


STRATEGIC PLAN

2015 - 2020

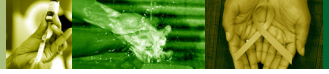
health

Department:
Health
REPUBLIC OF SOUTH AFRICA

A long and healthy life for all South Africans

Strategic Plan

2015/16 - 2019/20

FOREWORD BY THE MINISTER OF HEALTH

It is a privilege and an honour for me to present the five year Strategic Plan of the National Department of Health. This Strategic Plan is presented at an interesting moment when the world is slowly but steadfastly recognising the looming danger of the antimicrobial drugs resistance. The fact about this emerging catastrophe is that the overuse and misuse of antimicrobial medicines are among the factors that have contributed to the development of drug-resistant microbes. Microbes are constantly evolving enabling them to efficiently adapt to new environments or grow in the presence of a chemical (medicines) that would normally kill them or limit their growth.

Antimicrobial resistance makes it harder to eliminate infections from the body as existing drugs become less effective. As a result, some infectious diseases are now more difficult to treat than they were just a few decades ago. As more microbes become resistant to antimicrobials, the protective value of these medicines is reduced. And if we do not come up with some intervention, in few years from now we will be unable to cure ailments such as gastroenteritis because there will be no antibiotics strong enough to cure it.

What can be done? World leaders are seriously urging their citizen to embrace healthy lifestyle to prevent diseases and promote wellness.

Our world is also waking up to the reality now that for us to win the fight towards an AIDS free generation, we must fiercely combat TB. Our government, since 2009, made crushing AIDS a top priority and we have been able to accomplish what many would have said 10 years ago was impossible. But let us not forget that if the dream of making this the generation that defeats AIDS is to become reality, we must also tackle the second leading killer in the world – tuberculosis (TB). What is making the need to double our efforts even more pressing is the growing threat of strains of the disease that do not respond to most antibiotics (multi-drug resistant TB or MDR-TB).

The overlap of TB and HIV is a deadly combination with tragic consequences. TB is the leading killer of people with HIV, accounting for one in four HIV-related deaths. Globally, one-third of people living with HIV are also infected with TB, and if left unchecked and untreated, TB can kill a person with HIV/AIDS in a matter of weeks.

It is for this reason that we commit ourselves, in this Strategic Plan, to tackle TB much more fiercely than before. We have a historic opportunity to turn the tide on an age-old killer that has plagued human race for generations. By the global community banding together with resources and endorsements to meet the challenge, the goal of ending TB deaths in our lifetime is within our reach.

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Without concerted efforts to improve our health services, particularly at the primary health care levels, it will be impossible to eliminate TB and have an AIDS free generation.

Late last year, the President launched Operation Phakisa – which aims at turning every public health clinic to a facility that is people-centred and provides comprehensive, quality health care services. We know that health services that are timely lead to best health outcomes: *prevention of disease and disability, detection and treatment of health conditions, quality of life, preventable death and life expectancy.*

Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Barriers to services include: Long queues, Lack of availability of services, high transport costs and dirtiness of the facility and unfriendly attitudes of our staff. In turn, these barriers to accessing health services lead to: unmet health needs delays in receiving appropriate care, inability to get preventive services and hospitalisations that could have been prevented.

In addition to improving primary care and preventive services, emergency medical services (EMS) are a crucial link in the chain of care. Most maternal deaths would be prevented if we improve our EMS and referral system.

There a need to double our efforts in improving and maintaining infrastructure at our clinics and hospitals. Some of our institutions are not suitable for the provision of healthcare. We will have to ensure the availability of medicine at health facilities, especially chronic medicine.

Operation Phakisa is our vehicle to tackle these mountainous but not insurmountable challenges. We invite you to work with us to turn the tide against the quadruple burden of disease facing our country.

Dr PA Motsoaledi, MP

Minister of Health

STATEMENT BY THE DIRECTOR-GENERAL

I am pleased to share with you the National Department of Health (NDoH) Stra¬tegic Plan 2015 -2020. This strategic planning document articulates our vision, goals, strategies and indicators of achievement. It reflects our values – a commitment to excellence in healthcare that is community-centred, strategic thinking, quality, compassion, social justice, equity, diversity, innovation and a sense of urgency in overcoming the enormous challenges we face. It is also aligned with the National Development Plan for the entire country. It builds on strengths and contributions of previous year's efforts unique to the health system.

The Department created this Strategic Plan to ensure that the nation's resources are working toward the same goals as articulated in the National Development Plan. This Strategic Plan establishes that direction with its five broadly defined goals with realistic objectives that prioritise and focus the Department's efforts towards a long and healthy life for all South Africans.

Through this Strategic Plan, NDoH proposes to achieve measurable improvement in critical public health. The goals and objec¬tives contained in this Strategic Plan are the cornerstone of the maturity of NDoH into a successful performance-based state department. These goals and objectives sup¬plement the many excellent programmes and services currently provided by NDoH and represent strategic investments for the Department in the practice of public health in our country over the next five years.

The strategic plan for the next five years calls for partnership with communities in the prevention of diseases and promotion of health and wellness. It also calls for a patient-centred system of care that emphasises quality and effectiveness, and solves some of the persistent access problems faced by many communities who are seeking care. It is the firm belief of the leadership of the Department that achieving this vision will not only benefit many generations to come, but will create a stronger base of support for social consciousness that values prevention of illnesses than treating them.

The NDoH executive and senior management team developed five goals for the Depart¬ment. The goals address strategic issues and provide broad direction. While the priorities of public health are numerous, with a great degree of difficulty, the NDoH narrowed its goals to areas of public health that require additional im¬mediate attention while remaining achievable with limited resources of the country.

These 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.

The first goal addresses issues of health promotion and the prevention of diseases. The long-term goal beyond these five years is to have a generation which totally embraces healthy lifestyle and reject habits that shorten one's life. The second goal is focused on earnest implementation of the NHI. The third goal addresses re-engineer of primary healthcare as prerequisite to the successful implementation of NHI. The last two goals address preparing the public health workforce of tomorrow and enhancing the quality and timeliness of the Department's administrative functions.

The Department has developed rel¬evant performance measures and confirmed the relevance of these perfor¬mance measures with management and staff. These performance measures help refine and fo¬cus the goals by identifying measurable activities with targets that determines progress in attaining the goals.

In short, each performance measure, combined with its target and its timelines (dead¬line), becomes an objective. The goals and objectives developed by the NDoH management team are described in the following pages.

I wish to thank the executive for its guidance in the development and finalisation of this Strategic Plan, senior management team for their aptitude in grasping the strategic vision and goals of the Department and the staff that worked tirelessly to meet tight deadline in the compilation, editing and production of this document.

Ms MP Matsoso

Director-General: Health

OFFICIAL SIGN OFF

It is hereby certified that this Strategic Plan:

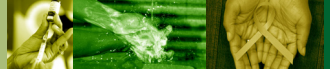
- Was developed by the management of the National Department of Health under the guidance and support of the Ministry of Health;
- Takes into account all the relevant policies, legislation and other mandates for which the Department of Health is responsible for; and
- Accurately reflects the strategic outcome oriented goals and objectives which the Department of Health will endeavour to achieve over the period 2015/16 - 2019/20.

MR I VAN DER MERWE
CHIEF FINANCIAL OFFICER

MS M WOLMARANS
CHIEF DIRECTOR: POLICY CO-ORDINATION AND INTEGRATED PLANNING

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH

DR PA MOTSOALEDI
MINISTER OF HEALTH

ACRONYMS

AG	Auditor-General
AIDS	Acquired Immune Deficiency Syndrome
AMC	Academic Medical Center
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
CHC	Community Health Center
CHW	Community Health Worker
CMS	Council for Medical Schemes
CRA	Comparative Risk Assessment
CSIR	Council for Scientific and Industrial Research
CTOP	Choice of Termination of Pregnancy
DBSA	Development Bank of Southern Africa
DCST	District Clinical Specialist Teams
DHIS	District Health Information System
DORA	Division of Revenue Act
EDMS	Electronic Document Management System
EML	Essential Medicines List
EMS	Emergency Medical Services
ESMOE	Essential Steps in Managing Obstetric Emergencies
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
LBW	Low Birth Weight
MBOD	Medical Bureau for Occupational Diseases
MDG	Millennium Development Goal
MDR	Multi Drug Resistance
MISP	Master Information Systems Plan
MMR	Maternal Mortality Rate
MRC	Medical Research Council
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NAPHISA	National Public Health Institutes of South Africa
NCD	Non-Communicable Disease
NDP	National Development Plan
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
OHSC	Office of Health Standards Compliance
OPV	Oral Polio Vaccine
OSD	Occupation Specific Dispensation
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPIP	Perinatal Problem Identification Programme
PPP	Public Private Partnership
QIP	Quality Improvement Plan
RDP	Reconstruction and Development 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
SRH	Sexual and Reproductive Health
STATSSA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
THP	Traditional Health Practitioners
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WBOT	Ward Based Outreach Teams
WHO	World Health Organisation
YFS	Youth Friendly Services

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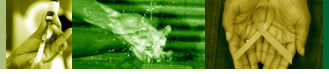
PART A:
STRATEGIC OVERVIEW

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 of Health is guided by the following sections and schedules, among others:

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

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

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

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

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

(1) Everyone has the right to have access to –
   a. Health care services, including reproductive health care;
   b. Sufficient food and water; and
   c. Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
(3) No one may be refused emergency medical treatment.
Section 28 of the Constitution provides that every child has the right to 'basic nutrition, shelter, basic health care services and social services'.

3.2. National Health Act, 61 of 2003

Provides a framework for a structured 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.

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

- **Medicines and Related Substances Act, 101 of 1965**
  Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.
- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 (as amended)**
  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.
- **Hazardous Substances Act, 15 of 1973**
  Provides for the control of hazardous substances, in particular those emitting radiation.
- **Occupational Diseases in Mines and Works Act, 78 of 1973**
  Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.
- **Pharmacy Act, 53 of 1974 (as amended)**
  Provides for the regulation of the pharmacy profession, including community service by pharmacists
- **Health Professions Act, 56 of 1974 (as amended)**
  Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.
- **Dental Technicians Act, 19 of 1979**
  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.
- **Allied Health Professions Act, 63 of 1982 (as amended)**
  Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.
- **Human Tissue Act, 65 of 1983**
  Provides for the administration of matters pertaining to human tissue.
- **National Policy for Health Act, 116 of 1990**
  Provides for the determination of national health policy to guide the legislative and operational programmes of the health portfolio.
- **SA Medical Research Council Act, 58 of 1991**
  Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

- **Academic Health Centres Act, 86 of 1993**
  Provides for the establishment, management and operation of academic health centres.
- **Choice on Termination of Pregnancy Act, 92 of 1996 (as amended)**
  Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.
- **Sterilisation Act, 44 of 1998**
  Provides a legal framework for sterilisations, including for persons with mental health challenges.
- **Medical Schemes Act, 131 of 1998**
  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.
- **Tobacco Products Control Amendment Act, 12 of 1999 (as amended)**
  Provides for the control of tobacco products, the prohibition of smoking in public places and of advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry.
- **National Health Laboratory Service Act, 37 of 2000**
  Provides for a statutory body that offers laboratory services to the public health sector.
- **Council for Medical Schemes Levy Act, 58 of 2000**
  Provides a legal framework for the Council to charge medical schemes certain fees.
- **Mental Health Care Act, 17 of 2002**
  Provides a legal framework for mental health in the Republic and, in particular, the admission and discharge of mental health patients in mental health institutions, with an emphasis on human rights for mentally ill patients.
- **Nursing Act, of 2005**
  Provides for the regulation of the nursing profession

3.4. Other legislation applicable to the Department

- **Criminal Procedure Act, Act 51 of 1977, Sections 212 4(a) and 212 8(a).**
  Provides for establishing the cause of non-natural deaths.
- **Child Care Act, 74 of 1983**
  Provides for the protection of the rights and well-being of children.
- **Occupational Health and Safety Act, 85 of 1993**
  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.
- **Compensation for Occupational Injuries and Diseases Act, 130 of 1993**
  Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.
- **The National Roads Traffic Act, 93 of 1996**
  Provides for the testing and analysis of drunk drivers.
- **Constitution of the Republic of South Africa Act, 108 of 1996**
  Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.
- **Employment Equity Act, 55 of 1998**
  Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.
- **State Information Technology Act, 88 of 1998**
  Provides for the creation and administration of an institution responsible for the state's information technology system.
- **Skills Development Act, 97of 1998**
  Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.
- **Public Finance Management Act, 1 of 1999**
  Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.
- **Promotion of Access to Information Act, 2 of 2000**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.
- **Promotion of Administrative Justice Act, 3 of 2000**
  Amplifies the constitutional provisions pertaining to administrative law by codifying it.
- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**
  Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.
- **The Division of Revenue Act, 7 of 2003**
  Provides for the manner in which revenue generated may be disbursed.
- **Broad-based Black Economic Empowerment Act, 53 of 2003**
  Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.
- **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

3.5. Planned policy initiatives

3.5.1. Facilitate Implementation of National Health Insurance (NHI)

South Africa is at the brink of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system in order to realize universal health coverage. The phased implementation of National Health Insurance (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.

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

The focus areas of these interventions include (i) improving the management of health facilities; (ii) improving throughput from training institutions to address key Human resources for Health requirements; (iii) strengthening infrastructure programme and procurement of equipment; (iv) health information systems and technology; (v) rationalising of laboratory services; (vi) effective and integrated procurement of Health Commodities; (vii) the implementation 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.

