an integrated monitoring and evaluation plan aligned to health outcomes and outputs contained in the Health Sector Strategy	NHI Phase 1 Evaluation Conducted	NHI Phase 1 evaluation report published	NHI Phase 1 evaluation report disseminated and used to inform further planning for NHI

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

The Government of South Africa has committed itself to outcome planning. The National Department of Health is providing leadership to Outcome 2 "A long and healthy life for all South Africans". The Medium Term Strategic Framework 2014-2019 provides a road map with outcome targets to achieve "A long and healthy life for all South Africans" that National and Provincial Departments of Health must reach by 2020.

Strategic Objective Statement	Performance Indicator	Baseline 2016/17	Target 2019/20
To implement combination of prevention and treatment interventions to reduce burden of HIV, STI and TB infections	Total number of clients remaining on ART (TROA)	3 831 730	5 800 000
	Number of people reached in the National Health Screening and Testing campaign annually	14 000 000	14 000 000
	Medical Male Circumcisions performed	413 880	550 000
	Number of undiagnosed TB infected persons (new cases) found	80 000	110 000
To reduce under 5 mortality rate to less than 33 per 1 000 live births	EPI coverage survey conducted	Survey protocol developed and field work completed	Survey report completed and used to strengthen EPI programme
	EPI surveillance and coverage external review recommendations implemented	Implementation plans developed in partnership with Provincial DoH	Six (6) provincial trainings conducted

PROGRAMME 4: PRIMARY HEALTH CARE (PHC) SERVICES

Strategic Objective Statement	Performance Indicator	Baseline 2016/17	Target 2019/20
Eliminate Malaria in South Africa	National Malaria elimination Strategic Plan for South Africa	New Indicator	Malaria Elimination Strategic Plan for South Africa published M&E report produced on the key indicators for Malaria Elimination
Implement the International Health Regulations Joint External Evaluation recommendations	Joint External Evaluation (JEE) Recommendations implemented	Joint External Evaluation (JEE) conducted by WHO	Work plan for JEE recommendations developed and implemented
Strengthen district governance and improve management and leadership of the district health system	Number of Districts compliant with the minimum requirements of the District Health Management Office structure guidelines	Guidelines for uniform structure for District Health Management developed	Plans developed for 30 districts structures to meet the minimum requirements of the guidelines
Improve district governance and strengthen management and leadership of the district health system	Number of PHC facility committees assessed to determine functionality	3211 PHC facility committees assessed to determine its functionality	All 3400 PHC facility committees assessed to determine its functionality; Report on findings with recommendations completed
Improve quality of services at primary health care facilities through the Ideal Clinic Initiative	Number of primary health Care facilities in the 52 districts that qualify as Ideal Clinics	786 primary health Care facilities in the 52 districts qualify as Ideal Clinics	1800 primary health care facilities in the 52 districts qualify as Ideal Clinics
Improve accessibility of Primary Health Services to people with disabilities	Proportion of PHC facilities accessible to people with disabilities	40% of 3400 PHC facilities accessible to people with disabilities	50% of 3400 of PHC facilities accessible to people with disabilities
Improve quality of services at District Hospitals through the Ideal District Hospitals Programme	Ideal District Hospital Framework implemented	Status of all district hospitals determined against the Ideal District hospital framework version 1	80% of district hospitals score at least 60% against the Ideal District hospital framework
Improve environmental health services in all 52 districts and metropolitan municipalities in the country	Number of public health facilities assessed for adherence to Health Care Risk Waste (HCRW) Norms and Standards	9 Provincial Implementation Plans developed	78 Major Health Care Risk Waste (HCRW) generating public health facilities (hospitals that generate more than 25kg per day) assessed for adherence to HCRW Norms and Standards
	Number of municipalities that are randomly selected and audited against environmental health norms and standards in executing their environmental health functions	35 municipalities are randomly selected and audited against environmental health norms and standards in executing their environmental health functions	Municipalities that achieved less than 65% compliance during 2018/19 audited against environmental health norms and standards
Strengthen district mental health services	Number of Districts with Mental Health Teams established	8 District mental health teams established	20 District mental health teams established
Expand provision of rehabilitation services, and accessibility of Primary Health Services to people with physical disabilities	Number of multi-disciplinary rehabilitation teams (physiotherapist, optometrist, audiologist, occupational therapist) established	New Indicator	5 multi-disciplinary rehabilitation teams established

