ANNUAL REPORT 2010/11

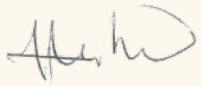
health
Department:
Health
REPUBLIC OF SOUTH AFRICA

A Long and Healthy Life for All South Africans

SUBMISSION OF THE ANNUAL REPORT

1. In terms of Section 40(1)(d) of the Public Finance Management Act 1 of 1999 as amended, and the Public Service Act of 1994 as amended, I hereby submit to the Minister the Annual Report of the National Department of Health for the Financial Year 2010/2011.

2. In terms of Section 65(1) of the Public Finance Management Act 1 of 1999 as amended, the Minister is required to table the report to the National Assembly by 30 September 2011.



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MS MP MATSOSO
DIRECTOR GENERAL
Date of submission: 26-09-2011

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1. GENERAL INFORMATION

VISION, MISSION AND VALUES

Vision

An accessible, caring and high quality health system

Mission

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

ORGANISATIONAL STRUCTURE

The organisational structure has been reviewed and submitted to the Department of Public Service and Administration (DPSA). The department is awaiting feedback in order to implement a more streamlined organisational structure aligned to key priorities.

LEGISLATIVE MANDATES

OVERARCHING MANDATE

Constitution of the Republic of South Africa Act 108 of 1996

Pertinent sections provide for the rights of access to healthcare services, including reproductive health and emergency medical treatment

- **National Health Act 61 of 2003**

  Provides for a transformed national health system for the entire Republic

- **Medical Schemes Act 131 of 1998**

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

- **Medicines and Related Substances Act 101 of 1965**

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

- **Mental Health Care Act 17 of 2002**

  Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with emphasis on human rights for mentally ill patients

- **Choice on Termination of Pregnancy Act 92 of 1996**

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

- **Sterilisation Act 44 of 1998**

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

- **South African 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

- **Tobacco Products Control Act 83 of 1993**

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

- **National Health Laboratory Services Act 37 of 2000**

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

- **Health Professions Act 56 of 1974**

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

- **Pharmacy Act 53 of 1974**

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

- **Nursing Act 33 of 2005**

  Provides for the regulation of the nursing profession

- **Allied Health Professions Act 63 of 1982**

  Provides for the regulation of health practitioners like chiropractors, homeopaths and others, and for the establishment of a council to regulate these professions

- **Dental Technicians Act 19 of 1979**

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

- **Hazardous Substances Act 15 of 1973**

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

- **Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972**

  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular setting quality and safety standards for the sale, manufacturing and importation thereof

- **Occupational Diseases in Mines and Works Act 78 of 1973**

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

- **Human Tissue Act 65 of 1983**

  Provides for the administration of matters pertaining to human tissue

NON-ENTITY SPECIFIC LEGISLATION

- **Public Service Act, Proclamation 103 of 1994**

  Provides for the administration of the public service in its national and provincial spheres, as well as provides for the powers of ministers to hire and fire

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

  Amplifies the constitutional provisions pertaining to administrative law by codifying it

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

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

- **Labour Relations Act 66 of 1996**

  Regulates the rights of workers, employers and trade unions

- **Compensation for Occupational Injuries and Diseases Act 130 of 1993**

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

- **Basic Conditions of Employment Act 75 of 1997**

  Provides for the minimum conditions of employment that employers must comply with in their workplaces

- **Occupational Health and Safety Act 85 of 1993**

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

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

  Provides for the manner in which revenue generated may be disbursed

- **Skills Development Act 97 of 1998**

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

- **Preferential Procurement Policy Framework Act 5 of 2000**

  Provides for the implementation of the policy on preferential procurement pertaining to historically disadvantaged entrepreneurs

- **Employment Equity Act 55 of 1998**

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

- **State Information Technology Act 88 of 1998**

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

- **Child Care Act 74 of 1983**

  Provides for the protection of the rights and wellbeing of children

- **The Competition Act 89 of 1998**

  Provides for the regulation of permissible competitive behaviour, regulation of mergers of companies and matters related thereto

- **The Copyright Act 98 of 1998**

  Provides for the protection of intellectual property of a literary, artistic and musical nature that is reduced to writing

- **The Patents Act 57 of 1978**

  Provides for the protection of inventions including gadgets and chemical processes

- **The Merchandise Marks Act 17 of 1941**

  Provides for the covering and marking of merchandise and incidental matters

- **Trade Marks Act 194 of 1993**

  Provides for the registration of, certification and collective trademarks and matters incidental thereto

- **Designs Act 195 of 1993**

  Provides for the registration of designs and matters incidental thereto

- **Promotion of Equality and the Prevention of Unfair Discrimination Act 4 of 2000**

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

- **State Liability Act 20 of 1957**

  Provides for the circumstances under which the State attracts legal liability

- **Broad Based Black Economic Empowerment Act 53 of 2003**

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

- **Unemployment Insurance Contributions Act 4 of 2002**

  Provides for the statutory deduction that employers are required to make from the salaries of employees

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

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

- **Protected Disclosures Act 26 of 2000**

  Provides for the protection of whistle-blowers in the fight against corruption

- **Control of Access to Public Premises and Vehicles Act 53 of 1985**

  Provides for the regulation of individuals entering government premises, and incidental matters

- **Conventional Penalties Act 15 of 1962**

  Provides for the enforceability of penal provisions in contracts

- **Intergovernmental Fiscal Relations Act 97 of 1997**

  Provides for the manner of harmonisation of financial relations between the various spheres of government, and incidental matters

- **Public Service Commission Act 46 of 1997**

  Provides for the amplification of the constitutional principles of accountability, governance and incidental matters

- **List of legislation tabled in Parliament during the 2010/2011 financial year**

  No legislation was tabled in Parliament during the 2010/2011 financial year. The National Health Amendment Bill 2011 was published for comment in January 2011

ENTITIES REPORTING TO THE MINISTER

Name of entity	Legislation	Nature of business
South African Medical Research Council (MRC)	South African Medical Research Council Act 58 of 1991	The objectives of the council are to promote the improvement of health and quality of life through research, development and technology transfer
National Health Laboratory Services (NHLS)	National Health Laboratory Service Act 37 of 2000	The service supports the public health sector by providing cost effective laboratory services to all public clinics and hospitals
Council for Medical Schemes (CMS)	Medical Schemes Act 131 of 1998	Regulates the private medical scheme industry
Health Professions Council of South Africa (HPCSA)	Health Professions Act 56 of 1974	Regulates the medical, dental and related professions

Name of entity	Legislation	Nature of business
South African Nursing Council (SANC)	Nursing Act 33 of 2005	Regulates the nursing profession
South African Pharmacy Council (SAPC)	Pharmacy Act 53 of 1974	Regulates the pharmacy profession
Allied Health Professions Council of South Africa (AHPCSA)	Allied Health Professions Act 63 of 1982	Regulates allied health professions including chiropractors and homeopaths
South African Dental Technicians Council (SADTC)	Dental Technicians Act 19 of 1979	Regulates the dental technicians profession

MINISTER'S STATEMENT

The year 2010/11 was an historic period that will remain imprinted in the memories of South Africans for a long time. During this period, South Africa hosted the very first FIFA World Cup held on the African continent. The public health sector played its role in buttressing the country's preparations for this event. Additionally, the health sector had its watershed moments during the year under review, which altered the course of service delivery to the people of South Africa. These are outlined below.