3.5.2. South Africa Health Products Regulatory Authority (SAHPRA)

The Medicines and Related Substances amendment bill to create the South African Health Products Regulatory Authority (SAHPRA) is currently being deliberated by the Portfolio Committee on Health. The proposal is to bring the medical devices industry, cosmetics and foodstuffs as well as pharmaceuticals under the jurisdiction of the SAHPRA. The SAHPRA will be established as a Section 3A Public Entity and would thus be able to retain funds from application fees which can be utilised to employ experts to evaluate applications on a full time basis.

3.5.3. Traditional Medicine

The Traditional Health Practitioners bill for the establishment of the Traditional Health Practitioners Council. The bill will bring to an end the existence of the Interim Traditional Health Practitioners Council established in terms of Act 22 of 2007.

3.5.4. Operation Phakisa and Ideal Clinic Initiative

The Ideal Clinic Realisation and Maintenance process started in 2013 to systematically build on the work of the Facility Improvement Teams. An Ideal Clinic is a clinic 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 will cooperate with other government departments as well as with the private sector and non-governmental organizations 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) will be 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 Issues Facing the Department 2010-2014

The Health Sector’s Negotiated Service Delivery Agreement (NSDA) for 2010-2014 served as the strategic framework for addressing the Burden of Disease (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. The NSDA presented four key outputs that the health sector must endeavor to achieve namely:

- Increasing Life Expectancy;
- Decreasing Maternal and Child Mortality rates;
- 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 intersectoral collaboration to address social determinants of health, can improve health outcomes.
Significant milestones were achieved through the strategic interventions implemented by the health sector, in partnerships with communities across the country. These are outlined in the Epidemiological Profile section.

4.2. Demographic Profile

For 2014, Statistics South Africa (StatsSA) estimates the mid-year population as 53.7 million. Figure 1 displays the percentage distribution of the projected provincial share of the total population according to the 2014 midyear estimates. Gauteng comprises the largest share of the South African population. Approximately a quarter of South Africa’s population (12.9 million people)live in this province. KwaZulu-Natal is the province with the second largest population, with 10.5 million people (19.7%) living in this province. With a population of approximately 1.17 million people (2.2%), Northern Cape remains the province with the smallest share of the South African population.
In terms of migrating patterns between provinces, there has been a gradual outflow of population in 5 provinces with 2 provinces that had no change. Gauteng and Western Cape experienced a significant population influx between 2002 and 2013.

Figure 1: South Africa's Mid-year Population Estimates for 2014

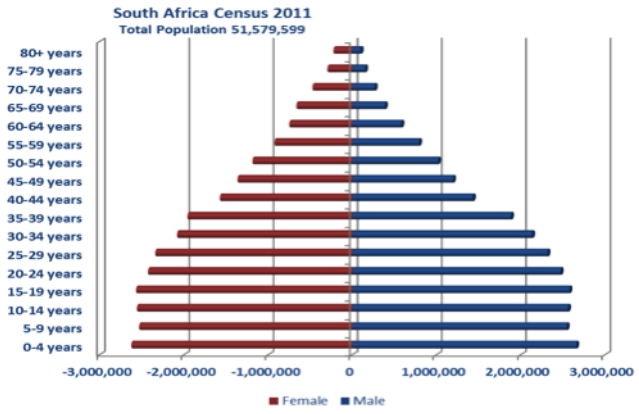
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Eastern Cape	13,2	13,1	13,0	13,0	12,9	12,9	12,8	12,8	12,7	12,7	12,6	12,6	12,6
Free State	5,9	5,8	5,7	5,7	5,6	5,5	5,5	5,4	5,4	5,3	5,3	5,2	5,2
Gauteng	22,8	23,0	23,1	23,2	23,3	23,4	23,5	23,5	23,6	23,7	23,8	23,9	23,9
KwaZulu-Natal	20,0	20,0	19,9	19,9	19,9	19,9	19,9	19,9	19,8	19,8	19,8	19,8	19,8
Limpopo	10,5	10,5	10,5	10,5	10,5	10,5	10,5	10,5	10,4	10,4	10,4	10,4	10,4
Mpumalanga	7,7	7,7	7,7	7,7	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
North West	6,8	6,8	6,8	6,8	6,8	6,8	6,8	6,8	6,8	6,8	6,8	6,8	6,8
Western Cape	10,8	10,9	10,9	11,0	11,0	11,1	11,1	11,2	11,2	11,2	11,3	11,3	11,3
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**

Source: Mid-year population estimates 2014 (StatsSA, July 2014)

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

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

Figure 2: South Africa's Population Estimates for 2011



Source : Census 2011 (StatsSA)

In 2014, about 30,0% of the population is aged younger than 15 years and approximately 8,4% (4,54 million) is 60 years or older. Of those younger than 15 years, approximately 22,7% (3,66 million) live in KwaZulu-Natal and 18,8% (3,05 million) live in Gauteng. The province with the smallest population namely Northern Cape has 28% of its population aged younger than 15 years, and nearly one tenth of the population aged 60 and older.

4.3. Social Determinants of Health

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

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

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

c) Improved availability of data has resulted in better targeting with 3,5million households being identified as indigent;
d) Progress has also been made towards achieving universal primary education[2] with

- Adjusted net enrolment ratios in primary education increased from:
  - 96,5% in 2002 to 98,9% in 2013 for males;
  - 96,8% in 2002 to 99,2% in 2013 for females;
- Proportion of learners starting Grade 1 who reach last grade of Primary School increased from:
  - 89,2% in 2002 to 93,4% in 2013 for males;
  - 90,1% in 2002 to 96,1% in 2013 for females;
- Literacy rate of 15 to 24 year olds increased from:
  - 83,3% in 2002 to 90,7% in 2013 for males; and
  - 88,4% in 2002 to 94,6% in 2013 for females.

4.4 Epidemiological Profile

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

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

4.4.1. Life Expectancy

The 2011 Census population estimates (StatsSA 2012) indicated that the population size was different from what was expected. The age distribution of the population below 30 years and the overall size of the population were particularly significant. This new data was used to determine the mortality indicators in the Rapid Mortality Surveillance (RMS) Report, 2012 and 2013.
The life expectancy of South Africans for both males and females has significantly improved between 2009 and 2013 while premature mortality has decreased for both males and females during the same period (see Table 1 below).

Table 1: Life Expectancy and Adult Mortality

Indicator	Baseline	Progress			
	2009	2010	2011	2012	2013
Life expectancy at birth: Total	57.1	58.5	60.5	61.3	62.2
Life expectancy at birth: Male	54.6	56.0	57.8	58.5	59.4
Life expectancy at birth: Female	59.7	61.2	63.2	64.0	65.1
Adult mortality (45q15): Total	46%	43%	40%	38%	36%
Adult mortality (45q15): Male	51%	48%	46%	44%	42%
Adult mortality (45q15): Female	40%	38%	35%	32%	30%

Source: MRC, Rapid Mortality Surveillance Report 2013)

These findings commensurate well with StatsSA's 2014, midyear population estimates, where the average provincial life expectancy at birth has increased for both males and females in all the provinces and has reached 57.7 years and 61.4 years for males and females respectively in 2013 as illustrated in Table 2 below. Free State province has the lowest life expectancy and Western Cape the highest amongst the nine provinces.
The Adult Mortality downward trend commensurate with the Life Expectancy upward trend for the past 5 years. The probability of population 15 years and older dying before their 60th birthday (Adult Mortality (45q15)) has declined by 10% from 46% in 2009 to 36% in 2013.

Table 2: Life Expectancy

Province	2001-2006		2006-2011		2011-2016	
	Male	Female	Male	Female	Male	Female
Eastern Cape	46.7	50.2	48.2	53.6	53.0	59.0
Free State	42.0	45.4	45.4	48.6	50.7	53.6
Gauteng	56.1	60.2	58.7	62.2	62.9	66.4
KwaZulu-Natal	45.7	50.2	49.2	53.8	54.4	59.4
Limpopo	51.5	58.6	55.1	59.8	58.3	62.5
Mpumalanga	49.0	52.5	51.5	55.5	56.9	60.1
North West	46.7	49.0	49.7	53.2	56.6	58.8
Northern Cape	50.4	56.1	51.8	56.9	52.9	57.5
Western Cape	57.9	63.8	61.0	65.7	63.7	67.9

Source: Mid-year population estimates 2013 (StatsSA, July 2014)

Table 3 below details the birth rate, life expectancy for People Living with HIV (PLWHIV), infant mortality, under 5 mortality and death rate. This table best summarises the country trend in terms of demography. Life expectancy has continued to steadily increase, with the crude birth rate (CBR) remaining stable around 22. The infant and under 5 mortality rates have continued to decrease but not at the targeted rate.

Table 3: Summary of key health outcomes 2002 to 2014

Year	Crude	Life expectancy at birth with HIV			Infant mortality rate (IMR)	Under 5 mortality rate	Crude death rate
		Male	Female	Total			
2002	24.4	51.1	55.7	53.4	57.8	85.2	13.9
2003	24.2	50.5	54.8	52.7	56.2	83.5	14.5
2004	24.0	50.2	54.1	52.2	54.3	80.9	15.0
2005	23.8	50.2	53.9	52.1	52.0	77.4	15.2
2006	23.6	51.0	54.8	53.0	49.4	72.9	14.5
2007	23.4	52.7	56.6	54.7	45.8	67.4	13.4
2008	23.2	53.8	58.1	56.0	45.0	64.7	12.6
2009	23.1	55.1	59.4	57.3	40.9	59.9	11.8
2010	23.0	56.1	60.3	58.2	38.9	53.8	11.4
2011	22.8	56.6	60.6	58.7	37.8	50.4	11.3
2012	22.7	57.3	61.3	59.3	36.8	48.3	11.0
2013	22.6	58.2	62.1	60.2	35.2	45.6	10.7
2014	22.4	59.1	63.1	61.2	34.4	44.1	10.2

Source: Statistics South Africa. Mid-year population estimates, 2014

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

4.4.2. HIV and AIDS and TB

South Africa is experiencing serious generalised HIV and TB epidemics. It continues to be home to the world's largest number of people living with HIV. The total number of persons living with HIV in South Africa increased from an estimated 4,09 million in 2002 to 6.4million by 2012. The proportion of South Africans infected with HIV has increased from 10.6% in 2008 to 12.3% in 2012, according to the Human Sciences Research Council (HSRC).For 2012 an estimated 12.2.% of the total population is HIV positive. This is a increase from the 2008 estimate of 10.6%. The estimated national HIV prevalence among the general adult population (15-49 years old) is 18.8% in 2012. The evolution of HIV prevalence among women presenting for antenatal care has been routinely measured since 1990, and has stabilised at approximately 29% since 2004. Approximately one-fifth of South African women in their reproductive ages are HIV positive. The country also ranks third among countries with the highest burden of TB in the world after India and China (WHO 2012). Levels of HIV and TB co-infection are very high, with as many as 60% of patients dually infected. There is also increasing incidence of multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB.

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

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

Table 4: HIV mortality, incidence estimates and the number of people living with HIV, 2002-2014

Year	Total number of deaths	Total number of AIDS related deaths	Percentage AIDS related deaths	Incidence Adult 15-49	HIV population (Millions)
2002	631 383	275 444	43.6	1.64	4.09
2003	667 902	313 477	46.9	1.64	4.20
2004	697 473	344 141	49.3	1.69	4.29
2005	716 083	363 910	50.8	1.73	4.38
2006	694 227	343 194	49.4	1.69	4.48
2007	647 827	267 659	45.9	1.59	4.61
2008	617 202	257 504	41.7	1.47	4.75
2009	590 322	228 051	38.6	1.36	4.88
2010	578 953	213 864	36.9	1.29	5.02
2011	580 460	211 839	36.5	1.25	5.14
2012	575 546	203 293	35.3	1.16	5.26
2013	565 310	189 376	33.5	1.14	5.38
2014	551 389	171 733	31.1	1.11	5.51

Source: Statistics South Africa. Mid-year population estimates, 2014

Table 5 Improved Access to ART

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

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

There has been rapid scale up of ART services resulting in a four-fold increase in the number of people receiving ART between 2009 and 2012. The number of patients receiving ART in SA has increased exponentially between 2004 and 2011, with women and users of the public sector gaining greater access to ART.

Above tables are reflective of the close relationship between the scale up of ART services and the reduction in AIDS related deaths over the past 14 years.

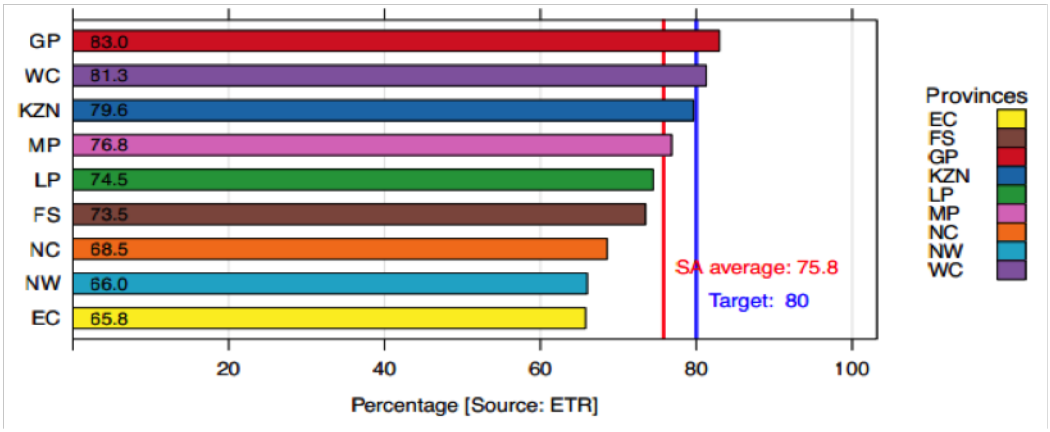
On the HIV prevention front, the HIV incidence has steadily declining for the past 12 years amongst the most vulnerable population.