PROGRAMME 5: HOSPITALS, TERTIARY SERVICES AND WORKFORCE MANAGEMENT

Strategic Objective Statement	Performance Indicator	Baseline 2016/17	Target 2019/20
Strengthen local decision making and accountability of central hospitals to facilitate semi-autonomy	Number of central hospital organisational structures aligned with Guidelines on Organisational Structures for Central Hospitals	Organisational structure for Central Hospitals developed and submitted to NHC for approval	Costed implementation plans for improvement of 10 Central hospitals organisational structures completed
Ensure quality health Care by improving compliance with National Core Standards at all Central, Tertiary, Regional and Specialised Hospitals	Number of Hospitals that achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	18 Hospitals (3 Central 8 Tertiary, 11 Regional)	All Hospitals assessed, and achieved an overall performance of 75% (or more) compliance with NCS
	Oncology services improvement plan developed	Oncology service improvement plan developed for public hospitals	Implementation monitored
	Obstetric services improvement plans developed	Obstetric service improvement plan developed for public hospitals	Implementation monitored
Ensure access to and efficient effective delivery of quality Emergency Medical Services (EMS)Ensure access to and efficient effective delivery of quality Emergency Medical Services (EMS)	Number of provinces that are monitored for compliance with the EMS regulations	EMS Regulations revised, and a compliance checklist drafted and presented to National Committee Emergency Medical services (NCEMS)	9 provincial DoH monitored for compliance with the EMS regulations using the approved checklist annually and 9 x EMS Improvement plans developed and implemented
To build new and improve quality of existing health infrastructure in South Africa	Number of facilities that comply with gazetted infrastructure Norms & Standards.	65 facilities	800 facilities compliant with Infrastructure norms and standards
	Number of clinics and Community Health Centres constructed or revitalised	22 clinics and Community Health Centres constructed or revitalised	60 clinics and Community Health Centres constructed or revitalised
	Number of hospitals constructed or revitalised	3 hospitals constructed or revitalised	5 hospitals constructed or revitalised
	Number of facilities maintained, repaired and/or refurbished in NHI Districts	67 facilities maintained, repaired and/or refurbished in NHI Districts	All PHC facilities maintained, repaired and/or refurbished in NHI Districts
	Number of facilities maintained, repaired and/or refurbished outside NHI Districts	37 facilities maintained, repaired and/or refurbished outside NHI pilot Districts	100 facilities maintained, repaired and/or refurbished outside NHI pilot Districts
Improve management of PERSAL data to track implementation of staffing norms and facilitate HRH planning	HR Regulations developed and promulgated to ensure WISN based HRH planning in PHC facilities	Draft HR Regulations for consideration by NHC	Draft HR Regulations for WISN implementation approved by NHC and promulgated
Improve the Human resource planning by strengthening the placement process for medical interns and community service personnel	Percentage South African Medical Interns and Community service personel allocated in health facilities that studied at South African universities	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively
Develop and support implementation of health workforce staffing norms and standards	National Human Resources for Health (HRH) Strategy 2019-2024 drafted	HRH Strategic plan 2019- 2024 drafted	HRH Strategic plan 2019- 2024 published and implementation commenced
Increase production of Human Resources for Health to strengthen capacity in the health system through the implementation of the Nelson Mandela Fidel Castro Medical Programme	Number of medical students returning to South Africa from the expanded Nelson Mandela Fidel Castro Medical Programme placed in local medical schools	Consultation with key stakeholders and provinces on planning for the returning South African medical students.	All students returning from Cuba placed for final clinical training in the local medical schools
Improve management of health facilities at all levels of are through the Health Leadership and Management Academy	Number of managers accessing the knowledge hub information system for coaching and mentoring	2 Hospital and 6 PHC managers using the knowledge hub information system for coaching and mentoring	250 Hospital and 1800 PHC Managers accessing the knowledge hub information system for coaching and mentoring
Strengthen Nursing Education Training and Practice through implementation of the objectives of the Nursing Strategy.	New basic Nursing qualification programmes and draft curricula developed	New basic nursing qualification programmes and draft curricula developed in line with the national nursing education and training policy	New basic nursing qualification programmes implemented and monitored at all 17 public nursing colleges
	Norms and standards for clinical training platform developed	Norms and standards for clinical training platform disseminated in provinces	Provinces supported in the development of implementation plans of the Norms and Standards for Clinical Training Platforms
Eliminate the backlog of blood alcohol tests by 2018/19 and toxicology tests by 2020/21	Percentage backlog eliminated for blood alcohol tests	67% Backlog of blood alcohol tests eliminated	Backlog eliminated
	Percentage backlog eliminated for toxicology tests	Review of all the samples with CAS number completed to determine the extent of backlog	70%backlog eliminated for toxicology tests

PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT

Strategic Objective Statement	Performance Indicator	Baseline 2016/17	Target 2019/20
To establish the National Public Health Institutes of South Africa (NAPHISA) for coordinated and integrated disease and injury surveillance.	Legal framework to establish National Public Health Institutes of South Africa (NAPHISA)	Comments on draft NAPHISA legislation considered and revised. NAPHISA bill approved by cabinet for tabling in parliament.	NAPHISA established as a public entity, and NAPHISA board appointed
Improve oversight and Corporate Governance practices by establishing effective governance structures, policies and tools.	Governance monitoring system implemented to strengthen oversight and corporate governance	4 health Entities' and 5 statutory health professional councils	Biannual governance progress reports produced of all health entities and councils
Ensure integrated and coordinated governance and management oversight of public entities and statutory professional councils	Handbook for Board members serving on public health entities and statutory professional councils.	New Indicator	Handbook for departmental representatives serving on Entities Boards developed and implemented.