Through this Annual Report the National Department of Health (NDoH) accounts to the people and Parliament of the Republic of South Africa on its performance against the Strategic Plan for 2010/2011-2012/2013, now termed the Annual Performance Plan. The department also reports on the use of resources allocated from the national fiscus for the reporting period.

During the period under review, the strategic framework used to guide the work of the NDoH was the 10 Point Plan for 2009-2014, and the Negotiated Service Delivery Agreement (NSDA) 2010-2014 signed in October 2010. I have signed agreements with various Ministers in Cabinet and with all the 9 MECs for health to ensure that as a sector we can implement the NSDA. The National Health Council is the implementing forum for the NSDA and is meeting at regular intervals to provide leadership to the health sector.

To improve the co-ordination and harmonisation of donor funding, we have launched an Aid Effectiveness Framework that seeks to ensure that donor funding is catalytic and enhances the performance of the health system.

In 2010, government revised its medium-term strategic framework (MTSF) for 2009-2014, and adopted a set of 12 key outcomes aimed at enhancing the pace of service delivery and accountability. The department is responsible for Outcome 2, which is: "A long and healthy life for all South Africans". The health sector's NSDA 2010-2014 is an implementation plan for Outcome 2.

To realise Outcome 2, the health sector must achieve four outputs: Output 1: increasing life expectancy; Output 2: decreasing maternal and child mortality rates; Output 3: combating HIV and AIDS and TB; and Output 4: strengthening health systems effectiveness. These outputs are consistent with the health-related Millennium Development Goals (MDGs) that the nations of the world need to achieve by 2015.

In steering the country's efforts towards the NSDA 2010-2014, the common theme that permeated the work of the health sector was advocacy and community mobilisation through campaigns aimed at promoting and securing health. Three successful campaigns were implemented in keeping with this theme - the HIV counselling and testing (HCT) campaign, community-based TB campaigns, and immunisation campaigns.

With regard to combating HIV and AIDS and TB, the common trend amongst South Africans in the past was that only two million people on average would get tested for HIV every year. The HCT campaign was launched by the President of South Africa in April 2010. By the end of the financial year under review, a total of 9.7 million people had agreed to be tested. This watershed moment marked a threefold increase from the previous trends. By March 2011, the country's antiretroviral (ARV) treatment programme had reached a total of 1.4 million people since its inception.

The community-based approach for combating TB that was implemented incorporated an active case-finding programme to trace people diagnosed with TB, screen their family members and counsel them for HIV in their homes. This campaign reached more than 20 000 families by the end of March 2011.

The TB programme has been further strengthened with the introduction of GeneXpert technology. This is the first ever breakthrough in the diagnosis of TB in 50 years. The GeneXpert technology takes only 2 hours, while it used to take up to a week with microscopy and culture. Whereas the microscopy method served us well for the past 50 years, its sensitivity was only around 72%, meaning that 28% of people with TB could be misdiagnosed or missed. The sensitivity with GeneXpert is at 98% meaning that we may only miss 2% of the diagnosis. Additionally, it used to take us at least 3 months to know that a patient has multidrug resistant TB or MDR-TB. Now we are able to have this knowledge in only 2 hours. We have distributed 30 of these machines in districts that have high caseloads. We will be rolling these out to every district in the next six months and to every facility in the next 18 months.

Targeted interventions were implemented to improve child health. Highly successful measles and polio campaigns were conducted to protect South African children against these two vaccine preventable conditions. Furthermore, 89.4% of South African children under the age of one year were fully immunised and 72% were provided with pneumococcal conjugate and rotavirus vaccines to protect them against pneumonia and diarrhoea. Other achievements of note were that scientific evidence reflected that the health sector's programme for preventing HIV transmission from mother–

to-child was proving to be very effective and had begun to yield the desired outcomes. During the reporting period, empirical studies found that mother-to-child transmission rates decreased from 8.5 % nationally to 3%.

Significant reductions in the prices of HIV drugs were also achieved. The NDoH awarded a tender to the value of R4.2 billion over two years for procurement of ARVs. The department amended the usual procurement strategies which resulted in a saving of 53% (R4.4 billion). The benefit of the savings to South Africans is that the health sector will be able to treat more patients with the same resource envelope.

To improve maternal health outcomes, basic antenatal care services were provided in 79.4% of public sector facilities. Over 96% pregnant women presenting in public health facilities agreed to be tested for HIV. About 79% of those pregnant women who were eligible were placed on highly active antiretroviral therapy. This progress is important as HIV and AIDS contribute to over 40% of maternal deaths in South Africa.

An area that requires programme enhancement is the provision of post-natal care to new mothers and their babies. Only 29.9% of babies and 27% of mothers were reviewed within the stipulated six-day post-natal period during 2010/2011.

Attainment of the vision of a Long and Healthy Life for All South Africans requires a strengthened and well performing health system. Key priority areas in which progress was made in strengthening health systems included, amongst many others: re-orienting the system towards primary healthcare (PHC); development of a national health insurance (NHI) policy; reduction in the price of antiretroviral medicines; and improving financial management.

Major strides were made towards improving the quality of services provided in our health facilities. National core standards were produced and used across all provinces to conduct reviews of the state of compliance of health facilities. The National Health Amendment (NHA) Bill, which provides for the establishment of the new Office of Health Standards Compliance, was gazetted in January 2011. It was approved by Cabinet for tabling in Parliament after certification. Preparatory work has begun on establishing the office as envisaged in the Bill.

During the reporting period, we organised and hosted a nursing summit which was attended by close to 1800 participants. The summit emphasised that the profession used to be known and respected as a noble profession and a calling. However, in recent times this has changed and it has been characterised by an uncaring attitude and sometimes outright rudeness. All in the summit agreed that the nobility and respect for the profession has to be brought back.

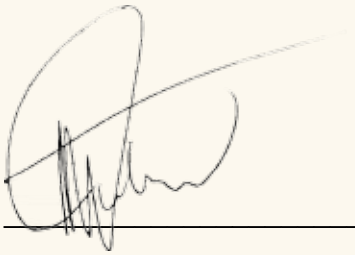
Moreover the summit underscored the rights enshrined in the constitution and the constitutional

responsibility that nurses have to ensure that citizens obtain good quality healthcare. The summit concluded with adopting a nursing pledge which highlighted the fact that nurses are central to the achievement of health revitalisation goals as they are the backbone of the country's hospitals and clinics. The nursing pledge and the summit resolutions are being used as a strategic document by the Department to assist the profession to improve its image and improve the quality of care for patients.

During the period under review, we have processed and published 60 regulations to ensure the full force and effect of the National Health Act of 2003.

I wish to express my gratitude to my colleagues, the Deputy Minister of Health, Honourable Dr Gwen Ramokgopa, and all the provincial MECs for Health with whom I worked in 2010/2011.

I also wish to thank the Director-General of Health, Precious Matsoso and her team for the sterling work the Department has done during the reporting period.



DR A MOTSOALEDI, MP
MINISTER OF HEALTH
DATE: 26-09-2011

ACCOUNTING OFFICER'S OVERVIEW

The 2010/2011 financial year has been a very productive year on the health calendar. We managed to implement key interventions that seek to improve the performance of the National Department of Health (NDoH) and the health sector in general. A significant milestone was the smooth running of the FIFA 2010 World Cup, where the sector working with local and international partners was well prepared to respond to disasters and epidemics. Of particular importance is the partnership that was established between the public and private sector on emergency medical services, hospitals and disease surveillance and outbreak response.