The HIV Counselling and Testing (HCT) campaign resulted in more than 13 million tests for HIV and over three million people screened for TB. There is universal coverage of PMTCT services. TB case detection has increased and the number of sites initiating MDR-TB treatment has increased from 11 to 45. The Department of Health (DoH) appears to be on course to meeting its targets as defined in the National Strategic Plan on HIV, STIs and TB (2012-2016).

Tuberculosis remains a significant public health problem in the country. The cure rate for new pulmonary smear-positive TB patients has increased over the last six years from 61.6% in 2006 to 75.8%% in 2012. This is a 1.6% increase from 2011. Figure 3 shows the TB cure rate (new pulmonary smear-positive) by province in 2012. Only Gauteng and Western Cape are achieving the set targets for South Africa. The lowest cure rate is found in the Eastern Cape Province.

There were just under 300 000 new tuberculosis cases reported in 2013. This is a decrease from the 2011 numbers reported of 389 000. The 2014 Global WHO TB report indicates that South Africa's TB incidence rate has decreased from 993 cases per 100 000 in 2011, to 860 cases per 100 000 in 2013. While there are still many missed opportunities to identify and treat existing cases to curb transmission at community level, positively, South Africa has remained the leading country in providing Isoniasid Preventive Therapy (IPT) to all HIV positive patients. This has been shown to decrease TB risk in this vulnerable population.

Figure 3: the TB cure rate (new pulmonary smear-positive) by province in 2012.



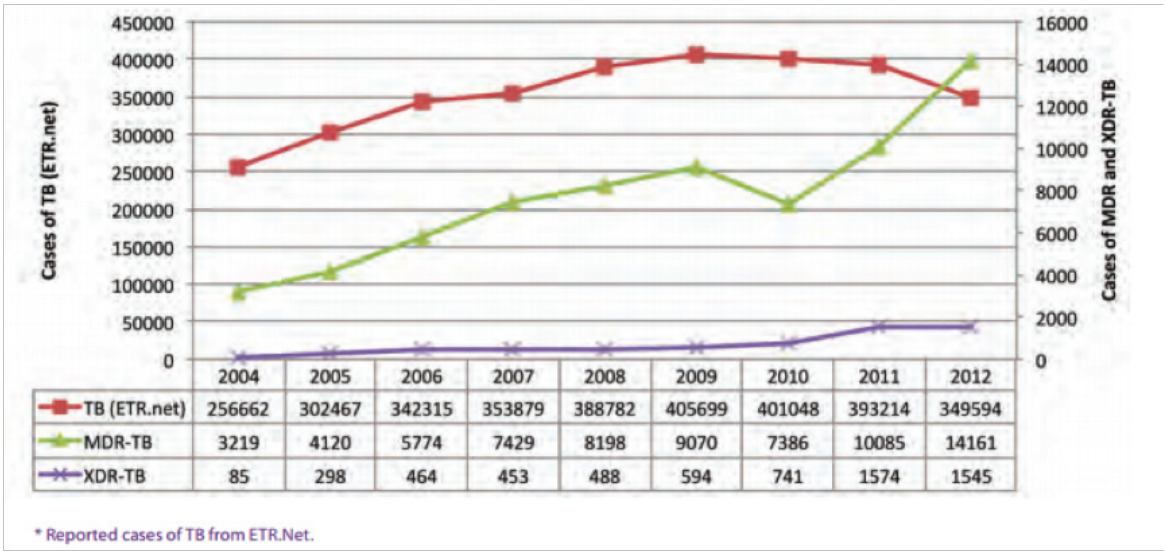
Source: District Health Barometer 2013/14 (Health Systems Trust)

South Africa's TB epidemic is worsened by poor adherence as a result of patients not being initiated on, or lost to treatment. Resultantly, they expand the pool of infection, and also develop resistance to "normal" treatment, requiring much more complex and expensive forms of treatment. In 2012 the estimated cases of MDR-TB rose to 450 000 globally and XDR-TB was reported in just under 100 countries, highlighting the threat of drug-resistant TB to global TB control. South Africa has the second highest number of reported MDR-TB cases globally, and Figure 4 below illustrates the rapidly rising numbers of patients with MDR-TB and more slowly rising numbers of XDR-TB, together with (since 2009) the declining number of TB patients in the country .

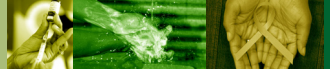
Table 6: Key TB Indicators

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

Figure 4: Reported TB Cases 2004-2012



Source: District Health Barometer 2013/14

4.4.3. Maternal and Child Health

In line with MDG targets the South African health system aimed to reduce its child mortality by two-thirds between 1990 and 2015. "The 1998 South African Demographic and Health Survey (DHS) report indicated an under-five mortality rate of 59 per thousand live births during the period 1993–98. Using this as a benchmark, the implication for South Africa was a reduction of under-five mortality rate (U5MR) to 20 per thousand live births by 2015. Similarly, an infant mortality rate (IMR) of 18 per 1000 live births has been set for the 2015 MDG target for IMR."

South Africa has made remarkable progress against these 3 very critical health outcome indicators of maternal, child and infant mortality. The South African health system delivered against its Negotiated Service Delivery Agreement 2010-2014 targets for all 3 indicators. The Rapid Mortality Surveillance Report 2013 reflects that:

- The Under-5 mortality rate (U5MR) has significantly decreased from 56 deaths per 1,000 live births in 2009, to 41 deaths per 1,000 live births in 2013. This was against the Negotiated Service Delivery Agreement 2010-2014 target of 50 deaths per 1,000 live births.

- The Infant Mortality Rate (IMR) has decreased from 39 deaths per 1,000 live births in 2009, to 29 deaths per 1,000 live births in 2013. This was against the Negotiated Service Delivery Agreement 2010-2014 target of 35 deaths per 1,000 live births.

- The Neonatal Mortality Rate (NMR) has also declined, but at a much slower pace. It reduced from 14 deaths per 1,000 live births in 2009 to 11 deaths per 1,000 live births in 2013. It has remained stable at 11 deaths per 1,000 live births for the past 2 years. This was against the Negotiated Service Delivery Agreement 2010-2014 target of 12 deaths per 1,000 live births.

- The maternal mortality ratio (MMR) reduced from 281 deaths per 100,000 live births in 2008 to 197 deaths per 100,000 live births in 2011. This was against the Negotiated Service Delivery Agreement 2010-2014 target of 252 deaths per 100,000 live births.

Table 7: IMR, U5-MR and MMR progression

Health indicator	Source[1]	Baseline (2009) [1]	NSDA Target (2014) [1]	Progress (2013)
Maternal Mortality Ratio	Vital Registration Data Birth estimates from Actuaries Society of South Africa (ASSA) 2008	310 per 100 000 live births (2008)	270 per 100 000 live births	269 [3]
Infant Mortality Rate	Deaths from the national population register.	40 per 1000 live births	36 per 1 000 live births	29 per 1 000 live births[2]
Under five Mortality Rate	Birth estimates from ASSA 2008	56 per 1000 live births	50 per 1 000 live births	41 per 1 000 live births[2]
Life expectancy	Deaths from the national population register. Population estimates from ASSA2008	56.5 years 54 years for males 59 years for females	58.5 years 56 years for males 61 years for females	59.6 years[2] 56.9 years for Males[2] 62.4 years for females[2]

[1]: Source: Health Data Advisory and Co-ordination committee report (Published: February 2012)
[2]: Source: Rapid Mortality Surveillance Report 2013 (Published: 2014)
[3]: Source : Causes of Death s data from Civil Registration and Vital Statistics System (CRVS)

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

Table 8: Institutional Maternal Mortality Ratio

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

Source: National Committee of Confidential Enquiry into Maternal Deaths

4.4.4. Violence and Injuries

Violence and injuries forms one of the four components of the quadruple burden of disease that South Africa faces. SA has an injury death rate of 158 per 100 000, which is twice the global average of 86,9 per 100 000 population and higher than the African average of 139,5 per 100 000 . Key drivers of the injury death rates are:

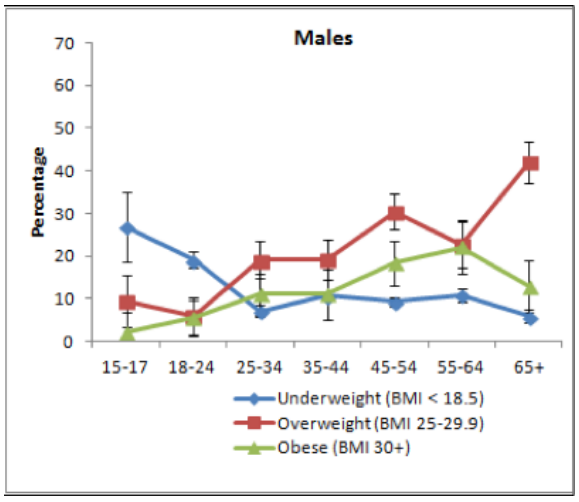
- intentional injuries due to interpersonal violence (46% of all injury deaths);
- road traffic injuries (26%);
- suicide (9%);
- fires (7%);
- drowning (2%),
- falls (2%) and
- poisoning (1%).

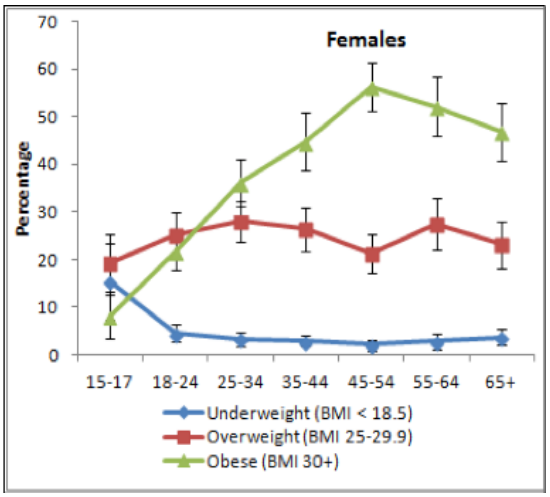
A need exists to implement a comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate.

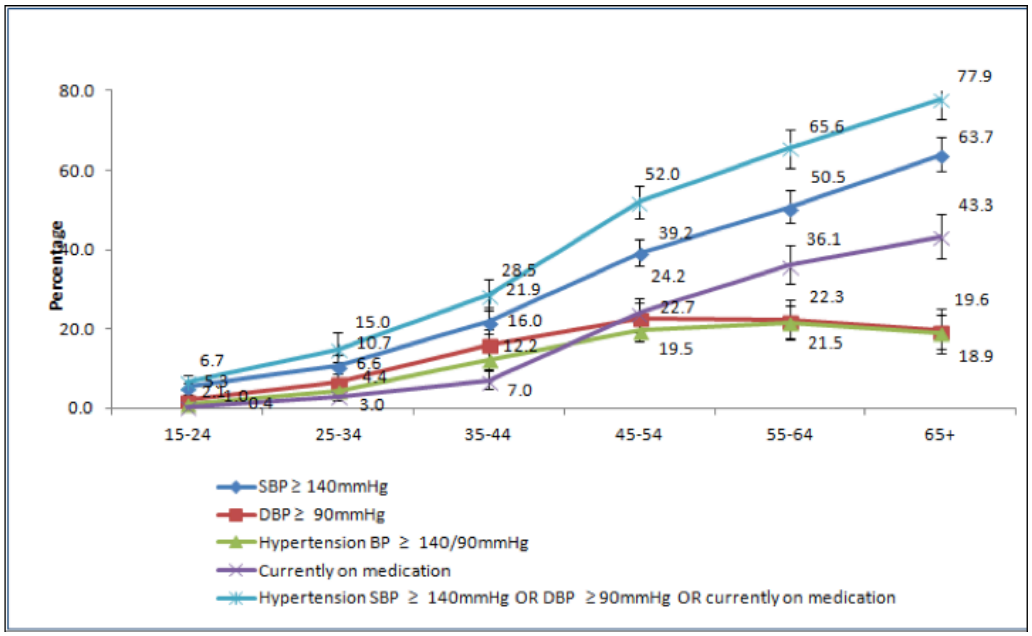
4.4.5. Non-Communicable Diseases (NCDs)

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

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







Research evidence also 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.

The National Mental Health Policy Framework and Strategic Plan 2013-2020 that was adopted in July 2013 sets out key objectives and milestones that must be realised to transform mental health services in this country and in the main the priorities are (i) improving detection rates and management of mental disorders especially in primary health care setting; (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.

4.4.6. Communicable Diseases

Seasonal, zoonotic, and pandemic influenza is a major public health threat throughout the world. Seasonal influenza is a highly communicable respiratory tract infection causing an estimated 250,000 to 500,000 deaths in persons of all ages annually. In South Africa, it is estimated that from 5,000 to 10,000 deaths and from 70,000 to 100,000 hospitalisations are due to influensa each year. The primary effective prevention strategy is vaccination before the influenza season sets in. The programme will continue vaccinating high risk individuals to mitigate the impact of the disease. South Africa is also endemic to neglected tropical diseases with geographical distribution overlapping with areas endemic to malaria. South Africa is also pone to infectious disease such as rabies, cholera and hemorrhagic fevers. Strengthening the core capacities for surveillance and response in line with the International Health Regulations (2005) will mitigate the morbidity and mortality associated with the outbreaks, epidemics and pandemics.