ANNEXURE B: TECHNICAL INDICATOR DESCRIPTIONS (TIDS)

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 1: ADMINISTRATION

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Audit opinion from Auditor General	Audit opinion from Auditor General for National Department of Health	To strengthen financial management monitoring and evaluation	Documented Evidence: Annual Report Auditor General's Report	N/A	N/A	Outcome	N/A	Annual	No	Clean Audit opinion for the NDOH for 2017/18	Chief Financial Officer
Number of Provincial DoH that demonstrate improvements in Audit Outcomes or Opinions	Number of Provincial DoH that demonstrate improvements in Audit Outcomes or Opinions	To strengthen financial management monitoring and evaluation	Provincial Auditor General's Reports used to determine improvements	N/A	N/A	Outcome	N/A	Annual	No	5 Provincial DoH that demonstrate improvements in Audit with no significant matters for 2017/18	Chief Financial Officer of National DoH; and Chief Financial Officers of Provincial Departments of Health

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 2: NATIONAL HEALTH INSURANCE, HEALTH PLANNING AND SYSTEMS ENABLEMENT

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Legislation for NHI	Determination of the legal framework to enable the implementation of NHI	To monitor the development of an enabling legislative framework to support the phased implementation of NHI.	Documented evidence confirming submission to parliament	N/A	None	Process	N/A	Quarterly	No	NHI Bill submitted to Parliament	Cluster: NHI
Private Health providers contracted to expand coverage of care	Private Health providers contracted to expand coverage of care of priority populations	To monitor the contracting of private providers	Approved contract(s) between the Department and private health providers	N/A	None	Process	N/A	Quarterly	Yes	Private health providers contracted to purchase health services on behalf of population	Cluster: NHI
eHealth Strategy 2019-2023 published	A Strategic roadmap for the implementation of eHealth components in the South African Health system	To track the publication of the eHealth Strategy	Published eHealth Strategy 2019-2023	N/A	NA	Output	NA	Quarterly	Yes	eHealth Strategy 2019-2023 published	Health Information Research Monitoring and Evaluation (HIRME) Cluster
Number of health facilities implementing health patient registration system (HPRS)	Number of public health facilities implementing the Health Patient Registration System (HPRS)	Track the roll out of the HPRS in public health facilities	System generated report from web based system that confirms the number of facilities implementing the system hosted by CSIR	Sum of facilities that has HPRS installed at facilities	Not Applicable	Output	Cumulative	Quarterly	No	3000 PHC Facilities maintained; Additional 470 PHC facilities and 22 Hospitals implementing the health patient registration system (HPRS)	NHI Information Systems Programme

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 2: NATIONAL HEALTH INSURANCE, HEALTH PLANNING AND SYSTEMS ENABLEMENT

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Perfor-mance	Responsi-bility
Number of individuals from the population registered on the NHI Patient Beneficiary Registry	Number of individuals from the population registered on the NHI Patient Beneficiary Registry	Track registration of individuals on the NHI Patient Beneficiary Registry	System generated report from web based system that confirms the number of-individuals registered on HPRS	Sum of individuals registered on HPRS	Potential Duplications may exist	Output	Cumulative	Quarterly	Yes	35 million	NHI Information Systems Programme
Total number of health facilities reporting stock availability at national surveillance centre	Health facilities reporting stock availability at national surveillance centre for triangulation of stock out signals, verification and tracking	To track number of facilities that are reporting stock availability of medicines on the stock verification system (SVS) thereby reducing stock outs	Dashboard report from National surveillance centre that confirms facilities reporting stock out	Sum of facilities reporting stock availability at national surveillance centre to monitor medicine availability	Reporting by stake holders	Output	Sum	Quarterly	No	3625 of health facilities reporting stock availability at national surveillance centre (cumulative)	Cluster: Sector Wide Procurement
Number of patients enrolled for receiving medicines through the centralised chronic medicine dispensing & distribution (CCMDD) programme	Number of patients enrolled for receiving medicines through the centralised chronic medicine dispensing & distribution system	Measure implementation of CCMDD Programme	Monthly reports from contracted suppliers that track patients enrolled into the CCMDD programme	Cumulative Sum of patients enrolled for receiving medicines through the centralised chronic medicine dispensing & distribution (CCMDD) system	Enrolled patients may not collect the medication through CCMDD for a variety of factors.	Output	Sum	Quarterly	No	2,500, 000 patients enrolled for receiving medicines through the CCMDD programme (cumulative)	Cluster: Sector Wide Procurement
Surveillance system implemented for monitoring resistance	Surveillance system implemented to track antimicrobial resistance	Track Implementation of a surveillance system for monitoring antimicrobial resistance to improve the use of antibiotics in South Africa	Resistance Surveillance Reports	NA	None	Output	None	Quarterly	No	Surveillance system for monitoring resistance accessible to 3 provincial DoH	Cluster: Sector Wide Procurement
Traditional Health Practitioners Amendment Bill drafted and published for comment	Provides regulatory framework for traditional health practice	Improve traditional health practice in South Africa	Published Traditional Health Practitioners Amendment Bill	N/A	N/A	Process	NA	Quarterly	No	Amendment Bill published for comment	Chief Director DHS
Single Exit Price Adjustments Published and Implemented Annually	Publish and Implement Single Exit Price Adjustments Annually	Track publication of SEP annual adjustments	SEP Publication for 2018/19 year	None	None	Process	N/A	Annual	No	2018/19 Annual Price Adjustments gazetted and implemented	Cluster: NHI