As the Minister has indicated, we have made progress towards realising the policy priorities in the 10-Point Plan and the Negotiated Service Delivery Agreement (NSDA). As part of overhauling the health system and its management, we concluded a study on management capacity for hospital CEOs and district managers. The development of the national policy on National Health Insurance (NHI) is one of the hallmarks of the department's performance during 2011/2012. The Ministerial Advisory Committee on NHI made its final recommendations to the Minister during the reporting period.

During the financial year, the Bill on the establishment of the Office of Health Standards Compliance was prepared and gazetted. Over the past financial year we have put systems in place to improve the quality of service we provide to the citizens. We have produced and adopted six core areas of quality which are aligned to other international definitions of quality. We will use indirect measures such as the setting up the Office of Health Standards and Compliance, accreditation of facilities, setting of norms and standards and ongoing re-certification of service providers to monitor quality as part of our regular activities.

The HIV Counselling and Testing (HCT) campaign is one of the most ambitious projects ever launched by government and particularly the health sector. It was during the reporting period, the financial year 2011/2012, that the campaign was implemented. The campaign has mobilised all sectors of our society to work together in partnerships for improved health outcomes. Additionally, it created the sense of urgency required in addressing the burden of disease resulting from HIV infection and AIDS related illness.

This has improved health seeking behaviour and ensured those who were tested got to know their HIV status. Some also received additional benefits such as screening for tuberculosis and chronic

diseases such as hypertension and diabetes. The latter are also known as “silent killers” due to the late detection when very little intervention is possible to prevent these diseases. This campaign fits in well with our strategic vision of ensuring that the department places emphasis on disease prevention, early detection and treatment through promoting healthy life styles and health care seeking behaviour.

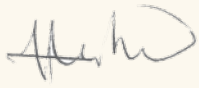
Another key campaign was the community-based advocacy for tuberculosis (TB), where teams were set up to visit each household in the designated district. This pilot project not only demonstrated feasibility but yielded the desired result as TB infected individuals were identified early and referred to the health services for treatment, and to social services for other forms of support. Active case finding of TB patients and the introduction of GeneXpert diagnostic tool will result in early diagnosis and treatment thus reducing the burden of infective people.

Our PHC re-engineering strategy is premised on this very principle: Health service delivery does not only depend on the fixed structures i.e. clinics and hospitals. A policy was approved to establish ward-based teams that would visit communities to provide health education, uncover health and social problems in households that would otherwise be picked up too late if we waited for clients to come to facilities.

A price reduction strategy was adopted and this has resulted in huge savings for ARVs and will be applied for all other medicines in the public health sector.

Over the past year we have begun a process of improving the performance of the health system to provide services and respond to the burden of disease. These include a more streamlined organisation aligned to our priorities; the development of a long-term human resource strategy, and mobilising and channelling resources appropriately, to where the greatest need is.

I wish to express my gratitude to the Minister of Health, Dr. A. Motsoaledi, MP, as well as the Deputy Minister, Dr. G. Ramokgopa, MP, for the leadership and guidance they provided to the health sector during the reporting period. Finally, I would like to thank the technical committee of the NHC, Heads of Department and officials in the National Department for the work done during the period under review.



MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE: 26-09-2011

2. INFORMATION ON PREDETERMINED OBJECTIVES

2.1 OVERALL PERFORMANCE

2.1.1 VOTED FUNDS

Main Appropriation R '000	Adjusted Appropriation R '000	Actual Amount Spent R '000	(Over)/Under Expenditure R '000
21 496 985	21 661 512	20 918 579	742 933
Responsible Minister	Minister of Health		
Administering Department	National Department of Health		
Accounting Officer	Director-General of the National Department of Health		

2.1.2 AIM OF THE VOTE

The aim of the Department of Health is to promote the health of all people in South Africa through an accessible, caring and high quality health system based on the primary healthcare approach.

2.1.3 SUMMARY OF PROGRAMMES

PROGRAMME 1: ADMINISTRATION

The purpose of the programme is to conduct overall management of the department. Activities include policy-making by the offices of the minister and director-general, and the provision of centralised support services. The *Administration Programme* includes transversal functions such as corporate finance, human resource, logistical services, office support, information technology, internal audit, legal services and communication.

PROGRAMME 2: STRATEGIC HEALTH PROGRAMMES

Strategic Health Programmes co-ordinates a range of strategic national health programmes by developing policies and systems, and manages and funds key health programmes. In 2010/2011, *Strategic Health Programmes* consisted of five sub-programmes to deal with its key policy areas:

- *Maternal, Child and Women's Health and Nutrition* formulates and monitors policies, guidelines, norms and standards for maternal, child and youth and women's health and nutrition.
- *HIV and AIDS and STI Management* develops policy and administers the national HIV and AIDS and STI programmes, including co-ordinating the implementation of the comprehensive HIV and AIDS plan and funding and supervision of the related conditional grant. The sub-programme also manages strategic partnerships and provides secretariat support to the South African National AIDS Council (SANAC).
- *Non-Communicable Diseases* establishes guidelines on the prevention, management and treatment of a range of chronic diseases, disability, older people, mental healthcare and oral health. The sub-programme is also responsible for developing a national forensic pathology service, rationalising blood transfusion services and overseeing the National Health Laboratory Services.
- *Communicable Diseases* is responsible for developing policies and supporting provinces to ensure the control of outbreak prone infectious diseases.
- *TB Control and Management* develops interventions to curb the spread of tuberculosis, and drug resistant TB, supports and oversees the implementation of the TB Crisis Management Plan, and aims to monitor and improve national tuberculosis performance indicators.

PROGRAMME 3: HEALTH PLANNING AND MONITORING

The Health Planning and Monitoring Programme is responsible for planning, monitoring and co-ordination of health services. There are five sub-programmes in this programme:

- *Health Information, Research and Evaluation* develops and maintains a national health information system, and commissions and co-ordinates research. The sub-programme provides disease surveillance and epidemiological analyses, and leadership during disease outbreaks; conducts training on epidemic prone disease prevention, preparedness and control; and monitors and evaluates health programmes. It provides funding to the South African Medical Research Council and oversees its activities.
- *Health Financial Planning and Economics* undertakes health economics research, develops policy for national health insurance and revenue collection, regulates medicine prices in the private sector, manages the national tertiary services grant and monitors public private partnerships in the health sector.
- *Pharmaceutical Policy and Planning* develops standard treatment guidelines for medical conditions at all levels of care, develops specifications for medicines on national tender, monitors the procurement and supply of essential medicines to provinces, and regulates facilities and individuals responsible for the dispensing of medicines; and develops policy relating to traditional medicine.
- *Office of Standards Compliance* develops policy on health quality standards, co-ordinates provincial quality assessments and investigates patient complaints. The cluster is also responsible

for radiation control.

PROGRAMME 4: HUMAN RESOURCE MANAGEMENT AND DEVELOPMENT

Human Resource Management and Development Programme plans and co-ordinates human resource for the health sector.

In 2010/2011 there were three sub-programmes:

- *Human Resource Policy, Research and Planning* supports medium to long-term human resource planning in the national health system. Its functions include implementing the national human resource for health plan, facilitating capacity development for sustainable health workforce planning and developing and implementing human resource information systems for planning and monitoring purposes.
- *Human Resource Development and Management* is responsible for developing human resource policies, norms and standards, and for ensuring the efficient management of the employees of the NDoH. This sub-programme funds the health professional training and development conditional grant, which is transferred to provinces.
- *Sector Labour Relations and Planning* provides the resources and expertise for bargaining in the national Public Health and Welfare Sectoral Bargaining Council.