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. The aggregated malaria incidence per 1000 population at risk for the 2014/15 malaria season is approximately 0.3 per 1000 population at risk. The key strategies for elimination of the disease will be to strengthen surveillance, health promotion, case management and vector control. South Africa will also be working closely with its neighbouring countries: Mozambique, Swaziland and Zimbabwe in regional malaria initiatives as this will contribute the elimination agenda of the country.

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. serious concerns about the quality of public health care;
c. an ineffective and inefficient health system; and
d. spiralling private health care costs.

Both the National Development Plan (NDP) 2030 and the World Health 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 (DoH) and the Provincial Heads of Department (HoDs) of Health in the 9 Provinces, and National DoH Deputy Director-Generals.[1]

5.2. National Development Plan 2030 vision

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

By 2030, South Africa should have:

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

5.3. Priorities to achieve Vision 2030

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

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

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

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

5.5. Strategic goals of the Department

The Department's five year strategic goals are to:

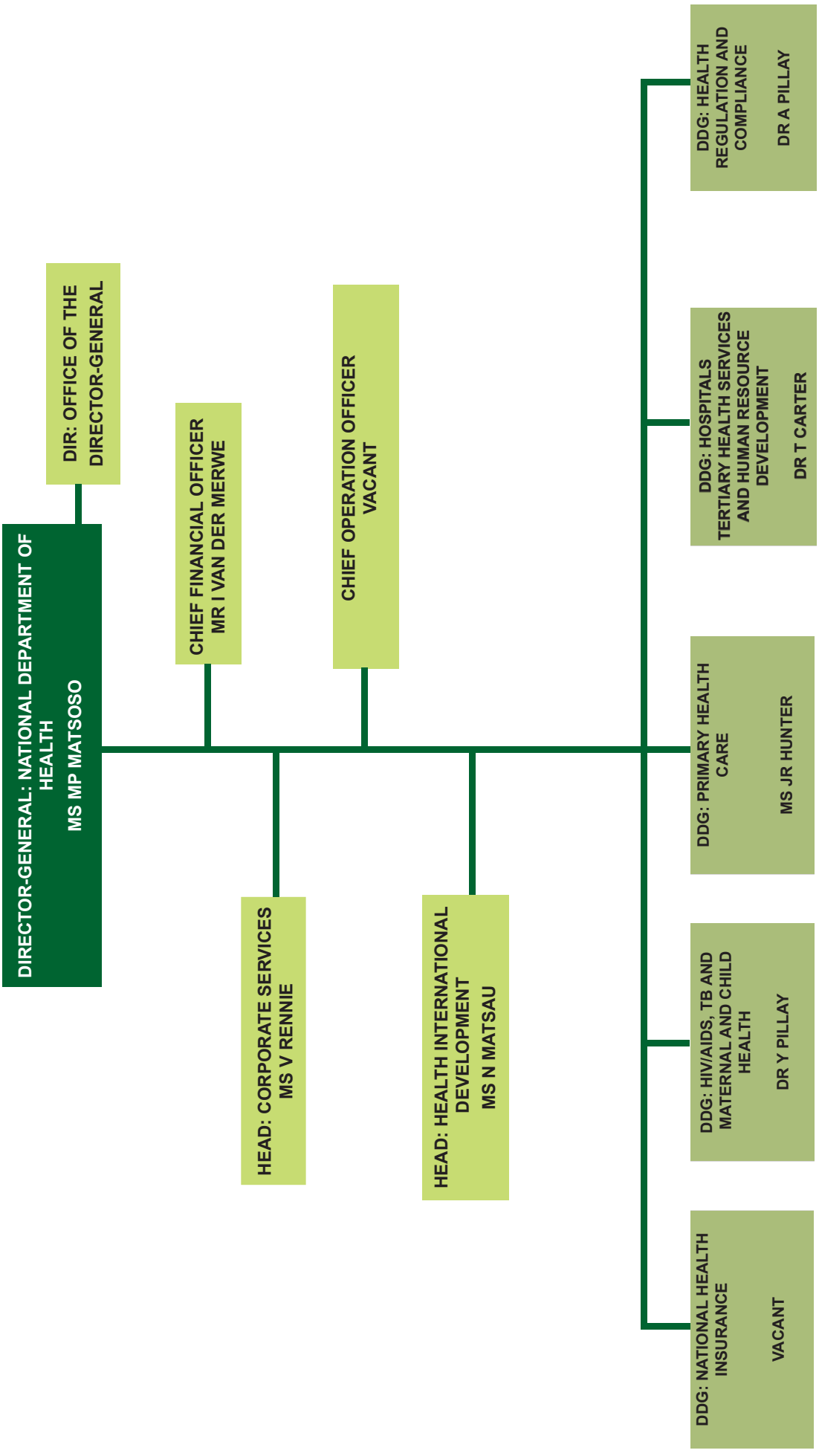
- Prevent disease and reduce its burden, and promote health;
- Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation;
- Re-engineer primary healthcare by: increasing the number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

6. ORGANISATIONAL ENVIRONMENT

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

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

ORGANISATIONAL STRUCTURE



7. OVERVIEW OF MTEF 2015/16 - 2017/18 BUDGETS

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	Revised estimate	Average growth rate (%)	Expenditure/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expenditure/ total: Average (%)
R million	2014/15	2011/12 - 2014/15		2015/16	2016/17	2017/18	2014/15 - 2017/18	
Programme 1	389.7	3.9%	1.2%	457.1	456.0	492.1	8.1%	1.2%
Programme 2	328.9	23.1%	0.9%	587.8	576.6	682.1	27.5%	1.4%
Programme 3	12 772.3	17.8%	34.0%	14 442.1	16 002.7	17 972.9	12.1%	40.4%
Programme 4	216.2	1.1%	0.7%	225.0	239.3	251.8	5.2%	0.6%
Programme 5	18 514.2	3.0%	59.3%	19 159.1	19 961.4	21 220.0	4.7%	52.1%
Programme 6	1 403.1	12.2%	3.9%	1 596.9	1 687.7	1 718.4	7.0%	4.2%
Total	**33 624.3**	**8.3%**	**100.0%**	**36 468.0**	**38 923.5**	**42 337.2**	**8.0%**	**100.0%**
Change to 2014 Budget estimate				(610.8)	(936.1)	(660.4)		
Economic classification								
Current payments	**1 736.8**	**7.0%**	**4.6%**	**2 351.5**	**2 226.0**	**2 388.1**	**11.2%**	**5.7%**
Compensation of employees	656.5	8.9%	2.0%	772.1	813.8	854.7	9.2%	2.0%
Goods and services	1 080.3	5.9%	2.6%	1 579.5	1 412.3	1 533.4	12.4%	3.7%
of which: Administration fees	1.0	16.1%	–	1.0	0.4	0.2	-41.1%	–
Advertising	57.8	14.4%	0.1%	32.4	23.9	9.3	-45.6%	0.1%
Assets less than the capitalisation threshold	29.7	28.4%	–	15.5	6.7	4.8	-45.5%	–
Audit costs: External	30.7	4.4%	0.1%	35.7	33.1	38.7	8.0%	0.1%
Bursaries: Employees	1.5	-1.3%	–	1.6	1.3	2.0	10.3%	–
Catering: Departmental activities	7.7	9.9%	–	8.2	4.9	2.8	-28.5%	–
Communication	27.4	13.8%	0.1%	23.3	25.9	21.8	-7.3%	0.1%
Computer services	29.6	-0.2%	0.1%	23.9	16.5	13.8	-22.4%	0.1%
Consultants and professional services: Business and advisory services	114.4	-21.2%	0.5%	123.1	142.4	126.8	3.5%	0.3%
Consultants and professional services: Infrastructure and planning	59.6	–	0.1%	13.0	13.0	13.0	-39.8%	0.1%
Consultants and professional services: Laboratory services	0.1	–	–	0.1	0.4	–	-100.0%	–

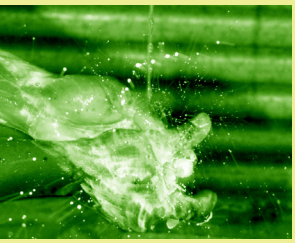
Programme	Revised estimate	Average growth rate (%)	Expenditure/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expenditure/ total: Average (%)
R million	2014/15		2011/12 - 2014/15	2015/16	2016/17	2017/18		2014/15 - 2017/18
Consultants and professional services: Scientific and technological services	45.6	–	0.1%	10.2	25.5	28.6	-14.4%	0.1%
Consultants and professional services: Legal costs	1.1	-66.7%	–	1.2	1.0	7.0	83.7%	–
Contractors	85.8	111.5%	0.1%	341.5	324.4	412.3	68.7%	0.8%
Agency and support / outsourced services	17.4	10.9%	–	222.4	234.9	236.5	138.8%	0.5%
Entertainment	0.8	-2.4%	–	0.8	0.1	–	-100.0%	–
Fleet services (including government motor transport)	29.8	–	–	23.6	11.6	27.8	-2.2%	0.1%
Inventory: Clothing material and accessories	2.8	–	–	–	–	–	-100.0%	–
Inventory: Fuel, oil and gas	0.5	16.3%	–	0.5	1.0	1.3	39.4%	–
Inventory: Learner and teacher support material	0.2	–	–	0.2	–	–	-100.0%	–
Inventory: Materials and supplies	1.5	36.2%	–	0.7	0.7	0.4	-38.3%	–
Inventory: Medical supplies	153.2	0.2%	0.4%	189.3	210.1	192.6	7.9%	0.5%
Inventory: Medicine	74.1	52.2%	0.1%	196.2	2.9	0.6	-79.9%	0.2%
Inventory: Other supplies	12.4	–	–	14.9	13.0	13.4	2.6%	–
Consumable supplies	–	-100.0%	–	–	–	0.4	–	–
Consumables: Stationery, printing and office supplies	39.0	7.6%	0.1%	37.4	26.4	27.5	-11.0%	0.1%
Operating leases	111.3	5.8%	0.3%	127.9	132.5	139.8	7.9%	0.3%
Property payments	5.6	-1.7%	–	8.8	10.1	24.0	62.8%	–
Transport provided: Departmental activity	0.7	287.8%	–	0.7	0.8	–	-100.0%	–

Expenditure estimates by programme and economic classification (continued)								
Economic Classification	**Revised estimate**	**Average growth rate (%)**	**Expenditure/ total: Average (%)**	**Medium-term expenditure estimate**			**Average growth rate (%)**	**Expenditure/ total: Average (%)**
R million	**2014/15**		**2011/12 - 2014/15**	**2015/16**	**2016/17**	**2017/18**		**2014/15 - 2017/18**
Travel and subsistence	72.6	-13.9%	0.3%	66.1	95.4	110.7	15.1%	0.2%
Training and development	9.3	61.4%	–	4.8	6.2	8.1	-4.5%	–
Operating payments	35.2	-3.9%	0.1%	35.9	38.7	57.6	17.8%	0.1%
Venues and facilities	22.2	6.5%	–	18.5	8.4	11.6	-19.5%	–
Transfers and subsidies	**31 589.1**	**8.1%**	**95.0%**	**33 448.5**	**36 002.7**	**39 196.8**	**7.5%**	**92.7%**
Provinces and municipalities	30 164.1	7.9%	90.9%	31 857.9	34 338.2	37 495.5	7.5%	88.4%
Departmental agencies and accounts	1 212.9	13.4%	3.4%	1 416.4	1 493.9	1 516.1	7.7%	3.7%
Higher education institutions	3.0	-40.9%	–	3.1	3.3	3.5	5.0%	–
Foreign governments and international organisations	2.7	–	–	–	–	–	-100.0%	–
Non-profit institutions	206.4	6.0%	0.7%	171.1	167.2	181.8	-4.2%	0.5%
Households	–	-85.7%	–	–	–	–	-100.0%	–
Payments for capital assets	**298.4**	**103.1%**	**0.4%**	**668.0**	**694.8**	**752.3**	**36.1%**	**1.6%**
Buildings and other fixed structures	188.0	–	0.3%	562.5	587.1	634.0	50.0%	1.3%
Machinery and equipment	100.7	41.6%	0.2%	105.5	107.7	118.4	5.5%	0.3%
Software and other intangible assets	9.8	317.8%	–	–	–	–	-100.0%	–
Total	**33 624.3**	**8.3%**	**100.0%**	**36 468.0**	**38 923.5**	**42 337.2**	**8.0%**	**100.0%**

1.PERSONNEL INFORMATION

Number of posts estimated for 31 March 2015			Number and cost[2] of personnel posts filled / planned for on funded establishment															Number	
Number of funded posts		Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									Average growth rate (%)	Salary level/total: Average (%)
			2013/14			2014/15			2015/16			2016/17			2017/18			2013/14-2016/17	
			Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost		
Salary level	**1 504**	**–**	**1 842**	**628.0**	**0.3**	**1 880**	**656.5**	**0.3**	**1 898**	**772.1**	**0.4**	**1 898**	**813.8**	**0.4**	**1 897**	**854.7**	**0.5**	**0.3%**	**100.0%**
1 – 6	539	–	608	96.9	0.2	626	99.2	0.2	637	119.8	0.2	637	126.2	0.2	637	132.6	0.2	0.6%	33.5%
7 – 10	591	–	877	287.9	0.3	856	284.8	0.3	858	330.5	0.4	858	348.9	0.4	857	366.4	0.4	0.0%	45.3%
11 – 12	246	–	241	136.0	0.6	267	153.5	0.6	269	181.5	0.7	269	191.6	0.7	269	201.3	0.7	0.2%	14.2%
13 – 16	128	–	116	107.2	0.9	131	119.1	0.9	134	140.3	1.0	134	147.1	1.1	134	154.5	1.2	0.8%	7.0%
Programme	**1 504**	**–**	**1 842**	**628.0**	**0.3**	**1 880**	**656.5**	**0.3**	**1 898**	**772.1**	**0.4**	**1 898**	**813.8**	**0.4**	**1 897**	**854.7**	**0.5**	**0.3%**	**100.0%**
Programme 1	458	–	506	149.9	0.3	468	156.1	0.3	468	177.1	0.4	468	185.9	0.4	467	195.2	0.4	-0.1%	24.7%
Programme 2	194	–	184	85.6	0.5	177	78.7	0.4	177	96.1	0.5	177	101.4	0.6	177	106.5	0.6	–	9.3%
Programme 3	137	–	132	62.5	0.5	137	64.4	0.5	137	68.9	0.5	137	72.7	0.5	137	76.4	0.6	–	7.2%
Programme 4	105	–	437	140.9	0.3	440	147.7	0.3	458	176.5	0.4	458	186.2	0.4	458	195.5	0.4	1.3%	24.0%
Programme 5	291	–	282	95.0	0.3	300	106.4	0.4	300	116.0	0.4	300	122.4	0.4	300	128.5	0.4	–	15.8%
Programme 6	319	–	301	94.2	0.3	358	103.2	0.3	358	137.4	0.4	358	145.1	0.4	358	152.6	0.4	–	18.9%

1. Data may not necessarily reconcile with official government personnel data.
2. Rand million.




PART B:
PROGRAMMES AND STRATEGIC OBJECTIVES




PROGRAMME 1: ADMINISTRATION

1.1 PROGRAMME PURPOSE

To manage and monitor the provision of central support services to all clients in partnership with other stakeholders in the furtherance of the Department's objectives as reflected in the National Development Plan (NDP); Medium Term Strategic Framework (MTSF), and the Strategic Plan of the National Department of Health.