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 2: NATIONAL HEALTH INSURANCE, HEALTH PLANNING AND SYSTEMS ENABLEMENT											
Indicator name	**Short Definition**	**Purpose /Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Perfor-mance**	**Responsi-bility**
Number of PHC health facilities conducting Patient Experience of Care Survey	Number of PHC health facilities that conduct their annual Patient Experience of Care Survey	Track the implementation of the Patient Experience of Care guidelines	Ideal Clinic Dashboard assessment reports as captured on the system by Provincial DoH	Sum of PHC facilities conduct their annual Patient Ex-perience of Care Survey	None	Process	None	Quarterly	No	1500 PHC facil-ities conducting Patient Expe-rience of care surveys annually	Cluster: Quality Assurance
NHI Phase 1 Evaluation Conducted	Evaluation conduct-ed on NHI Phase 1 Implementation	Track Evaluation of NHI Phase 1 to review health outcomes and outputs according to the Health Sector Strategy	Published NHI Evaluation Report	N/A	N/A	Process	NA	Quarterly	No	NHI Phase 1 evaluation report published	Health Information Research Monitoring and Evalua-tion (HIRME) Cluster

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 3: HIV / AIDS, TB AND MATERNAL AND CHILD HEALTH											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsi-bility**
Total number of clients remaining on ART (TROA)	Total clients remaining on ART (TROA) are the sum of the following: - Any client that has a current regi-men in the column designating the month at the end of the reporting period. - Any client that has a star without a circle (someone who is not yet considered lost to follow-up (LTF) in the column desig-nating the month at the end of the reporting period.	Track the number of pa-tients on ARV Treatment	Monthly DHIS reports submit-ted by Provincial DoH	Numerator: SUM [Total clients remaining on ART at end of the reporting period]	None	Output	Sum	Quarterly	Yes	Higher total in-dicates a larger population on ART treatment	Cluster: HIV/ AIDS; STIs and TB
Number of people reached in the National Health Screen-ing and Testing campaign annually	Number of people that received screening for HIV, TB, Diabetes and/ or Hypertention in the national screening and testing campaign	To track the number of people reached in the national health screening campaign	Monthly DHIS reports submit-ted by Provincial DoH	Sum of People screened	There may be duplicate individuals report should they receive screening addi-tional screen-ings at different facilities	Output	Sum	Quarterly	Yes	Higher total indicates a larg-er population received health screenings	Cluster: HIV/ AIDS; STIs and TB
Medical Male Circumcisions performed	Total number of Medical Male Circumcisions (MMCs) performed	Tracks the number of the MMCs performed to implement combination of prevention and treatment interventions to reduce burden of HIV, STI and TB infections	Monthly DHIS reports submitted by Provincial DoH	Total number of Medical Male Circumcisions (MMCs) con-ducted	None	Output	Sum	Quarterly	No	Higher number indicates great-er availability of the service or greater uptake of the service	Cluster: HIV/ AIDS; STIs and TB