PROGRAMME 5: HEALTH SERVICES

Special Programmes and Health Entities Management Programme supports the delivery of health services in provinces including primary healthcare, hospitals, emergency medical services and occupational health.

In 2010/2011 there were four sub-programmes:

- *District Health Services* promotes and co-ordinates the development of the district health system, monitors the implementation of primary healthcare and activities related to the integrated sustainable rural development programme and the urban renewal programme.
- *Environmental Health, Health Promotion and Nutrition* is responsible for policy making and monitoring of health promotion, environmental health and nutrition. It also provides technical support and monitors the delivery of municipal health services by local government, provides port health services and supports poison information centres.
- *Occupational Health* promotes occupational health and safety in public health institutions and ensures the training of occupational health practitioners in risk assessment, including the provision of benefit medical examinations.
- *Hospital Services and Health Facilities Management* develops policy on health facility infrastructure, health technology, emergency medical services and governance of hospitals. This

cluster also manages the hospital revitalisation grant and the health professions training and development grant.

PROGRAMME 6: INTERNATIONAL RELATIONS, HEALTH TRADE AND HEALTH PRODUCT REGULATION

International Relations, Health Trade and Health Product Regulation co-ordinates bilateral and multilateral international health relations including donor support, regulations of procurement of medicines and pharmaceutical supplies and regulation and oversight of trade in health products.

In 2010/2011 there were three sub-programmes

- *Multilateral Relations* develops and implements bilateral and multilateral agreements to strengthen the health system, concludes agreements on the recruitment of health workers from other countries, provides technical capacity to South Africa in fields such as health technology management and surveillance systems and mobilises international resources for priority health programmes.
- *Food Control and Non-Medical Health Product Regulation* ensures food safety by developing and implementing food control policies, norms and standards and regulations.
- *Pharmaceutical and Related Product Regulation and Management* regulates trade in medicine and pharmaceutical products through the Medicines Control Council (MCC) to ensure access to safe and affordable medicines.

2.1.4 KEY STRATEGIC OBJECTIVES AND ACHIEVEMENTS

During the reporting period, the department embarked on advocacy work that formed the basis of mobilising communities and partners through major campaigns. This will, over time, contribute to improving the health status of all South Africans. Key strategic achievements of the department include: the implementation of the largest HIV Counselling and Testing (HCT) campaign globally; a 53% reduction in the price of antiretroviral medicines; an active case-finding programme to trace all persons diagnosed with TB, screen their family members, and counsel them to be tested for HIV in their homes; and the emerging successes of the prevention of mother-to-child transmission (PMTCT) programme. These are discussed in detail in the section below.

2.1.5 OVERVIEW OF THE SERVICE DELIVERY ENVIRONMENT

In April 2010, the President of South Africa launched the largest HCT campaign in the world. This campaign is intended to provide an opportunity for community members to be tested for HIV, tuberculosis (TB), and chronic diseases such as diabetes and hypertension. The HCT campaign is one of the biggest partnerships between government, civil society and the private sector South Africa has ever witnessed. All the partners rallied around the President's call to the nation to actively participate in the campaign. The campaign has resulted in significantly increased numbers of people coming forward for counselling and testing. The number of people screened and tested through the campaign is three times the number that the public sector is able to screen annually. This demonstrates that working together as a sector with single mindedness we can face the challenges confronting the health system. Available data indicates that by the end of the financial year, over 11.4 million South Africans had been counselled and over 9.7 million had agreed to be tested. South Africans responded to the call to test so that they know their HIV status and to act responsibly.

During 2010/2011, the department was able to achieve a significant reduction in the price of antiretroviral medicines. The department awarded a tender for the supply of antiretroviral medicines to the value of R4.2 billion over two years, which resulted in savings of R4.4 billion (53%) - when compared with previous tender prices. These lower prices will enable the health sector to place more people on antiretroviral treatment (ART) using the existing budget. Access to ART will be expanded to an additional 650 000 people in 2011, which will culminate in 1 950 million people living with HIV receiving treatment by the end of the next financial year.

During the year under review South Africa continued to face the quadruple burden of diseases consisting of HIV and AIDS and TB, high maternal and child mortality, non-communicable diseases (NCDs), and violence and injuries. The strategic focus and interventions of the Department of Health are geared towards ameliorating the suffering and poor quality of life resulting from this high burden of disease. To effectively deal with the developmental challenges in South Africa, there has been a need to come up with a responsive service delivery environment across all government departments.

In the course of 2010, government adopted an outcome-based approach to service delivery and performance management, and adopted 12 key outcomes. The health sector provides leadership over the country's efforts to achieve Outcome 2: *"A long and healthy life for all South Africans*". Specific focus is placed on four key outputs namely: increasing life expectancy; reducing maternal

and child mortality rates; combating HIV and AIDS and TB; and strengthening the effectiveness of the health system. Interventions to achieve these outputs are outlined in the health sector's Negotiated Service Delivery Agreement (NSDA) 2010-2014. The NSDA is premised on the principle that healthcare delivery is a partnership between all key stakeholders and communities. In keeping with this, advocacy, social mobilisation and communication constitute the core strategies to enhance access to health services and systematically improve the health status of all South Africans, in partnership with communities.

There are several factors which make TB a priority for the country. Firstly, South Africa is one of the high burden countries globally and, secondly, there is a high proportion of TB-HIV co-morbidity which is estimated to be as high as 73%. On the commemoration of World TB Day on 24 March 2011, the department launched an active case-finding programme to trace all persons diagnosed with TB, screen their family members, and counsel them to be tested for HIV in their homes. By the end of the reporting period, 20 000 households had been visited. This social mobilisation approach will assist in reducing levels of TB and HIV infections in households, families and the community at large. Furthermore, the department also acquired the latest technology in the diagnosis of TB, the Gene-Xpert equipment. This equipment has the capacity to release TB results within two hours. This will massively improve access to treatment for people diagnosed with TB.

Reducing the burden of vaccine preventable diseases is both an international and a departmental goal. In partnership with communities across the country, successful mass immunisation campaigns were conducted during 2010/2011. Specifically for measles, all of the children within the targeted age groups were immunised.

The goal of overhauling the healthcare system, which consists of re-invigorating the primary healthcare (PHC) approach to healthcare delivery, and improving the functionality and management of the health system, was achieved. During the reporting period, a new PHC model for the country was developed and endorsed by the National Health Council (NHC). The new PHC model places greater emphasis on both the individual and the family, and focuses on promotion and prevention, and rehabilitative and referral services rather than exclusively on curative services. It avoids fragmentation that results in multiple community health workers visiting families, and ensures that a single integrated team establishes relations with families in the catchment area. It accentuates strong community participation as well as inter-sectoral collaboration. Three pillars of the new PHC model are: deployment of PHC outreach teams consisting of professional nurses, enrolled nurses and community health workers in different wards across the country; the establishment of medical

specialist teams to support the PHC teams; and strengthening school health services. This will contribute significantly to improving health outcomes in the country.