The programme plays a crucial role in the delivery of the Department's services through providing a full range of support services in the areas of organisational development, HR and Administration including Labour Relations Services; Information Technology; Property Services; Security Services; Legal Services; Communication Services; Financial Management and Supply Chain Management.

The services provided by this programme include provision of:

- Human Resources Management and Development in order to review and maintain and strengthen the organisational structure, including the evaluation of staff utilisation; human capital development (performance development, internship, bursary scheme, Skills development, ABET and conditions of services).
- Legal Services and support, including legal opinions, in order to provide legal framework (international Agreements, contracts and SLAs) for departmental activities aimed at achieving the set goals and priorities and strengthening health system effectiveness, as well as the management of litigation for and against the Department with a view to decrease or minimise litigation against the Department and succeed in litigation for the Department. Management of Promotion of Access to Information Act (PAIA) request.
- Internal and external Communication expertise to the Department, consistent with government strategic direction of service delivery and give accurate and timely information while maintaining consistency, in partnership with other stakeholders.
- Information Communication Technology (ICT) services to the Department within a secured environment, ensure continuous availability of such services (IT Service Continuity) and be able to recover the defined services in the event of a disaster..
- Security services which include management of physical security, information security and coordination of the implementation of Occupational Health and Safety as well as liaising with the law enforcement agencies.
- Auxiliary and professional secretariat (committee) support services packages to the satisfaction of both internal and external stakeholders

1.2 STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2014/15)	Target (2019/20)
Ensure effective financial management and accountability	Ensure effective financial management and accountability by improving audit outcomes	Audit opinion from Auditor General	Unqualified audit opinions	Clean Audit Opinion for the NDOH
		Audit opinion from Auditor General for Provincial Departments of Health	2 Unqualified audit opinions	7 Unqualified audit opinions
Ensure efficient and responsive Human Resource Services to the National Department of Health	Ensure efficient and responsive Human Resource Services through the implementation of efficient recruitment processes and responsive Human Resource support programmes	Average Turnaround times for recruitment processes	6 months	3 months
		Employee health and wellness programme that comply with Public Service Regulations (PSR) and Employee Health and Wellness Strategic Framework (EHWSF) Implemented	None	Employee Health and Wellness Programme that adhere to Part VI of the PSR and EHWSF fully implemented
Ensure resilient and continuously available ICT systems	Ensure resilient and continuously available ICT systems by fully implementing Departmental Information Communication Technology (ICT) Service Continuity Plan by the 31st March 2018	Establish ability to access domain services outside the National DoH premises	An approved ICT Service Continuity Plan exist	ICT Service continuity plan fully implemented
Provide support for effective communication	Provide support for effective communication by developing an integrated communication strategy and implementation plan	An integrated communication strategy and implementation plan Developed	Fragmented communication programme	Integrated Communication strategy and implementation plan developed and implemented
A National Health Litigation Strategy developed and fully implemented	A National Health Litigation Strategy developed and fully implemented	National Health Litigation Strategy Developed	The Medico -Legal Workshop held with Provincial Departments of Health, State Attorney and other relevant stakeholders	The National Health Litigation Strategy implemented

1.3 RESOURCE CONSIDERATIONS

Refer to Section 7 in Part A, which provides an overview of MTEF 2015/16-2017/18 budgets and espenditure for the period 2011/12 - 2014/15

1.4 RISK MANAGEMENT

Risk Name	Mitigating Factor
Lack of stakeholder buy-in and poor performance	• Angagement of stakeholders to create awareness • Enforcement of MOUs with stakeholders
Non-Compliance to legislative framework, laws and regulations	• Implementation of corrective measures for non-compliance • Prioritisation of non-compliance with key legislation
Inadequate and or ineffective ICT services	• Full implementation of ICT governance frameworks
Inadequate human resource skills and capacity	• Reduction of inefficiencies • Continuous training and development • Coordination and mobilisation of resources • Establishing Strategic partnerships with other organisations to expand the skills and capacity
Poor service contract management	• Explore alternative contracting strategies • Penalty clauses for poor performance to be included in all relevant documents • Enforcement of contracts with service providers • Traini and develop all SCM stakeholders
Ineffectiveness of governance structures	• Educating and training individuals appointed in governance structures • Develop standard operating procedures for appointment of new boards/ councils and filling of vacancies • Monitor and evaluate of the effectiveness of governance structures

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

2.1 PROGRAMME PURPOSE

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

There are five budget sub programmes:

Technical Policy and Planning provides advisory and strategic technical assistance on policy and planning, and supports policy analysis and implementation,

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

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

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

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

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

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

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

Medicines availability - a network of linked stock system will be established throughout the supply chain value chain to improve availability. In order to simplify the supply chain and its responsiveness direct deliveries are being implemented to central and regional hospitals. The National Department of Health


maintains a buffer stock of vital medicines at the central procurement unit for deployment in the event of stock shortages.

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

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

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

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

International Health and Development sub programme develops and implements bilateral and multilateral agreements with strategic partners such as the Southern African Development Community (SADC), the African Union (AU), United Nations (UN) agencies as well as other developing countries and emerging economic groupings such as Brazil-Russia-India-China-South Africa (BRICS) and IBSA (India, Brazil, and South Africa) to strengthen the health system and coordinates international development support.

The specific roles of the branch include coordinate and facilitate South-South partnerships and collaboration, ensuring effective and efficient well-coordinated and responsive partnerships and collaborations with Africa and Middle East countries, mobilisation of health technical and financial resources from international development agencies and international financial institutions, facilitation and coordination of the implementation of health related outcomes of the African Union Commission to meet the targets essential for Africa's Renewal and achievement of the African Agenda, and effective management of the deployment of Health Attaches.

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

South Africa is signatory to a number of international treaties and instruments such as International Health Regulations (2005), Framework Convention on Tobacco Control (FCTC), including other human rights conventions such as International Covenant on Civil and Political Rights, International Convention on the Elimination of All Forms of Racial Discrimination, African Charter on Human and Peoples' Rights and the SADC Protocol on Health. Furthermore, South Africa has supported adoption of some important international reports and resolutions such as WHO Action Plan for the prevention of avoidable blindness and visual impairment, follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health, Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, patient safety and Global strategy to reduce the harmful use of alcohol, Abuja Call for Action and Maseru Declaration on HIV and AIDS. As such, the cluster will accelerate the domestication and implementation of these treaties and resolutions in this mid-term cycle.

STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Indicator	Baseline (2014/15)	Target (2019/20)
Achieve Universal Health Coverage through the phased implementation of National Health Insurance	Achieve Universal Health Coverage through the phased implementation of National Health Insurance	White Paper on the Implementation of NHI	Green paper on NHI	White Paper on NHI finalised and adopted by Cabinet by 2015/16
		Legislation for NHI	None	National Health Insurance legislation and regulations developed and published by 2018/19
		Establishment of the National Health Insurance Fund	Conceptual document of the NHI Fund as per the Draft White Paper on National Health Insurance	Functional NHI Fund purchasing services on behalf of the population from accredited and contracted providers established.
Establish A national stock management surveillance centre to improve medicine availability	Establish A national stock management surveillance centre to improve medicine availability	Implement an Electronic system for the early detection of stock outs of medicines at hospitals	Electronic system developed	Electronic stock management system implemented and Functional at all Hospitals
		Implement an Electronic system for the early detection of stock outs of medicines at PHC Facilities	Electronic stock management system functional in 600 PHC facilities	Electronic stock management system functional in all PHC facilities
		Establish a national surveillance centre to monitor medicine availability	Business plan for the a national surveillance centre developed	National surveillance centre functional and reporting stock availability at all health Facilities
Improve contracting and supply of medicines	Improve contracting and supply of medicines through innovative service delivery models	Establish Provincial Control Towers for the management of direct delivery of medicines	Control towers have been established in Limpopo and Gauteng.	Control towers have been implemented in 7 Provinces.
		Number of patients receiving medicines through the centralised chronic medicine dispensing & distribution system	200,000 patients	1,500,000 patients
		Contracts are available at least 8 weeks prior to expiration of outgoing tender	ARV Tender awarded 3 months prior to expiry	100% of contracts are available at least 8 weeks prior to expiration of outgoing tender
Implement the Strategy to address antimicrobial resistance (AMR)	Implement the Strategy to address antimicrobial resistance (AMR)	Implement the National AMR strategy	Approved National AMR Strategy	AMR strategy fully implemented
Regulate African Traditional Practitioners	Regulate African Traditional Practitioners	Establish Council for Traditional Practitioners	Interim Council for Traditional Practitioners established and meets quarterly	Council for Traditional Practitioners is established and fully operational
Strengthen Revenue collection by incentivising hospitals to maximise revenue generation.	Strengthen Revenue collection by incentivising hospitals to maximise revenue generation.	Develop and implement a Revenue Retention Model (RRM) at central hospitals	A discussion paper on revenue retention models developed and presented to NHC	Revenue Retention Model (RRM) fully implemented at all 10 central hospitals

Strategic objective	Objective Statement	Indicator	Baseline (2014/15)	Target (2019/20)
Implement eHealth Strategy of South Africa	Implement eHealth Strategy of South Africa through the development of the system design of patient information systems	Develop System design for a National Integrated Patient based information system	Normative Standards for eHealth developed and approved Standards based basic Health Information Exchange architecture conceptualised	System Architecture developed and implemented through the development of Health Information Exchange
		Number of PHC health facilities with required IT Hardware for the reference implementation eHealth project	698 PHC Facilities received required IT Hardware for the reference implementation of the eHealth Programme	All PHC Facilities with the required hard-ware to implement the reference eHealth Programme
		Number of PHC health facilities connected to the internet	50PHCFacilitiesinNHIPilotDistricts	All PHC Facilities accessing email and internet
		Number of health facilities implementing improved patient administration and web based information systems	50 PHC Facilities implementing improved patient administration and web based information systems	All PHC Facilities implementing improved patient administration and web based patient information systems
Ensure research contribute to the improvement of health outcomes.	Develop and implement a National Health Research strategy	National Health Research strategy implemented	Draft National Research Plan developed	National Health Research strategy imple-mented and priority research conducted
Integrated monitoring and evaluation system established to generate evidence for planning and performance management	Implement an integrated monitoring and evaluation plan aligned to health outcomes and outputs contained in the Health Sector Strategy	Integrated monitoring and evaluation system implemented	Draft Monitoring and Evaluation plan	Integrated monitoring and evaluation system providing evidence for planning and performance management
Ensure SA meets it international obligation	Domestication of international treaties and implementation of multilateral cooperation on areas of mutual and measurable benefit	Number of International treaties and multilateral frameworks implemented	International treaties and multilateral frameworks implemented	Five International treaties and multilateral frameworks implemented
	Implementation of bilateral cooperation on areas of mutual and measurable benefit	Number of Bilateral projects implemented	two strategic bilateral projects implemented	Eight strategic bilateral projects implemented

2.3 RESOURCE CONSIDERATIONS

Refer to Section 7 in Part A, which provides an overview of MTEF 2015/16-2017/18 budgets and espenditure for the period 2011/12 - 2014/15

2.4 RISK MANAGEMENT

Risk Name	Mitigating Factor
Lack of stakeholder buy-in and poor performance	• Engagement of stakeholders to create awareness • Enforcement of MOUs with stakeholders
Inadequate human resource skills and capacity	• Reduction of inefficiencies • Training and developing staff members • Establishing strategic partnerships with other organisations to expand skills and capacity
Poor service contract management	• Exploring alternative contracting strategies • Implement IDMS that will provide direction on systems and procedures as clarity on roles and re-sponsibilities • Inserting penalty clauses for poor performance to be included in all relevant documents • Enforcement of contracts with service providers • Training and development of all SCM stakeholders
Ineffectiveness of governance structures	• Educating and training individuals appointed in governance structures • Review regulations relating to the appointment of board/council members • Developing standard operating procedures for appointment of new boards/councils and filling of vacancies • Monitoring and evaluating effectiveness of governance
Poor data and information management	• Implement the e-health strategy


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

3.1 PROGRAMME PURPOSE

Develop national policies, guidelines, norms and standards, and targets to decrease the burden of disease related to the HIV and tuberculosis epidemics; to minimise maternal and child mortality and morbidity; and to optimise good health for children, adolescents and women; support the implementation of national policies, guidelines, and norms and standards; and monitor and evaluate the outcomes and impact of these.