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 3: HIV / AIDS, TB AND MATERNAL AND CHILD HEALTH											
Indicator name	Short Definition	Purpose / Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
Number of undiagnosed TB infected persons (new cases) found	Number of missing (and undiagnosed) TB infected persons (new cases) found	To track new TB cases	Provincial quar-terly progress reports	Sum of undiagnosed TB infected persons (new cases) found	Separating the missing cases found through this initiative from those found through routine means	Output	Sum	Quarterly	Yes	80 000	Cluster: TB
EPI coverage survey conduct-ed	EPI Survey conducted	EPI Survey conducted to use results to implement strategies to reduce under 5 mortality rate	EPI Survey Report	NA	None	Output	NA	Quarterly	No	Survey protocol developed and field work completed	Cluster: Child, Youth & School Health
EPI surveillance and coverage external review recommenda-tions implement-ed	EPI surveillance and coverage external review recommendations implemented	To track the development of provincial implementa-tion plans and trainings for surveillance	Approved provincial Implementation Plans; and attendance reg-isters confirming training	NA	None	Process	MA	Quarterly	Yes	Implementation plans developed in partnership with Provincial DoH; and Three (3) provincial train-ings conducted	Cluster: Child, Youth & School Health

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 4: PRIMARY HEALTH CARE SERVICES (PHC)											
Indicator name	Short Definition	Purpose / Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
The National Malaria elimination Strategic Plan for South Africa Published	National Malaria elimination Strategic Plan for South Africa published	To eliminate malaria by implementing the National Malaria strategic plan	Published Nation-al Malaria elimina-tion Strategic Plan for South Africa	NA	NA	Process	NA	Quarterly	Yes	Malaria Elimination Strategic Plan for South Africa published	Cluster: Communica-ble Diseases
Joint External Evaluation (JEE) Recommendations implemented	International Health Regulations(IHR) Joint External Evaluation (JEE) recommendations implemented	To track the implementation of the IHR JEE Rec-ommendations	Approved work-plan to implement JEE recommen-dation	Numerator: Total number of JEE recommendations implemented Denominator: Total number of JEE rec-ommendations	NA	Process	NA	Quarterly	Yes	Work plan for JEE recommendations developed 1	Cluster: Communica-ble Diseases

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 4: PRIMARY HEALTH CARE SERVICES (PHC)											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsi-bility**
Number of Districts compliant with the minimum require-ments of the District Health Management Office structure guidelines	Number of Districts compliant with the minimum require-ments of the District Health Management Office	To track the implementation of the District Health Management Office (DHMO) guidelines	10 District Plans with recommen-dations to meet the minimum requirement of the guidelines	Sum of District struc-tures compliant with minimum require-ments of the DHMO Structure guidelines as received from completed audit forms	Dependent on audit forms being completed fully and returned on time	Output	Sum	Quarterly	No	Plans developed for 10 districts structures to meet the minimum re-quirements of the guidelines	Cluster: District Health Services
Number of PHC facility committees assessed to deter-mine functionality	Determines whether a clinic's health ser-vice provision ac-tivities are planned, implemented and monitored and eval-uated in collabora-tion with community representatives	Services at clinic level that are not planned and ex-ecuted in collab-oration with the communities may not meet com-munities' needs. Clinics benefit in multiple ways from community involvement	Ideal Clinic Dashboard assessment reports as captured on the system by Provincial DoH	Sum of primary health Care facilities assessed to de-termine functional committees	Dependent on complete records kept by PHC facilities and districts	Output	Sum	Quarterly	No	3400 PHC facility commit-tees assessed to determine its functionality; Report on findings with recommenda-tions completed	Cluster: District Health Services
Number of primary health Care facilities in the 52 districts that qualify as Ideal Clinics	Measures the Facilities that have implemented the ideal clinic standards and adhering to more than 70% of the elements as defined in the Ideal Clinic Dashboard	To track imple-mentation of the ideal clinic standards	Ideal Clinic Dash-board assess-ment reports as captured on the system by Provin-cial DoH	Sum of primary health Care facilities in the 52 districts that qualify as Ideal Clinics as per the dashboard	Depends on accuracy of status de-terminations reported by provincial DoH	Output	Sum	Quarterly	No	1400 primary health Care facilities in the 52 districts qualify as Ideal Clinics	Cluster: District Health Services
Proportion of PHC facilities accessible to people with disabil-ities	Proportion of health facilities accessible to people with physical disabilities	To track acces-sibility of public PHC facilities by people with disabilities	Ideal Clinic Dash-board assess-ment reports as captured on the system by Provin-cial DoH	Numerator: Number of PHC facilities accessible to people with disabilities, Denominator: 3400 (total number of PHC facilities in South Africa)	Depends on accuracy of status de-terminations reported by Provinciual DoH	Output	Proportion	Quarterly	No	40% of 3400 PHC facilities accessi-ble to people with disabilities	Cluster: Non Communica-ble Diseases

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 4: PRIMARY HEALTH CARE SERVICES (PHC)