Strengthening management of the health systems in general, with particular emphasis on hospital and district management, is a strategic objective of the current administration. Consequently, an audit of the organisational environment in which hospital chief executive officers (CEOs), hospital senior managers and district managers function was conducted in partnership with the Development Bank of Southern Africa (DBSA). A number of gaps have been identified and development and implementation of appropriate interventions to strengthen management have commenced.

In addition to general management, the improvement of financial management skills is integral to overhauling the management and leadership in the health sector. An audit of financial management practices in all nine provincial health departments was successfully completed. The audit reflects a financial profile of each health department and the analysis of the cost drivers and budget pressures of the health services. The findings of this audit reflect that there are huge disparities in spending patterns between the public and private sector. In 2000 about R8.25 billion was spent on drugs, with the state spending only 24% of this. The State, for example, had a drug expenditure of R59.36 per person while the private sector spent R800.29 per person. This demonstrates the huge inequities and funding gap between the public and private health sectors. When the benefits of a medical scheme member run out, the State still has to provide services. As a result, provincial health departments are under pressure and need to balance their constitutional obligations of rendering health services to all South Africans and statutory requirements outlined in the Public Finance Management Act (PFMA), which states that they must be prudent and avoid over expenditure on allocated funds. This challenge has resulted in the provincial health departments overspending their allocated funds for the last three to four years (2006/2007 – 2009/2010).

Another reason for provincial departments' over expenditure is accruals and bank overdrafts from prior years. In some provinces, since prior year accruals and overdrafts become the first call for a new financial year, the incurred expenditure reduces the allocation for the current financial year, which then results in funding being exhausted during the last two or three months of the new financial year.

For the year under review, the implementation of financial management remedial interventions also commenced, in partnership with the Technical Assistance Unit (TAU) of National Treasury, with the

purpose of putting mechanisms in place to address the inefficiencies and also address the under-funding where applicable.

Risk: A massive public sector strike took place during the reporting period which negatively affected service delivery across all three levels of the department (i.e. national, provincial and district). Access to critical services, such as antiretroviral treatment for people living with HIV and AIDS, was curtailed and the department had to implement various contingency measures, including deploying nationally based officials with a health background to the hospitals and clinics and encouraging other officials to volunteer in providing administrative and other support services.

2.1.6 OVERVIEW OF THE ORGANISATIONAL ENVIRONMENT 2010/2011

Significant progress has been made in terms of aligning the departmental structure to function. This was necessitated by the poor health outcomes despite a reasonable amount of expenditure and Cabinet's adoption of an outcome-based approach to service delivery. This has meant that the NSDA cannot effectively be responded to within the current configuration of the department. As a result, a revised structure of the NDoH was produced and aligned to the functions of the department as reflected in the NSDA 2010-2014. The reconfigured organogram creates a structure that will bring about the improved outputs outlined in the NSDA. Most importantly, the new structure enhances the capacity of the department for the implementation of the National Health Insurance (NHI). The new structure has been submitted to DPSA for concurence.

2010 FIFA World Cup: The department developed and established a web-based disease notification surveillance system for use during the FIFA 2010 World Cup. This was a partnership with private health sector partners and international agencies such as the private hospital groups (Lifecare, Netcare, Mediclinic and independent hospital groups); main airports, including Lanseria; three main harbours; eight public viewing areas and 10 stadia. This collaboration has strengthened our ability as a country to detect epidemic-prone diseases and respond in time. Additional spin-offs demonstrated a feasibility for the public and private health sectors to jointly implement the National Health Act 61 of 2003 and the International Health Regulations on Priority Health Notifiable Conditions specific to the World Cup, as well as ensure that all data was sent to a single repository at J9 surveillance desk at the South African Medical Health Services (SAMHS) head quarters.

The legacy left by this project is the ability to establish an early warning system to detect outbreaks or epidemic-prone disease outbreaks occurring in the health sector. The staff trained during the project

came from various entities such as the NDoH, infection control staff at provincial level, informatics at all levels, surveillance data capturers, emergency medical services (EMS) staff, health inspectors, port health officials, retired nurses and doctors. These categories of staff were all trained in the implementation of the web-based notification system and active surveillance during mass gatherings and the skills base has remained in South Africa.

2.1.7 KEY POLICY DEVELOPMENTS AND LEGISLATIVE CHANGES

In 2010/2011, the department produced 60 sets of regulations to give effect to various pieces of health legislation. These regulations range from dealing with the safety of medicines and food quality, strengthening systems in preparation for the NHI, and the national department's improved oversight role. All these serve as building blocks for the NHI and seek to improve the quality and safety of health products and to strengthen health systems performance.

The Batho Pele principles and other related policies seek to ensure accountability within the public sector. The health sector has taken this further by developing a set of uniform standards for meeting basic standards of good clinical care and health service management. The National Health Amendment Bill was gazetted on 24 January 2011 to give effect to the core standards and to enforce them in the health system.

In keeping with the target for 2010/2011, the Public Health and Social Development Sector Bargaining Council (PHSDSBC) Resolution 2 of 2010, which makes way for the implementation of the Occupation Specific Dispensation (OSD) PHSDSBC Resolution for therapeutic, diagnostic and other allied health professionals, was signed on 5 November 2010. The NDoH conducted a 5% sampling in all nine provinces to ensure correct interpretation and application of Resolution 2.

The National Health Act of 2003 requires that the National Consultative Health Forum (NCHF) convene at least once a year. During the financial year 2010/2011, the NCHF convened for the first time since 2008/2009 – a major achievement. The NSDA gained impetus through the designation of the NHC as the Implementation Forum for the NSDA 2010-2014, and the Technical Advisory Committee of the NHC as the Technical Implementation Forum.

The department launched, with overwhelming support from the development partners, the *Aid*

Effectiveness Framework (AEF), which is the policy framework for harmonising and co-ordinating all the support provided by international development partners towards national health priorities set by the government. The five key principles of the *Paris Declaration on Aid Effectiveness* will form the foundations of the AEF for the health sector in South Africa. These are:

- **Ownership** of development strategies by the government of South Africa
- **Alignment** of aid by development partners in line with these strategies
- **Harmonisation** of actions by development partners through co-ordinating their actions, sharing information and simplifying procedures
- **Managing for results** by producing and measuring development results
- **Mutual accountability** for development outcomes by the government and development partners.

2.1.8 COLLECTION OF DEPARTMENTAL REVENUE

Table 1: Collection of departmental revenue

	2007/08	2008/09	2009/10	2010/11	2010/11	% Deviation from target
	Actual	Actual	Actual	Target	Actual	
	R'000	R'000	R'000	R'000	R'000	
Sales of goods and services other than capital assets	39 514	29 747	38 412	30 535	25 966	-14.96
Interest, dividends and rent on land	297	249	1 012	252	355	+40.87
Financial transactions in assets and liabilities	1 382	1 192	5 766	670	927	+38.36
Total departmental receipts	**41 193**	**31 188**	**45 190**	**31 457**	**27 248**	**-13.38**

The department collects revenue from the licensing unit of the Affordable Medicines Cluster of Pharmaceutical Policy and Planning Unit. The categories are dispensing and yellow fever licence application, and pharmacy licence applications. For dispensing and yellow fever licence application, 597 applications were received and 428 licenses were issued. There were incomplete and cancelled applications of 116 and 37 respectively. The revenue generated through this process was R1 434 775. With respect to pharmacy license applications, the total number of applications received and

submitted to the Pharmacy Council are 421 and the number of licenses issued 360. There are 95 outstanding applications, two were cancelled and the remainder still in the process. The table above reflects the department's revenue collection for 2010/2011, as well as for three previous financial years. For 2010/2011, the department raised a total amount of R27 248 million, which is lower than the estimated R31 457 million.