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

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

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

TB Control and Management sub-programme is responsible for coordination and management of a national response to TB that incorporates strategies needed to prevent, diagnose and treat both drug sensitive TB (DS-TB) and drug resistant TB (DR-TB) TB. The sub-programme shall develop national policies and guidelines, norms and standards to inform good practice at provincial, district, sub-district and health facility levels. The sub-programme shall also monitor implementation of the National Strategic Plan on HIV, STIs and TB, 2012-2016 with its vision of achieving zero infections, mortality, stigma and discrimination from TB and HIV/AIDS.

Until recently, the world relied on treating TB using drugs that were developed more than 50 years ago. Since about 2 years ago, a new drug, bedaquiline, which is much more efficacious, and has little side effects (such as loss of hearing), was introduced globally. South Africa was the first in the world to use the drug formally within its TB programme, and beyond small scale research sites. The drug will be rolled out to ensure wide-scale availability to eligible DR-TB patients. The TB information systems (ETR.Net and EDRWeb) will be integrated to those in the HIV/AIDS programme (TIER.Ndet) and DHIS. A system for tracing initial treatment interrupters, defaulters and contacts will also be developed.

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

Child, Youth and School Health sub programme is responsible for policy formulation, coordination, and monitoring and evaluation of child, youth and school health services. Each province also has a unit which is responsible for fulfilling this role, and for facilitating implementation at the provincial level. Most MNCWH and nutrition services are provided by the provincial Departments of Health, who are thus central role-players in efforts to improve coverage and quality of MNCWH & Nutrition services. At district level, services are provided by a range of health and community workers, and other workers. Many stakeholders outside of the health sector also have key roles to play in promoting improved child and youth health and nutrition – these include other government departments (such as Social Development, Rural Development, Basic Education, Water Affairs and Forestry, Agriculture and Home Affairs), local government, academic and research institutions, professional councils and associations, civil society, private health providers and development partners, including United Nations and other international and aid agencies.

3.2 STRATEGIC OBJECTIVE

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2019/20)
To reduce maternal morbidity and mortality	To reduce maternal mortality by implementing strategies such as the MNCWH &N Strategic Plan 2012-2016 and the CARMMA strategy	Maternal Mortality Ratio	Maternal Mortality Ratio of 269/100 000 live births	Maternal Mortality Ratio of <100/100,000 live births
		Antenatal 1st visit before 20 weeks rate	50%	80%
		Mother postnatal visit within 6 days rate	72.9%	95%
To reduce neonatal morbidity and mortality	To reduce neonatal mortality to under 6 per 1000 live births by implementing strategies such as the MNCWH &N Strategic Plan 2012-2016 and the CARMMA strategy	Inpatient Neonatal death rate (annualised)	13.9 / 1000 live births	6 / 1000 live births
To improve access to sexual and reproductive health services	To improve access to sexual and reproductive health services by expanding the availability of contraceptives	Couple year protection rate (annualised)	37%	75%
		Cervical cancer screening coverage (annualised)	45.11%	75%
Expand the PMTCT coverage to pregnant women	Expand the PMTCT coverage to pregnant women by ensuring thatall HIV positive antenatal clients are initiated on lifelong ART and reducing the positivity rate to below1%	Antenatal client initiated on ART rate	76.7%	98%
		Infant 1st PCR test positive around 6 weeks rate	2.6%	<1%
Reduce under-five mortality rates	To reduce under-five mortality rates to less than 30 per 1,000 live births.	Under five mortality rate	42 per 1,000 Live births	30 per 1,00 Live births
		Child under 5 years diarrhoea case fatality rate	4.2%	<2%
		Child under 5 years pneumonia case fatality rate	3.5%	<2%
		Child under 5 years severe acute malnutrition case fatality rate	11.2%	< 5%
		Infants Exclusively breastfed at HepB 3rd Dose rate	44.5%[1]	75%
		Confirmed measles case incidence per million total population	< 5/ 1,000,000	<1/1,000,000
		Immunisation coverage under 1 year (Annualised)	83.38%	95%
		DTaP-IPV-HB-Hib 3 - Measles 1st dose drop-out rate	8%	<5%
		Measles 2nd dose coverage	75%	90%
Improve health and learning amongst school-aged children	To improve health and educational outcomes amongst school-aged children by rolling out ISHP services	School Grade 1 screening coverage (annualised)	19.8%[2]	50%
		School Grade 8 screening coverage (annualised)	4%[2]	25%
To protect girls against cancer of the cervix	To vaccinate at least 90% of grade 4 girls annually to reduce cervical cancer	HPV 1st dose coverage	80%	90%
		HPV 2nd dose coverage	New Indicator	90%
Undertake a massive TB screening campaign	Screen all health facility attendees for TB	Client 5 years and older screened at health facilities for TB symptoms rate	New Indicator	90%
Improve access to treatment	Increase access to treatment initiation for no less than 90% of lab-diagnosed DS-TB and 90% of lab-diagnosed RR-TB clients	TB client 5 years and older initiated on treatment rate	New Indicator	90%
		TB Rifampicin resistant client treatment initiation rate	60 % (2013)	90%

• 1. estimated for 2014/15, 2. Baseline is for Q1 and Q2 schools only

Strategic objective	Objective Statement	Indicator	Baseline (2013/14)	Target (2019/20)
Strengthen patient retention in treatment and care	Strengthen the system for retaining patients in treatment and care by reducing lost to follow up by 50%	TB client loss to follow up rate	6.6% (2012)	3.0%
		TB client successfully completed treatment rate	76% (2012)	90%
		TB client death rate	8.4% (2012)	<5%
		TB MDR client lost to follow up rate	20 %(2011)	10 %
		TB MDR client successfully completed treatment rate	45%(2011)	70%
		TB MDR client death rate	18% (2011)	8%
Strengthen TB/HIV integration	Increase the proportion of TB/HIV co-infected patients on ART to 90%	TB/HIV co-infected client on ART rate	65% (2012)	90%
Improve TB prevention, diagnosis and treatment among key populations at risk	Improve TB prevention, diagnosis and treatment among key populations at risk	Number of community members in 6 peri-mining communities screened for TB	New Indicator	924,000
		Percentage of controlled mines inspected on TB control & management	30%	100%
To scale-up combination of prevention interventions to reduce new HIV, STI and TB infections	To scale up combination of prevention interventions to reduce new infections including HCT, male medical circumcision and condom distribution	HIV Tests (15 years and older) including ANC clients	6 688 950	22 million annually
		Number of medical male circumcisions performed	512 902	4 350 000 (cumulative target)
		Male condoms Distributed	506 427 732	800 million annually
		Female Condoms Distributed	13 254 025	22 million annually
Providing quality and an appropriate package of treatment care and support to 80% of HIV positive people and their families	Providing quality and an appropriate package of treatment care and support by scaling up the treatment programme to ensure 80% of HIV positive people are supported	Total clients remaining on ART (TROA) at the end of the month	2.7 million	7.5 million

3.3 RESOURCE CONSIDERATIONS

Refer to Section 7 in Part A, which provides an overview of MTEF 2015/16-2017/18 budgets and espenditure for the period 2011/12 - 2014/15

3.4 RISK MANAGEMENT

Risk Name	Mitigating Factor
Lack of stakeholder buy-in and poor performance	• Engagement of stakeholders to create awareness • Enforcement of MOUs with stakeholders
Inadequate human resource skills and capacity	• Reducing inefficiencies • Continuosly training and developing staff memebers • Coordinating and mobilising resources by forming strategic partnerships
Poor service contract management	• Exploring alternative contracting strategies • Inserting penalty clauses for poor performance in all relevant contracts
Ineffectiveness of governance structures	• Educating and Training individuals appointed in governance structures • Developing standard operating procedures for appointment and filling of vacancies in committees • Monitoring and evaluating the effectiveness of governance structures • Implementing performance management systems for board members
Insufficient funding of health service delivery programmes	• Reviewing and reprioritising funds on an ongoing basis • Mobilising additional resources
Inadequate health promotion and education	• Educating the public and promoting health to prevent disease • Implementing the communication strategy on the health risk factors
Poor data and information management	• Implement the e-health strategy

PROGRAMME 4: PRIMARY HEALTH CARE (PHC) SERVICES

4.1 PROGRAMME PURPOSE

Develop and oversee the implementation of legislation, policies, systems, and norms and standards for: a uniform district health system, environmental health, communicable and non-communicable diseases, health promotion, and nutrition.

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. We need functioning district health management offices manage the primary health care facilities such that they meet the standards of the Office of Health Standards Compliance (OHSC) as well as achieve their key population health indicators. The National Health Facilities Audit report (2012) lists 3760 health facilities as primary health care facilities (different categories of clinics, community health centres and district hospitals). Over the next five years this sub-programme will collaborate with other programmes within the national department of health, other government departments, development partners, private sector and civil society organisations to ensure that weaknesses within the DHS are addressed over this term. We will:

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

Environmental Health and Port Health services: Environmental Health is at the heart of public health intervention for the health sector, which is able lead the implementation of public awareness, health promotion and disease prevention, surveillance and inspection of both private and public premises. The sub programme will work towards strengthening the delivery of Environmental Health services including Port Health services. The department has transferred Municipal Health Services, to the District and Metropolitan Municipalities for which it must continue to provide oversight and supportive role through policy development and monitoring. The sub programme will collaborate with the District and Metropolitan Municipalities, South African Local Government Association (SALGA), Department of Cooperative Governance and Traditional Affairs (COGTA), Department of Environmental Affairs, Department of Human Settlements etc, to support the delivery of municipal health services, which have been promulgated in the Constitution, National Health Act and Municipal Systems Act to be the function of the District and Metropolitan Municipalities.

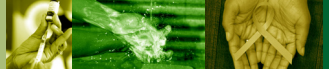
Health Promotion: Optimal health promotion and disease prevention is essential to the success of PHC. In recognising South Africa's quadruple burden of disease, this sub-programme will over the next five years improve health promotion strategies focussing on South Africa's burden of disease and reduce risk factors for Non-Communicable Diseases (NCDs) by designing and implementing a mass mobilisation strategy focussing on healthy options.

Nutrition: In South Africa, malnutrition is manifested in both under-nutrition and over-nutrition. This paradox of over and under-nutrition, as well as the range of micronutrient deficiencies of public health significance, requires complementary strategies and an integrated approach to ensure optimal nutrition for all South Africans. The situation is further complicated by the many causes of malnutrition, which could be direct factors such as inadequate food intake, or underlying factors such as household food insecurity or even basic factors such as a lack of resources. Improving nutrition is thus an ethical imperative, a sound economic investment and a key element of health care at all levels. In the next five years the focus will be on the prevention and management of obesity. This will require joint collaboration from other stakeholders from other government departments, civil society and the food industry to create an enabling environment which will see us curbing the prevalence of obesity in 2020 by 10%. Attention will also be given to improving the quality of nutrition services in hospitals through the development of clinical nutrition guidelines.

Non-Communicable Diseases: The World Health Organisation reports that more than 36 million people died globally from NCDs in 2008, which constituted 63% of all deaths. This was mainly from cardiovascular diseases (48%), cancers (21%), chronic respiratory diseases (12%), and diabetes (3%). Critically more than 9 million of these deaths could have been prevented. Premature deaths from NCDs are particularly high in poorer countries with around 80% of such deaths occurring in low and middle income countries. Globally deaths due to NCDs are projected to increase by 17% over the next ten years, but the greatest increase (24%) is expected in the African region. In managing NCDs we need to focus on disability as well. Disability, if not attended to appropriately, has implications for the optimal functioning of people, preventing them from being gainfully employed and or financially independent. This situation exacerbates the risk of out of pocket expenditure impacting negatively on the development of individuals, families and communities. Around 40% of deaths and 33% of the burden of disease in South Africa are attributable to NCDs.

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

During this term, this sub-programme will focus on the reduction of risk factors for NCDs, improvement of health systems and services for detection and control of NCDs, improvement of the

service delivery platform for PHC focused eye-care, oral health, care of the elderly, rehabilitation, disability and mental health. The sub-programme will expand services to prevent disability through coordinated multidisciplinary rehabilitation services. With regard to mental health, we will collaborate with other sectors to increase public awareness regarding mental health and reduce stigma and discrimination associated with mental illness and scale up decentralised integrated primary mental health services, which include community-based care, PHC clinic care, and district hospital level care.

Communicable Disease Control: Communicable diseases are major causes of morbidity and mortality and through effectively addressing communicable diseases, life expectancy will increase. Communicable Diseases are therefore central to obtaining the Departments vision of a long and healthy life for all South Africans.

The National HIV Antenatal survey will as in previous years, be conducted to provide South Africa with inforation to improve our response to HIV and sexually transmitted diseases.