Indicator name	Short Definition	Purpose / Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsi-bility
Ideal District Hospital Framework imple-mented	Provides a measurement framework for standards in District Hospitals	To improve service delivery in District Hospitals	Ideal District Hospital status determination system	Sum of district hospitals with known status	Depends on accuracy of reports from provincial DoH	Process	Sum	Quarterly	No	Status of all district hospitals determined against the Ideal District hospital framework version 1	Cluster: District Health Services
Number of public health facilities as-sessed for adherence to Health Care Risk Waste (HCRW) Norms and Standards	Number of public health facilities assessed for adherence to Health Care Risk Waste (HCRW) Norms and Standards	Track implemen-tation of HCRW Norms and standards	Assessment reports of 78 randomly selected public health facilities with recommendations	Sum of public health facilities assessed for adherence to Health Care Risk Waste (HCRW) Norms and Standards	N/A	Output	Annual status (non-cumulative)	Quarterly	No	78 Major Health Care Risk Waste (HCRW) generat-ing public health facilities (hospitals that generate more than 25kg per day) assessed for adherence to HCRW Norms and Standards	Cluster: Envi-ronmental and Port Health Services
Number of munic-ipalities that are randomly selected and audited against environmental health norms and standards in executing their environmental health functions	Measures the number of municipalities that meet environmental health norms and standards in executing their environmental health functions	To track the compliance with environmental health norms and standards	Audit reports from municipalities / (Completed Audit Tools)	sum of municipalities randomly selected and audited against environment health norms and standards	N/A	Output	Sum	Quarterly	No	21 municipali-ties randomly selected and audited against environmental health norms and standards	Cluster: Envi-ronmental and Port Health Services
Number of Districts with Mental Health Teams established	Number of Mental health teams established in each district .	Track implemen-tation of Mental Health policy in order to improve access to and quality of mental health services in South Africa	Letters from HODs confirming appointment of mental health teams.	Sum of Mental health teams in Districts with at least one member appointed	None	Input	Sum	Quarterly	No	15 District mental health teams established	Cluster: Non Communica-ble Diseases
Number of multi-dis-ciplinary rehabilitation teams (physiother-apist, optometrist, audiologist, occu-pational therapist) established	Number of multi-disciplinary rehabilitation teams with at least 3 spe-cialists appointed (physiotherapist, optometrist, audiol-ogist, occupational therapist)	Expand provision of rehabilitation services, and accessibility of Primary Health Services to peo-ple with physical disabilities	Letters of appoint-ment of special-ists	Sum of Districts with a multi-disciplinary rehabilitation team	None	Input	Sum	Quarterly	No	2 multi-disciplinary rehabilitation teams established	Cluster: Non Communica-ble Diseases

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 5: HOSPITAL, TERTIARY HEALTH SERVICES AND HUMAN RESOURCE DEVELOPMENT											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsibility**
Number of central hospital organisational structures aligned with Guidelines on Organisational Structures for Central Hospitals	Number of central hospitals implementing the standardised organisational structures as approved by NHC	Tracks implementation of decentralised decision making and accountability framework for Central hospitals	Guidelines on Organisational Structures for Central Hospitals approved by Tech NHC	Sum of Central Hospitals with approved guidelines on organisational structures for central hospitals	None	Process indicator	N/A	Quarterly	No	Guidelines on Organisational Structures for Central Hospitals approved by Tech NHC	Cluster manager: Hospital Services
Number of Hospitals that achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	Number of Hospitals that achieve an overall performance of 75% (or more) compliance with the National Core Standards assessment, which will either be done by OHSC or by other hospitals	Tracks quality of care at hospitals	OHSC report OR Peer assessment reports (where OHSC assessments did not take place)	Number of Hospitals that achieve an overall performance of 75% (or more) compliance with the National Core Standards assessment	None	Outcome indicator	N/A	Quarterly	No	10 Central Hospitals achieved an overall performance 75% (or more) compliance with the National Core Standards assessed	Cluster: Manager Hospital Services
Oncology services improvement plan developed	Oncology services improvement plan developed	To track the development of the Oncology services improvement plan	Approved Oncology services improvement plan	N/A	None	Process	N/A	Quarterly	Yes	Oncology service improvement plan developed for public hospitals	Chief Directorate: Hospital Services
Obstetric services improvement plans developed	Obstetric services improvement plan developed	To track the development of the obstetric services improvement plan	Approved obstetric services improvement plan	N/A	None	Process	N/A	Quarterly	Yes	Obstetric service improvement plan developed for public hospitals	Chief Directorate: Hospital Services
Number of provinces that are monitored for compliance with the EMS regulations	Number of Provinces that are monitored for compliance with the EMS regulations using a standardised monitoring system	Track implementation of EMS regulations	Provincial reports to monitor compliance with EMS regulations; and 9x EMS Improvement Plans	Sum of Provincial DoH monitoring reports	None	Output	Not Applicable	Quarterly	No	9 provincial department of health monitored for compliance with the EMS regulations using the approved checklist 9 x EMS Improvement plans revised accordingly	Directorate: EMS