2.1.9 DEPARTMENTAL EXPENDITURE

Out of a total allocation for the year under review amounting to R21 661 512 billion, the department spent R20 918 579 billion (96.6%) of the budget available. An amount of R742 933 million was under spent, resulting in a 3.4% under expenditure. The under expenditure is a slight increase compared with the previous financial year. Further details are provided in the annual financial statements.

2.1.10 TRANSFER PAYMENTS

The department makes transfers for conditional grants to the provinces as well as transfers to non-profit organisations (NGOs). Further details of the conditional grants can be found in the accounting officer's report under paragraph 6, Note 31 of the annual financial statements, and the annexures of the annual financial statements: 1A,1B, 1C ,1D and 1E. There are no transfers to municipalities.

2.1.11 CONDITIONAL GRANTS AND EARMARKED FUNDS

The Department is managing five conditional grants, namely:

- National Tertiary Services Grant
- Health Professions Training and Development Grant
- Hospital Revitalisation
- Comprehensive HIV and AIDS Plan
- Forensic Pathology Services.

Further details of the conditional grants can be found in the accounting officer's report under paragraph 6 as well as Note 31 of the annual financial statements. These funds flow to provincial health departments from where spending takes place on items as contained in a pre-approved business plan by both provincial and national accounting officers.

2.1.12 CAPITAL INVESTMENT, MAINTENANCE AND ASSET MANAGEMENT PLAN

- **Capital investment**

The department made no capital investment. All capital investment is planned and incurred by the Department of Public Works (DPW). A project that was ongoing for the year under review was the upgrading of the Johannesburg Chemistry Laboratory.

- **Asset Management**

The department has progressed substantially in completing its asset management implementation plan. A physical stock take of all assets was conducted (twice for those buildings that were relocated to the Civitas Building) during the year under review and an asset register was provoded for audit purposes. The department has initiated a project of automating the asset register as part of ensuring accuracy and completeness of the register. For the year under review, the department had 40 000 assets. Movable tangible capital assets are disclosed in note 29 to the financial statements at an amount of R130 111 000 and minor assets are disclosed in note 29.4 to the financial statements at an amount of R34 402 000. Details for the movement of assets for the year under review are in disclosure note number 29 of the annual financial statements

- **Maintenance**

The department leases all its buildings from the DPW from both government owned and private properties. Maintenance is therefore paid by the DPW which, in turn, bills the department.

2.2 PROGRAMME PERFORMANCE

The activities of the National Department of Health are organised in the following programmes:

Programme 1: Administration

Programme 2: Strategic Health Programmes

Programme 3: Health Planning and Monitoring

Programme 4: Human Resource Management and Development

Programme 5: Health Services

Programme 6: International Relations, Health Trade and Health Product Regulation.

The sections that follow reflect the key objectives, indicators, targets and achievements for each sub-programme of the six budget programmes.

PROGRAMME 1: ADMINISTRATION

Programme purpose: to conduct overall management of the department. Activities include policy-making by the offices of the Minister, and Director-General, and the provision of centralised support services. The *Administration* programme includes transversal functions such as corporate finance, human resource, logistical services, office support, information technology, internal audit, legal services and communication.

SUB-PROGRAMME: STRATEGIC PLANNING

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Support the development, implementation, monitoring and reporting on integrated health sector plans, which focus on National Health Systems (NHS) priorities (the 10 Point Plan)	Annual National Health Plan (ANHP) produced for each year of the planning cycle	ANHP 2010/2011 produced by the end of June 2010	ANHP 2010/2011 was produced	None	None
	9 provincial Annual Performance Plans (APPs) analysed and written and feedback provided	Written comments provided to all 9 provinces on the APPs for 2011/2012 to 2013/2014 in September 2010 and January 2011	All provinces were supported on the development of APPs	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Support the development, implementation, and monitoring of long-term plans of the health sector	Number of Service Transformation Plans (STPs) produced	1 national and 9 provincial STPs finalised and aligned to the 10 Point Plan	7 provinces produced draft STP's	2 draft provincial STP outstanding	Capacity constraints delayed the development of the STPs in the Eastern Cape The Western Cape is in the process of updating its 2020 plan using the Comprehensive Service Plan 2000-2010 The National STP will be developed once provinces had submitted their final STPs
Strengthen health planning in the 18 priority districts	Number of District Health Plans (DHPs) of 18 priority districts reviewed and written feedback provided	18 DHPs reviewed and feedback provided	15 draft DHPs were reviewed and written feedback was provided	3 DHPs were not reviewed	3 DHPs from 18 priority districts were submitted late to the NDoH
Track the performance of health system consistently and systematically	Number of progress reports produced annually	4 quarterly reports	4 quarterly progress reports were produced	None	None
Strengthen the use of the project management approach in the health system	Number of projects implemented in accordance with a project management approach	8 projects	10 macro projects	+2 macro projects	Project management principles and techniques were used throughout the department
	Number of consolidated reports on the implementation of projects	4 quarterly reports	4 quarterly reports	None	None

Overview of performance

Effective planning, equitable resource allocation, monitoring, evaluation and reporting on implementation are essential for strengthening the effectiveness of any health system.

The development of long-range plans of the health sector was enhanced during the financial year 2010/2011. With support from the NDoH, seven of the nine provincial departments produced their draft 10-year service transformation plans (STPs) for 2010-2020, with the exception of the Eastern Cape and the Western Cape. These plans were aligned to key health sector priorities espoused in the 10 Point Plan for 2009-2014 and the NSDA for 2010-2014. A framework for the development of a national STP was produced. The national STP has, however, not been completed due to the need to link it to all nine provincial STPs. Production of coherent long-term plans is vital for ensuring sustainable and affordable delivery of good quality health services to the people of South Africa moving into the future, and for shaping medium-term and short-term plans. Long-term planning is consistent with the vision of the government, as articulated by the National Planning Commission located in the Presidency.

Integrated planning at all levels has been strengthened through a process of linking the annual performance health plans of provinces and districts to the national health planning system. To this end, the NDoH conducted an analysis of provincial annual performance plans, as well as district health plans from the priority districts for the 2011/2012 planning cycle.

For the national department, four analytical quarterly progress reports, which tracked the performance of the NDoH against its annual performance plan for 2010/2011-2012/2013, were produced, reviewed by senior management and submitted to the executive authority. This bodes well for ensuring that managers use information for planning, budgeting and decision making.

The department has developed and implemented a project management approach for key strategic projects. During the period under review, 10 major projects were implemented in accordance with this project management approach in excess of the set target of eight projects for the reporting period. The project management approach has been particularly useful in ensuring successful delivery of health facilities, appropriate for providing good quality services.

Project management principles and techniques were used extensively by the infrastructure support systems programme of the department, which has six major sub-programmes namely: project management information system (PMIS); project monitoring and oversight support; infrastructure norms and standards; reporting on capital project status; cost modelling tools; and an integrated national project management information system which will enhance the oversight, monitoring and reporting of progress on health infrastructure projects in all nine provinces. At the end of 2010/2011, the PMIS project was at tender stage. When awarded, data and information gathered from the project status report, covering the contractual, financial and physical particulars and status of a total of 2 400 health infrastructure projects in all provinces, will be quality and quantity checked and lodged and registered in the PMIS. The system will be updated with the progress report of all projects enabling it to prepare a comprehensive infrastructure report as envisaged in the infrastructure plan of the NDoH.