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

4.2 STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Performance Indicator	Baseline (2013/14)	Target (2019/20)
Improve district governance and strengthen management and leadership of the district health system	Improve district governance and strengthen management and leadership of the district health system	Number of Districts with uniform management structures	Uniform management structures for Districts	52 Districts with uniform management structures
		Number of primary health care facilities with functional clinic committees	Implementation plan approved and Monitoring and evaluation system developed	3500 primary health care facilities with functional clinic committees
Improve access to community based PHC services	Improve access to community based PHC services	Number of functional WBPHCOTs8	1500 functional WBPHCOTs	3500 functional WBPHCOTs
Improve quality of services at primary health care facilities	Improve quality of services at primary health care facilities	Number of primary health care facilities in the 52 districts that qualify as Ideal Clinics	New Indicator	2325 (75%) primary health care facilities in the 52 districts qualify as Ideal Clinics
Improve environmental health services IN South Africa	Improve environmental health services in all 52 districts and metropolitan municipalities in the country	Number of municipalities that meet environmental health norms and standards in executing their environmental health functions	Environmental Health strategy developed	52 district and metropolitan municipalities meet environmental health norms and standards in executing their environmental health functions
		Hand hygiene campaign rolled out in all 9 (nine) provinces	Hand hygiene campaign launched	9 provinces implementing hand hygiene campaign targeting commuters, early childhood development centres and schools
		Health Care Risk waste Regulations Developed and monitored	Regulations developed and published in the government gazette for public comment	250 health facilities audited on Health Care Waste Management
Establish a National Health Commission	Establish a National Health Commission to address the social determinants of health	National Health Commission established	New Indicator	National Health Commission established

Strategic objective	Objective Statement	Performance Indicator	Baseline (2013/14)	Target (2019/20)
Reduce risk factors and improve management for Non-Communicable Diseases (NCDS) by implementing the Strategic Plan for NCDs 2012-2017	Reduce risk factors and improve management for Non-Communicable Diseases (NCDS) by implementing the Strategic Plan for NCDs 2012-2017	Number of government Departments oriented on the National guide for healthy meal provisioning in the workplace	New Indicator	All national government Departments
		Regulations relating to Labelling and packaging of tobacco products and smoking in indoor and outdoor public places Developed	New indicator	Regulations relating to labelling and packaging of tobacco products gazetted; and Regulations relating to smoking in indoor and outdoor public places gazetted
		Number of people screened for high blood pressure as part of comprehensive health screening	500 000 people screened for high blood pressure	8 million people screened for high blood pressure annually
		Number of people screened for raised blood glucose levels as part of comprehensive health screening	500 000 people screened for raised blood glucose levels	8 million people screened for raised blood glucose levels annually
		Awareness on risk factors relating to excessive salt intake, excessive sugar intake, physical inactivity and alcohol related harm created	Zero media campaigns	70% of targeted population (in sentinel sites) aware of messages contained in campaign creating awareness on alcohol related harm.
		Random Monitoring of salt content in foodstuffs conducted.	New Indicator	Random samples from each of 13 regulated food categories tested, reported on and corrective action taken
Improve access to and quality of mental health services in South Africa	Improve access to and quality of mental health services in South Africa	Percentage people screened for mental disorders	Information system and baseline established	35% prevalent population screened for mental disorders
		Percentage of people treated for mental disorders	Information system and baseline established	35% prevalent population treated for mental disorders
		Percentage of mental health inpatient units attached to designated district and regional hospitals	14.2% (39/274) of mental health inpatient units attached to designated district and regional hospitals	22% of mental health inpatient units attached to designated district and regional hospitals
		Mental health teams established in each district	Zero	30 Specialist mental health teams established

Strategic objective	Objective Statement	Performance Indicator	Baseline (2013/14)	Target (2019/20)
Improve access to disability and rehabilitation services through the implementation of the framework and model for rehabilitation and disability services	Improve access to disability and rehabilitation services through the implementation of the framework and model for rehabilitation and disability services	Number of Districts implementing the framework and model for rehabilitation services	Draft Framework and Model approved and costed	30 Districts implementing the framework and model for rehabilitation services
Prevent avoidable blindness	Prevent avoidable blindness	Cataract Surgery Rate	1 500 operations per million un-insured population	1700 cataract surgeries per million uninsured population
Eliminate Malaria by 2018, so that there is zero local cases of malaria in South Africa	Eliminate Malaria by 2018, so that there is zero local cases of malaria in South Africa	Malaria Incidence per 1000 population at risk	0.3 malaria cases per 1000 population at risk	0 malaria cases per 1000 population at risk
		Number of districts targeted for malaria elimination reporting malaria cases within 24 hours of diagnosis	1 district targeted for malaria elimination reporting malaria cases within 24 hours of diagnosis	10 districts targeted for malaria elimination reporting malaria cases within 24 hours of diagnosis
Strengthen preparedness and core response capacities for public health emergencies in line with International Health Regulations	Strengthen preparedness and core response capacities for public health emergencies in line with International Health Regulations	Number of Provincial Outbreak Response Teams capacitated to respond to zoonotic, infectious and food-borne diseases outbreaks	New indicator	Evaluation report on the capacity of all 9 provinces to respond to zoonotic, infectious and food-borne diseases
Improve South Africa's response with regard to Influenza prevention and control	Improve South Africa's response with regard to Influenza prevention and control	Number of high risk population covered by the seasonal influenza vaccination	750 000 high risk individuals covered with seasonal influenza vaccination	1 228 000 high risk individuals covered with seasonal influenza vaccination
Establish a coordinated disease surveillance system for Notifiable Medical conditions (NMC)	Establish a coordinated disease surveillance system for Notifiable Medical conditions (NMC)	A strategy and plan for the integration of disease surveillance systems for NMC Developed and Implemented	Draft strategy for the integration of disease surveillance systems for NMC developed	Strategy and plan to coordinate and integrate disease surveillance systems for NMC developed and implemented
Conduct Annual National HIV Antenatal Prevalence Survey	Conduct Annual National HIV Antenatal Prevalence Survey	Annual National HIV Antenatal Prevalence Survey conducted	2012 National Antenatal Sentinal HIV prevalence Report produced	National Antenatal HIV prevalence Report produced annually

4.3 RESOURCE CONSIDERATIONS

Refer to Section 7 in Part A, which provides an overview of MTEF 2015/16-2017/18 budgets and espenditure for the period 2011/12 - 2014/15

4.4 RISK MANAGEMENT

Risk Name	Mitigating Factor
Lack of stakeholder buy-in and poor performance	• Engaging stakeholders to create awareness • Enforcing MOUs with stakeholders
Non-Compliance to legislative framework, laws and regulations	• Implementing corrective measures for non-compliance • Prioritisation of non-compliance with key legislation
Inadequate human resource skills and capacity	• Reduce inefficiencies • Continuously training and developing staff members • Establishing strategic partnerships with other organisations to expand skills and capacity.
Insufficient funding of health service delivery programmes	• Review and reprioritisation of funds on an ongoing basis • Mobilising additional resources
Insufficient essential equipment	• Assessing and maintaining asset registers of facilities • Drafting legislation on essential equipment SCM model reassessment
Inadequate implementation of environmental health services	• Implementing and monitoring regulations for health care waste management • Centrally managing port health services • Implementing environmental health norms and standards
Inadequate health promotion and education	• Educating the public to prevent disease and promoting health • Visible media campaigns to reduce impact of health risk factors • Implementing communication strategy • Coordinating health promotion and education programmes from national department with all spheres of government
Poor data and information management	• Implement the e-health strategy

PROGRAMME 5: HOSPITALS, TERTIARY SERVICES AND WORKFORCE MANAGEMENT

5.1 PROGRAMME PURPOSE

The purpose of the programme is to develop policies, delivery models and clinical protocols for hospitals and emergency medical services. Ensure alignment of academic medical centres with health workforce programmes, training of health professionals and to ensure the planning of health infrastructure 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 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, ems and pathology medical services: To improve the governance, management and functioning of Emergency Medical Services (EMS) in the whole country through strengthening the capacity and skills of EMS personnel, identification of needs and service gaps and provision of appropriate and efficient EMS through providing oversight of Provinces.

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

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

The Cluster is responsible for ensuring the effective and efficient rendering of Forensic Chemistry services to support the Criminal Justice System and 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.

Office of nursing services sub-programme ensures that nursing and midwifery practitioners are competent and responsive to the burden of disease and population health needs. This subprogramme is responsible for providing leadership in the implementation of the recommendations emanating from the nursing strategy by coordinating the three core areas of nursing including education regulation and practice. This sub-programme is responsible for the promotion and maintenance of a high standard and quality of nursing and midwifery by ensuring that nursing education and training is harmonised with population health needs and are commensurate with competency framework, provide guidance in the production of sufficient numbers and the appropriate categories of nurses required to deliver healthcare services. This subprogramme is responsible for enabling intra and inter-professional liaison to harness nursing interventions into a coherent response to population and health service needs.

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, since 2013/14, the infrastructure component of the national health grant. In 2012/13, guidance was provided on infrastructure planning and design through the infrastructure unit systems support and 32 sets of national infrastructure norms, standards, guidelines and benchmarks for all levels of health care facilities were developed. In addition, the project monitoring information system was configured, tested and piloted.

Workforce development and planning 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.

4.2 STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Performance Indicator	Baseline (2013/14)	Target (2019/20)
Increase capacity of central hospitals to strengthen local decision making and accountability to facilitate semi-autonomy of central hospitals	Increase capacity of central hospitals to strengthen local decision making and accountability to facilitate semi-autonomy of 10 central hospitals	Number of central hospitals with full delegated authority.	None (New Indicator)	All 10 Central Hospitals with reformed management and governance structures
Ensure equitable access to tertiary health care	Ensure equitable access to tertiary service through implementation of the National Tertiary services plan	Number of gazetted Tertiary hospitals providing the full package of Tertiary1 Services	5 gazetted tertiary hospitals providing the full package of Tertiary 1 services	All 17 gazetted tertiary hospitals providing the full package of Tertiary 1 services
Improve the quality of hospital services	Ensure quality health care by improving compliance with National Core Standards at all Central, Tertiary, Regional and Specialised Hospitals	Number of Hospitals that comply fully with the National Core Standards.	Varying degrees of compliance with the National Core Standards in 5 Central Hospitals	Full compliance with the National Core Standards in 10 Central, 17 Tertiary, 46 Regional and 63 Specialised Hospitals
Develop and Implement health workforce staffing norms and standards.	Develop and Implement health workforce staffing norms and standards.	Develop guidelines for HRH norms and standards using the WISN methodology	Determine norms for PHC. Orientate District Hospital managers	Guidelines for HR Norms and standards published for all levels of care
		Number of facilities benchmarked against PHC staffing normative guides	New indicator	All PHC facilities bench-marked against PHC staff-ing normative guides
Implementation of the objectives of the Nursing Strategy	Professionalise Nursing Training and Practice through implementation of the objectives of the Nursing Strategy.	Public Nursing colleges offering new Nursing programmes (inline with National Qualifications Framework)	A scope of requirements for the implementation of the nursing strategy developed	All 17 Public Nursing Col-leges offering new nursing Programmes
		Develop a Nursing and midwifery educators' training and development programme	Audit of capacity of nurse educators completed	Nursing and midwifery educators in all 17 Public Nursing Colleges fully trained.
To build new and improve quality of existing health infrastructure in South Africa	To build new and improve quality of existing health infrastructure in South Africa	Number of facilities maintained, repaired and/or refurbished in NHI Districts	94 maintenance projects for health facilities in NHI Districts	872 facilities maintained, repaired and/or refurbished in NHI Districts
		Number of facilities maintained, repaired and/or refurbished outside NHI pilot Districts	249 maintenance projects for health facilities outside NHI pilot Districts	1580 facilities maintained, repaired and/or refurbished outside NHI Districts
		Number of clinics and Community Health Centres constructed or revitalised	72 clinics and community health centres constructed	216 clinics and Community Health Centres constructed or revitalised
		Number of hospitals constructed or revitalised	7 hospitals constructed or revitalised	44 hospitals constructed or revitalised
		Number of new facilities that comply with gazetted infrastructure Norms & Standards.	100% from date of gazetting	260 new health facilities compliant with gazetted norms and standards

Strategic objective	Objective Statement	Performance Indicator	Baseline (2013/14)	Target (2019/20)
Strengthen Monitoring of Infrastructure projects	Strengthen Monitoring of Infrastructure projects	Develop a Infrastructure Monitoring System	Non standardised system in place	Infrastructure Monitoring fully implemented for all projects
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 compliant with the EMS regulations	Draft EMS Regulations developed	9 Provinces fully compliant to EMS regulations
To eliminate the backlog of blood alcohol and toxicology tests by 2016	To eliminate the backlog of blood alcohol and toxicology tests by 2016	Number of Blood Alcohol reports issued	7500 reports per lab per quarter (4 FCLs)	Backlogs eliminated and 120 000 Alcohol test reports issued Annually
		Number of Toxicology reports issued	375 reports per lab(3 FCLs)	Backlogs eliminated and 4 500 Alcohol test reports issued Annually
To provide food analysis services	To provide food analysis services	Number of food tests performed	500 per lab per quarter(2 FCLs)	4 000 food tests completed annually
Improve management of health facilities at all levels of care	Improve management of health facilities at all levels of care through the health leadership and management academy	Establish a coaching mentoring and training programme for health managers	New Indicator	90% of Hospital CEOs and PHC Facility Managers benefiting from the coaching and mentoring programme.
		Develop a knowledge hub which includes a web based interactive information system	New Indicator	60% of Hospital CEOs and PHC Facility managers benefitting from the knowledge hub.