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 5: HOSPITAL, TERTIARY HEALTH SERVICES AND HUMAN RESOURCE DEVELOPMENT											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsibility**
Number of facilities that comply with gazetted infrastructure Norms & Standards.	To determine the extent to which specifications of health facilities submitted by Provincial DoH and those to be contracted by NDoH comply with Infrastructure norms and standards.	To track compliance with Infrastructure Norms and Standards	Self ssessment reports	Sum-of health facilities assessed for compliance by Provincial DoH and those to be contracted by NDoH comply with Infrastructure norms and standards.	None	Input	Sum	Quarterly	No	400 facilities compliant with Infrastructure norms and standards	Chief Directorate: Health Facilities and Infrastructure Planning
Number of clinics and Community Health Centres constructed or revitalised	Number of clinics and community health centres constructed and revitalised nationally	Track scale up of infrastructure programme	Practical Project completion certificates	Sum of clinics and community health centres constructed or revitalised	None	Output	Sum	Annual	No	20 clinics and Community Health Centres constructed or revitalised	Chief Directorate: Health Facilities and Infrastructure Planning
Number of hospitals constructed or revitalised	Number of hospitals constructed or revitalised Nationally	Track scale up of infrastructure programme	Practical Project completion certificates	Sum of hospitals constructed or revitalised	None	Output	Sum	Annual	No	2 hospitals constructed or revitalised	Chief Directorate: Health Facilities and Infrastructure Planning
Number of facilities maintained, repaired and/or refurbished in NHI Districts	Number of facilities receiving maintenance, repair and/or refurbishments in NHI pilot Districts	Track scale up of infrastructure programme	Practical Project completion certificates for projects that are procured using CIDB approved contracts, or, completion reports or job cards approved by Technical team for all other projects	Sum of facilities that received maintenance, repair and/or refurbishments in NHI pilot Districts (dependant on their status and need)	Number of facilities targeted is determined by the scope of work. This scope may be amended at the time of project inception	Output	Sum	Quarterly	No	125 facilities maintainted, repaired and/or refurbished in NHI Districts	Chief Directorate: Health Facilities and Infrastructure Planning
Number of facilities maintained, repaired and/or refurbished outside NHI Districts	Number of facilities receiving maintenance, repair and/ or refurbishments (dependant on their status and need) outside NHI Districts	Track scale up of infrastructure programme	Practical Project completion certificates for projects that are procured using CIDB approved contracts, or, completion report or job cards approved by Technical team for all other projects	Sum of facilities maintained, repaired and/or refurbished (dependant on their status and need) outside NHI pilot Districts during the reporting period	Number of facilities targeted is determined by the scope of work. This scope may be amended at the time of project inception	Output	Sum	Quarterly	No	100 facilities maintained, repaired and/ or refurbished outside NHI pilot Districts	Chief Directorate: Health Facilities and Infrastructure Planning

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 5: HOSPITAL, TERTIARY HEALTH SERVICES AND HUMAN RESOURCE DEVELOPMENT											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsibility**
HR Regulations developed and promulgated to ensure WISN based HRH planning in PHC facilities	Developing HR Regulations to enable implementation of WISN	To ensure accountability in WISN implementation in PHC facilities in all Districts	Documented evidence of drafting process for HR regulations; Minutes of meetings held with starkeholder engagements; Draft HR Regulations submitted to NHC for consideration	N/A	NA	Process	NA	Quarterly	Yes	Draft HR Regulations for consideration by NHC	Cluster: Workforce Development and Planning
Percentage South African Medical Interns and Community service personel allocated in health facilities that studied at South African universities	Percentage Medical Interns and Community service personel allocated in health facilities that studied at South African universities	To improve human resource planning and allocation of medical interns and community service personell	Numerator: signed allocation letter, Denominator: Interns and com servs placement (ICSP) system generated report with a Database of applicants	Numerator: Number of allocattion letters issued Denominator: Number of students that applied for placement	NA	Output	Percentage	Bi- annual	No	100 % of South African Medical Interns and Community service personel who studied at SA Universities allocated for placement by October for annual and April for asynchronous allocations respectively	Cluster: Workforce Development and Planning
National Human Resources for Health (HRH) Strategy 2019-2024 drafted	A strategic road map for Human Resources for Health (HRH) developed	Health workforce staffing norms and standards are available to inform planning for the health system	Draft National Human Resources for Health (HRH) Strategy 2019-2024	NA	NA	Process	NA	Quarterly	No	HRH Strategic plan 2019-2024 drafted	Cluster: Workforce Development and Planning
Number of medical students returning to South Africa from the expanded Nelson Mandela Fidel Castro Medical Programme placed in local medical schools	Efficient and effective management of the integration process of all medical students returning from Cuba	To integrate all students returning from Cuba into the SA training platform	University placement letters	Total number of students placed	N/A	Output	Sum	Quarterly	No	All students returning from Cuba during 2018/19 placed for final clinical training in the local medical schools	DDG: Hospital, Tertiary Health Services and Human Resource Development