The aims of strengthening project monitoring and oversight support are: to foster service delivery within agreed quality standards, time and budget as well as identifying deficiencies and challenges within the system; to provide an oversight role through the early identification of potential progress blockages and budget shortfalls; and to initiate remedial action with immediate effect.

During 2010/2011, the National Project Management Support Unit (PMSU) of the department assisted the provinces in the infrastructure delivery projects. Focus areas of the sub-programme included assisting the infrastructure unit in major projects such as: (a) five public private partnership (PPP) national flagship projects as a member of the joint implementation committees (JIC), where the PMSU served as expert project manager. This culminated in key progress with the feasibility studies on the Limpopo Academic Hospital and Chris Hani Baragwanath Hospital; (b) completion and occupation of the NDoH's Civitas Building in 2010/2011; and revitalisation of floors 27 and 28 of the Civitas Building. Project management principles and techniques were also used to support the refurbishment of the Johannesburg Forensic Laboratory. This laboratory will be officially completed and handed over to the department by the end of May 2011.

SUB-PROGRAMME: FINANCIAL SERVICES AND DEPUTY CFO

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement a turn-around strategy for improving audit outcomes and reducing the concerns raised by the auditor-general	Audit opinion of the auditor-general:NDoH	Unqualified	Qualified	NDoH did not obtain an unqualified audit opinion	Qualified audit opinion has been on asset management
	Project plan accepted by the Technical Advisory Committee (TAC) of the NHC	Financial Management Improvement Plan implemented in all 9 provinces	Financial Management Improvement Plan implemented in 7 provinces	-2 provinces	The two provinces not included in the provincial visits were the Western Cape and KwaZulu-Natal. They were in the process of implementing their own financial improvement plans
	Audit opinion of the auditor-general: Provincial health departments	4 provincial health departments with unqualified audit opinions	2 provinces, North West and Western Cape obtained an unqualified audit opinion	-2 provinces	Inadequate financial management system

Overview of performance

This sub-programme is responsible for ensuring that resources are well spent within the legislation and regulatory frameworks. Furthermore, the sub-programme acts as a link between the Department of Health and National Treasury. In keeping with its objectives for 2010/2011, the NDoH implemented measures to improve financial management and budget control, in compliance with the Public Finance Management Act of 1999 as amended. The NDoH, in conjunction with the Technical Assistance Unit (TAU) of the National Treasury, developed a financial management improvement plan, which was endorsed by both the Technical Advisory and Policy Committees of the National Health Council.

The first phase of the plan was implemented during the reporting period. Reviews of financial management were completed in seven of the nine provinces. Reports with recommendations were produced and tabled before the NHC, which endorsed these reports. Implementation of remedial interventions to enhance financial management commenced in seven of the nine provinces.

Implementation of an asset management improvement project also commenced in all provincial health departments. Three provinces (Eastern Cape, KwaZulu-Natal and Mpumalanga) are participating in a national project, while six other provinces have established their own asset management projects.

SUB-PROGRAMME: LEGAL SERVICES

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Prepare the National Health Amendment Bill for submission to Cabinet and Parliament	National Health Amendment Bill passed by Parliament	National Health Amendment Bill submitted to Cabinet for approval in April 2010 National Health Amendment Bill tabled in Parliament in September 2010	Bill was published for comment in January 2011	None	None
	Health Laws Amendment Bill passed by Parliament	Health Laws Amendment Bill submitted to Cabinet for approval in September 2010	Health Laws Amendment Bill not drafted	Bill not drafted.[1]	
Prepare the National Health Insurance Bill for submission to Cabinet and Parliament	National Health Insurance (NHI) Bill passed by Parliament	NHI Bill submitted to Cabinet for approval in September 2010	NHI policy was submitted to Cabinet Development of the NHI Bill should be preceded by policy formulation[2]	None. Development of the NHI Bill should be preceded by policy formulation	Development of the NHI Bill should be preceded by policy formulation

[1] The Department decided on a comprehensive review of all health legislation before the Bill could be drafted. The review is currently underway.
[2] The appropriate sequence is that the development of the National Health Insurance (NHI) Bill should be preceded by policy formulation. This has been achieved, as the NHI policy was submitted to Cabinet.

Overview of performance

The mandate of this sub-programme is to provide general legal support to the department internally and externally, which includes drafting of legislation (Acts, regulations, proclamations and other formal legal notices) and legal opinions as well as managing and co-ordinating litigation, and advising the department on legal matters in general. In keeping with its mandate and the target for 2010/2011 the National Health Amendment Bill was gazetted for public comment in January 2011, to provide for the establishment of an independent Office of Health Standards Compliance, which will enforce

compliance with quality norms and standards and conduct independent investigation of complaints relating to such quality norms and standards.

Furthermore, the department produced 60 sets of regulations to give effect to various pieces of health legislation. These regulations are significant in various respects. They relate to the regulatory functions of the department (medicines control, food control and human tissue regulation), administrative processes (licenses), professional matters (medical and dental, nursing, pharmacy). They also seek to improve the quality and safety of health products and strengthen health systems performance. Areas of slow progress during 2010/2011 include two pieces of legislation that were not processed through Cabinet during 2010/2011. These were: Health Laws Amendment Bill and the National Health Insurance Bill. The set target was to submit both Bills to Cabinet for approval in September 2010.

SUB-PROGRAMME: COMMUNICATION

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Develop a communication policy for the health sector, aligned to the 10 Point Plan for 2009-2014	Approved communication policy available	Communication policy approved by NHC and published	Draft communication policy has been developed and aligned to the Negotiated Service Delivery Agreement 2010-2014 (NSDA)	Draft communication policy not published	The communication policy had to be aligned to the government communication policy produced by the Government Communication and Information System (GCIS)
Develop a five-year communication strategy for the health sector, aligned to the 10 Point Plan for 2009-2014	Approved five-year communication strategy available	Five-year communication strategy approved by the NHC and published	Draft communication strategy	Draft communication strategy not published	Communication strategy had to be aligned to GCIS new policy

Overview of performance

This sub-programme is tasked with the responsibility of providing internal and external communication expertise to the department. Of significance is the responsibility of profiling the department well and maintaining a good image with the public and other stakeholders. During the reporting period, the department produced a draft communication policy for the health sector, which was aligned to the NSDA 2010-2014. The policy was revised and aligned to the government communication policy produced by Government Communication and Information Systems (GCIS) towards the end

of the year 2010. GCIS provides strategic communication leadership and support to all government departments, and sector specific policies must be informed by the macro GCIS policy. The health sector's communication policy will be finalised in consultation with provincial communicators in 2011/2012, to ensure alignment between communication policies produced by all health departments.

A five-year draft communication strategy, linked to the NSDA 2010-2014 was produced in 2010/2011, based on the GCIS framework. This will be finalised during 2011/2012.