5.3 RESOURCE CONSIDERATIONS

Refer to Section 7 in Part A, which provides an overview of MTEF 2015/16-2017/18 budgets and espenditure for the period 2011/12 - 2014/15

5.4 RISK MANAGEMENT

Risk Name	Mitigating Factor
Lack of stakeholder buy-in and poor performance	• Engaging stakeholders to create awareness • Enforcement of MOUs with stakeholders
Non-Compliance to legislative framework, laws and regulations	• Implementing corrective measures for non-compliance • Prioritisation of non-compliance with key legislation
Inadequate human resource skills and capacity	• Reduce inefficiencies • Continuous training and development • Establishing strategic partnerships with other organisations to expand skills and capacity
Poor service contract management	• Exploring alternative contracting strategies • Implementing Infrstructure Delivery Management Systems (IDMS) that will provide direction on systems and procedures and clarity on roles and responsibilities • Inserting penalty clauses for poor performance in all relevant contracts and agreements • Improving contract management • Training and developing all SCM stakeholders
Ineffectiveness of governance structures	• Educate and train individuals appointed in governance structures • Review regulations relating to the appointment of board/council members • Develop standard operating procedures for appointment of new boards/councils and filling of vacancies • Monitor and evaluate the effectiveness of governance structures Board evaluations • Implement performance management systems for board members
Insufficient funding of health service delivery programmes	• Review and reprioritisation of funds on an ongoing basis • Resource mobilisation
Insufficient essential equipment	• Continuous assessment and maintenance of asset registers of facilities • Draft legislation to reform procurement of essential equipment
Poor data and information management	• Implement the e-health strategy

PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT

6.1 PROGRAMME PURPOSE

Regulate the sale of medicines and pharmaceutical supplies, including food control, and the trade in health products and health technology. Promote accountability and compliance by regulatory bodies and public entities for effective governance and the quality of health care.

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

The sub-programme has been regulating allopathic medicines and recently embarked on complementary and alternative medicines (CAMS) as well as medical devices and in vitro diagnostics. During 2014/15 – 2016/17, the cluster will begin work on more robust regulation of cosmetics.

The regulator (the Medicines Control Council, MCC) has been experiencing an increasing workload both for new applications and post- registration variations. This has resulted in inordinately long review timelines and a backlog. Nonetheless, the sub-programme has managed to register 114 antiretrovirals within 15 months The Medicines Control Council is being re –engineered to a more responsive structure, through the establishment of South African Health Products Regulatory Authority (SAHPRA). Legislation to create SAHPRA is currently in Parliament.

Compensation Commissioner for Occupational Diseases and Occupational Health sub-programme 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 re-engineered 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.

The development of the sub-programmes's strategic objectives is guided by the enabling legislation, current legislative developments and best practice which promote good corporate governance.

Governance oversight over entities is conducted through monitoring compliance to legislative requirements based on entities enabling legislation, certain provisions of the Public Finance Management Act, 1999 (PFMA) (Act 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 the following entities falling within the mandate of the Department of Health:

HEALTH ENTITIES
The National Health Laboratory Service (NHLS)
The South African Medical Research Council (MRC)
The Council for Medical Schemes (CMS)
Office of Health Standards Compliance (OHSC)

HEALTH STATUTORY COUNCILS
Allied Health Professions Council (AHPC)
South African Dental Technicians Council (SADTC)
South African Nursing Council (SANC)
South African Pharmacy Council (SAPC)
Health Professions Council of South Africa (HPCSA)
Interim Traditional Health Practitioners Council of South Africa (ITHPCSA)
Medicines Control Council (MCC)

6.2 STRATEGIC OBJECTIVES

Strategic objective	Objective Statement	Performance Indicator	Baseline (2013/14)	Target (2019/20)
Improve efficiency of regulator through the establishment of SAHPRA.	Establish the South African Health Product Regulatory Authority (SAHPRA)	Establish SAHPRA as a public entity	National Portfolio Committee on Health deliberates over the bill.	SAHPRA established by 2016/17 and fully operational and functional by 2019/20
Establish Institute of Regulatory Science (IRS)	Improve regulatory capacity for health products by establishment of the Institute of Regulatory Science by March 2016.	Establish Institute of Regulatory Science (IRS)	None	IRS Established by 2015/16 and providing training by 2019/20
To develop the policy and legislative framework for occupational health and compensation	To develop the policy and legislative framework for occupational health and compensation	Review occupational health legislative framework	1 consultative meeting on amendments to the Occupational Diseases in Mines and Works Act, 1973	Occupational health legislative framework gazetted and implemented
To establish an occupational health cluster	To establish an occupational health cluster	Occupational health cluster established and functional	Discussion on integration of the governance and management of occupational health unis (NIOH, CCOD, and MBOD)	Governance, management and service delivery framework for the occupational health cluster integrated and operational
Provide occupational health and compensation services through development of One Stop Service centres in provinces	To provide occupational health and compensation services through development of One Stop Service centres in provinces	Number of provinces with One Stop Service Centres to deliver occupational health and compensation services	One Stop Service Centre for occupational health and compensation services in one health facility in Eastern Cape and Gauteng provinces established	One Stop Service Centre for occupational health and compensation services in one health per province established
Establish the National Public Health Institutes of South Africa (NAPHISA) for disease and injury surveillance	To establish NAPHISA to ensure coordinated disease and injury surveillance and research	Develop legal framework to establish National Public Health Institutes of South Africa (NAPHISA)	Report on conceptual framework and business case for NAPHISA	NAPHISA established and fully operational
Improve oversight and corporate governance practices at all Public Entities and Statutory Councils	Improve oversight and Corporate Governance practices by establishing effective governance structures, policies and tools	Number of Health entities' and Statutory Health professional Councils fully functional and compliant to good Governance practices (structures, Finance, HR , Supply Chain Management policies) and also respond to health sector priorities	2 health entities fully functional	4 health Entities' and 6 statutory health professional councils
		Develop and implement a performance management system for board members		A standardised performance management system institutionalised for board members

6.3 RESOURCE CONSIDERATIONS

Refer to Section 7 in Part A, which provides an overview of MTEF 2015/16-2017/18 budgets and espenditure for the period 2011/12 - 2014/15

6.4 RISK MANAGEMENT

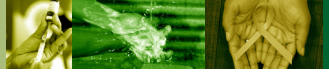
Risk Name	Mitigating Factor
Lack of stakeholder buy-in and poor performance	• Engaging stakeholders to create awareness • Enforcement of MOUs signed with stakeholders
Non-Compliance to legislative framework, laws and regulations	• Implementing corrective measures for non-compliance • Prioritisation of non-compliance with key legislation
Inadequate and or ineffective ICT services	Implementing ICT governance frameworks
Inadequate human resource skills and capacity	• Reduction of inefficiencies • Continuosly training and developing staff members • Establishing strategic partnerships with other organisations to expand the skills and capacity
Ineffectiveness of governance structures	• Educating and training individuals appointed in governance structures • Review regulations relating to the appointment of board/council members • Develop standard operating procedures for appointment of new boards/councils and filling of vacancies • Monitoring and Evaluating effectiveness of governance Board evaluations • Implementing performance management systems for board members
Poor coordination of entities objectives with the Departmental priorities	• Facilitate joint planning session with health entities on strategic initiatives




PART C:
LINKS TO OTHER PLANS







1. Conditional Grants

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

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

Name of Grant	Comprehensive HIV/AIDS Grant
Purpose	• To enable the health sector to develop an effective response to HIV and Aids and TB; • To support the Department with the PEPFAR transition process.
Performance Indicator	Reduction of new HIV infections and universal coverage of HIV treatment need
Continuation	Yes
Motivation for Continuation	HIV/AIDS is a National Priority and therefore prevention and treatment can only be effectively achieved through the conditional grant

Name of Grant	Health Facility Revitalisation Grant
Purpose	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including health technology (HT), organisational development (OD) systems and quality assurance (QA), • To enhance capacity to deliver infrastructure in health
Performance Indicator	Accelerate the revitalisation of facilities including the acquisition of health technology equipment.
Continuation	Yes
Motivation for Continuation	Funding infrastructure through conditional grant enables National Department of Health to ensure the delivery and maintenance of health infrastructure in a coordinated and efficient manner and ensure it is consistent with national norms, standards and guidelines of health facilities.

Name of Grant	National Health Insurance Grant
Purpose	• To test innovations in health services delivery and provision for implementing National Health Insurance, • allowing for each district to interpret and design innovations relevant to its specific context in line with the vision for realising universal health coverage for all • to undertake health system strengthening activities in identified focus areas ; • to assess the effectiveness of interventions/activities undertaken in the districts funded through this grant.
Performance Indicator	NHI piloting rolled out to all 52 health districts
Continuation	Yes
Motivation for Continuation	National Health Insurance is a high national priority . It allows both national and provincial departments to test innovations on service delivery and to undertake other health system strengthening initiatives in readiness for roll out of NHI

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

Name of Grant	National Health Grant - Human Papillomavirus (HPV) component
Purpose	• To enable the health sector to develop an effective response to preventing cervical cancer by making available HPV vaccination for grade 4 school girls; • To fund the introduction of HPV vaccination programme in schools
Performance Indicator	No of grade 4 girls vaccinated and no of schools covered.
Continuation	Yes
Motivation for Continuation	Cervical cancer is a high national priority. Cancer of the cervics is the commonest cancer diagnosed in women in south Africa and introduction of the vaccine will have a significant impact on disease prevention. Prevention of disease is one of the priorities of the NDP (National Development Plan).

2. Public Entities

Name of Public Entity	Mandate	Outputs	Current Annual Budget (R thousand	Date of next evaluation
Council for Medical Schemes	The Medical Schemes Act (1998) established the Council for Medical Schemes as the regulatory authority responsible for overseeing the medical schemes industry in South Africa.	• ensure that access to good quality medical scheme cover is maximised • ensure that medical schemes are properly governed and beneficiaries are informed and protected • enhance the effectiveness and efficiency of the organisation • provide strategic advice and support for the development and implementation of national health policies, • Including the development of national health insurance.	**2015/16** R130 769	**2015/16**
National Health Laboratory Service	The National Health Laboratory Service was established in 2001 in terms of the National Health Laboratory Service Act (2000). In terms of the act, the service is required to: provide cost effective and efficient health laboratory services to all public sector health care providers, other government institutions and any private health care provider in need of its service; support health research; and provide training for health science education.	• develop a new service delivery model that is more affordable for the public sector • deliver high quality, customer focused service • become the laboratory services employer of choice • prioritise innovation and research so that it is relevant, appropriate and leading edge • become a leading resource for information on health • drive stakeholder collaboration • protect the community and environment.	**2015/16** **R 6 147 112**	2017/18
South African Medical Research Council	The South African Medical Research Council was established in 1969 in terms of the South African Medical Research Council Acts, 58 of 1991 . The Intellectual Property, Rights from Publicly Financed Research and Development Act (2008) also informs the council's mandate. The council's strategic focus is determined in the context of the priorities of the Department of Health and government. The council's research therefore plays a key role in responding to government's key outcome 2 (a long and healthy life for all South Africans).	• administer health research effectively and efficiently in South Africa • lead the generation of new knowledge and facilitate its translation into policies and practices to improve health • support innovation and technology development to improve health • build capacity for the long term sustainability of the country's health research.	**2015/16** **R1 020 074**	2016/17
Compensation Commissioner for Occupational Diseases in Mines and Works	The Compensation Commissioner for Occupational Diseases in Mines and Works was established in terms of the Occupational Diseases on Mines and Works Act, 78 of 1973. In terms of the act, the commissioner is mandated to compensate workers and ex-workers in controlled mines and works for occupational diseases of the cardiorespiratory organs and reimbursement for loss of earnings incurred during tuberculosis treatment. In the case where the ex-worker is deceased, it compensates the beneficiaries of deceased worker.	• consolidate the overlapping administrative activities of the Medical Bureau for Occupational Diseases and the Mines and Works Compensation Fund • improve the overall management and sustainability of the compensation fund • provide decentralised services for ex-workers from controlled mines and works • collect and verify the levies from controlled mines and works.	**2015/16** **R171 905**	2018/19
Office of Health Standard Compliance	The Office of Health Standard Compliance is established in terms of the National Health Amendment Act (2013). The board of the office was inaugurated in January 2014 and the Office started to function as an independent entity on 1 April 2014.	The establishment of the Office of Health Standards Compliance is another step towards realising universal healthcare coverage and improving the quality of care in SA. The Office of Health Standards Compliance will conduct compliance inspections at health facilities. It will also have an ombudsman, which will make it possible for patients to complain about healthcare institutions.	**2015/16** **R 88 906**	2020/21


3. Public Private Partnerships (PPP)

Bio Vac

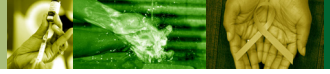
In 2003 the National Department of Health established the Biologicals and Vaccines Institute of Southern Africa (Biovac) through a strategic equity partnership with the Biovac Consortium (Pty) Ltd. The two aims of the partnership were: revive the declining vaccine production capacity in South Africa;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

Infrastructure PPPs

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

4. Technical Indicator Descriptions

The Department has developed the Annual Performance Plan (APP) for the MTEF period 2015/16 - 2017/18 in tandum with this Strategic Plan. The Technical Indicator Descriptions are only provided in the APP 2015/16 - 2017/18. The performance indicators provided in this 5 year Strategic Plan are common to both Strategic Plan 2015/16 - 2019/20 and the APP 2015/16 - 2017/18, and are both published simueltaneously.

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