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 5: HOSPITAL, TERTIARY HEALTH SERVICES AND HUMAN RESOURCE DEVELOPMENT											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calculation Type**	**Reporting Cycle**	**New Indicator**	**Desired Performance**	**Responsibility**
Number of managers accessing the knowledge hub information system for coaching and mentoring	Number of managers accessing the knowledge hub information system for coaching and mentoring	Track the usage of knowledge hub information system by managers and PHC facilities and Hospitals	System report reflecting the number of PHC managers and Hospital CEOs that are accessing the knowledge hub system	Sum of managers accessing the knowledge hub which includes a web based interactive information system	None	Output	Sum	Quarterly	No	150 Hospital and 900 PHC Managers accessing the knowledge hub information system for coaching and mentoring	Hospital, Tertiary Health Services and Human Resource Development
New basic Nursing qualification programmes and draft curricula developed	New basic Nursing qualification programmes and draft curricula developed	Implementation of the Nursing Strategy	Document with Customized Curricula for the 3yr Diploma in General Nursing	Number of colleges with customized curricula for the new 3 year Diploma in General Nursing	NA	Output	Sum	Quarterly	No	9/17 remaining colleges have customised curricula for the new 3yr Diploma in General Nursing New courses commenced in 2019 academic year	Office of the Chief Nursing Officer
Norms and standards for clinical training platform developed	Norms and standards for clinical training platform developed	To standardise norms and standards for clinical training platform	An approved document detailing the norms and standards for clinical training platform	N/A	NA	Output	NA	Quarterly	No	Norms and standards for clinical training platform approved	Office of the Chief Nursing Officer
Percentage backlog eliminated for blood alcohol tests	Percentage backlog [1]eliminated for blood alcohol tests in FCL Johannesburg (baseline – outstanding tests as at 31 March 2018, older than 90 days)	Track the scale up programme to eliminate backlog of blood alcohol tests	Blood Alcohol reports issued and Blood Alcohol report Register and LIMS (Laboratory Information Management System)	Numerator: Blood Alcohol test reports from backlogged samples Denominator: Total Number of Samples older than 90 days as at 31 December 2017	None	Output	Percentage	Quarterly	No	100% backlog eliminated for blood alcohol tests in Johannesburg laboratory	Chief Director: Violence Trauma and Injury
Percentage backlog eliminated for toxicology tests	Percentage backlog of toxicology tests on verified CJSRC list, reduced	Track the scale up programme to eliminate backlog of toxicology tests	Toxicology reports issued and Toxicology report Register and LIMS	Numerator: Toxicology test reports from backlogged samples on CJSRC list Denominator: Total Number of Samples on verified CJSRC list	None	Output	Percentage	Quarterly	No	60% backlog eliminated for toxicology tests	Chief Director: Violence Trauma and Injury

TECHNICAL INDICATOR DESCRIPTIONS (TIDS): PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT											
Indicator name	**Short Definition**	**Purpose / Importance**	**Source**	**Calculation Method**	**Data Limitations**	**Type of Indicator**	**Calcula-tion Type**	**Reporting Cycle**	**New Indicator**	**Desired Perfor-mance**	**Responsibility**
Legal framework to establish National Public Health Institutes of South Africa (NAPHISA)	Establish National Public Health Institutes of South Africa (NAPHISA) for coordinated disease and injury surveillance and research	Improve disease and injury surveillance, research, monitoring and evaluation of health and disease trends	Proclamation of the NAPHISA Act.	N/A	Progress depends on finalisation of parliamentary processes	Process	N/A	Annual	No	NAPHISA Act Promulgated into law.	Occupational Health Cluster
Governance monitoring system implemented to strengthen oversight and corporate governance	Governance monitoring system implemented	Governance monitoring system implemented to strengthen oversight and corporate governance	Approved Governance Reports of 4 health Entities' and 6 statutory health professional councils	N/A	Reports produced from information submitted by health entities and statutory health professional councils.	Process	N/A	Bi-Annual	No	Biannual governance progress reports produced of all health entities and councils	Cluster: Health Entities Management
Handbook for Board members serving on public health entities and statutory professional councils developed.	Governance handbook for Board Members	To provide roles and responsibilities for Board members on Governance of Public Entities and Statutory Councils	Drafted Handbook for Board Members	NA	NA	Output	NA	Bi-Annual	Yes	Handbook for departmental representatives serving on Entities Boards developed.	Cluster: Health Entities Management

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