SUB-PROGRAMME: HUMAN RESOURCE MANAGEMENT

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Review and redesign the organisational structure of the NDoH to enhance its capacity to implement the 10 Point Plan for 2009-2014 and the outcome-based Medium Term Strategic Framework (MTSF)	Organisational structure last reviewed in 2008/2009	Revised organisational structure approved by the minister and implemented by the department	Revised organisational structure approved by minister and submitted to Department of Public Service and Administration (DPSA)	None	None

Overview of performance

The sub-programme Human Resource Management is responsible for developing policies, norms and standards and ensuring the efficient management of employees of the NDoH. The target set for the financial year was to produce a revised organogram and, in keeping with this target, a revised organisational structure was produced, with technical support from external experts. The organisational structure was approved by the minister, and submitted to the Department of Public Service and Administration (DPSA). Implementation of the new structure will commence during 2011/2012.

SUB-PROGRAMME: INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) SERVICES

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PER-FORMANCE (2010/11)	VARIANCE	REASON FOR VARIANCE
Improve the provision of network services to the NDoH by upgrading the current network operating system (NOS); replacing the obsolete NOS and obsolete hardware and upgrading the Novell Linux platform	Percentage availability of NDoH network	90% network availability	60% uptime	30% dow time in July/August 2010	Relocation of data lines to Civitas Building and reconfigura-tion of systems
Establish a stable and sustainable network connec-tivity	Percentage availability of transversal systems	90%trans-versalsystem availability	50% uptime	40% down-time in July/ August 2010	Relocation of data lines to Civitas Building and reconfigura-tion of systems

Overview of performance

The ICT services sub-programme is tasked with the provision of network services to the NDoH and providing desktop support to employees. Key areas of performance over the reporting period were the upgrading of the network operating system and the physical migration of offices from three buildings into a single environment in the Civitas Building.

The department achieved a 60% network uptime and accessibility, as well as a 50% transversal system availability, both of which were inconsistent with the 2010/2011 target of 90%.

SUB-PROGRAMME: GENDER FOCAL POINT

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Conduct a gender audit for the DoH to contribute towards promoting women empowerment and gender equality	Number of audit reports produced	4 quarterly audit reports	0	-4 reports	Funding and capacity constraints impacted on the capacity to conduct the audits
Support all provinces in implementing the gender audit to contribute to ards promoting women empowerment and gender equality	Number of provinces producing quality audit reports	Annual gender audit reports produced by 9 provinces	0 annual gender audit reports	-9 reports	Funding and capacity constraints impacted on the capacity to conduct the audits

Overview of performance

The gender focal point sub-programme has the responsibility of ensuring that the NDoH develops policies that are gender responsive. The department set itself the objective of conducting a gender audit and supporting all nine provinces to conduct similar gender audits to contribute towards promoting women empowerment and gender equality. Interviews with senior management and focus group discussions with officials were conducted. Additional activities during the financial year included planning and preparatory processes for the gender audit. These included the development of the audit tool which was completed. However, the target of producing four quarterly gender audit reports, as well as provincial gender audit reports, was not achieved.

PROGRAMME 2: STRATEGIC HEALTH PROGRAMMES

Programme purpose: This programme co-ordinates a range of strategic national health programmes by developing policies and systems. It manages and funds key health programmes.

SUB-PROGRAMME: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Accelerate the provision of Cotrimoxazole prophylaxis to HIV-exposed infants	% HIV-exposed infants initiated on Cotrimoxazole prophylaxis from 6 weeks	60%	69.1%	+9.1%	Increased follow-up and monitor-ing of children exposed to HIV
Implement preven-tion of mother to child transmission (PMTCT) treatment guide-lines	% pregnant women who are tested for HIV	100%	96.9%	- 3.1%	Shortage of staff and stigma asso-ciated with testing
Increase routine immunisation coverage for chil-dren under 1 year of age	Percentage of fully immunised for chil-dren under 1 year	90%	89.4%	-0.6%	None
Increase coverage of targeted chil-dren immunised with new vaccines	% targeted children (at 6 weeks, 14 weeks and 9 months of age) immunised with the new vaccines (pneu-mococcal Conju-gate vaccine and rotavirus)	60% (for both)	Pneumo-coccal 3rd Dose = 72.8% Rotavirus = 72.2%	Pneumococ-cal 3rd Dose = 12.8% above the target Rotavirus = 12.2% above the target	Increased com-munity involve-ment and health promotion
Conduct a national measles immuni-sation campaign in all 9 provinces	Measles campaign conducted in 9 provinces	Measles campaign conducted in all 9 provinc-es by end of May 2010	Measles campaign conducted in all 9 provinces. 1st Round 12-23 April 2010; 2 Round 24-28 May 2010 (mop up cam-paign)	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Increase the proportion of mothers and babies reviewed within 6 days post-natal	% mothers and babies reviewed within 6 days post-natal (post discharge from health facilities)	40%	29.9% of babies were reviewed within 6 days post-natal 27% of mothers were reviewed within 6 days post-natal	Babies that were reviewed within 6 days post-natal, were 10.1% below the target Mothers that were reviewed within 6 days post-natal were 13% below the target	Indicator has been included in the District Health Information System (DHIS) and going forward improvement in data collection is anticipated. Awareness was raised among health workers
Increase the proportion of maternity facilities conducting peri-natal review meetings	% of maternity facilities conducting peri-natal review meetings by 2012/2013	100%	81%	-19%	Shortage of health workers and thus less prioritisation of perinatal reviews. Lack of skills for facilitation
Increase the proportion of primary level health facilities providing BANC	% of primary level health facilities providing BANC	60%	72%	12% above the target	Increased awareness and capacity for providing BANC
Increase access to HAART for HIV positive pregnant women	% of pregnant women on HAART	70%	79.4%	9.4% above the target	Initiation of nurse initiated management of ART increased training
Improve early diagnosis of HIV-exposed infants diagnosed early using DBS-PCR	% of HIV exposed infants diagnosed early using DBS-PCR	73%	83.1%	10.1% above the target	Increased effort at doing PCR tests. Improved follow up
Increase the proportion of primary level facilities in which healthcare providers are skilled in managing childhood illness	Percentage of primary level care facilities with IMCI healthcare providers managing children	75%	61%	-14%	Rotation of staff and implementation of the OSD led to attrition among IMCI trained personnel. Training of nurses with IMCI for paediatric ARV treatment also led to further losses from facilities

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Improve access to quality care for women and children by increasing the proportion of primary level care facilities with healthcare providers trained in emergency obstetric care (EmOC) and comprehensive emergency obstetric care (CEmOC)	Percentage of primary level care facilities with healthcare providers trained in EmOC and CEmOC	25%	Audit of the primary level care facilities with healthcare providers trained in EmOC and CEmOC commenced during the reporting period	Data on the actual proportion of primary level care facilities with healthcare providers trained in EmOC and CEmOC were not available, but an audit commenced	Audit of the primary level care facilities with healthcare providers trained in EmOC and CEmOC not conducted during the reporting period, but commenced in the new financial year
Facilitate implementation of household and community component (HHCC) of the IMCI in all districts by March 2012	Number of districts where HHCC services are provided	36	24	-12	Inadequate staff and skills for community mobilisation and empowerment. Inadequate material and human resource for PHC
Implementation of school health services in health sub-districts	Number of sub-districts implementing school health services	100/232	158/232	58 above the target	Rudimentary and infrequent health services were also included in the documentation
Improve monitoring of prevention, diagnosis and management of birth defects	% districts with trained HG care providers	40/52 (77%)	40/52 (77%)	None	None
Increase access to any choice of termination of pregnancy (CTOP) services	% designated health facilities who provide CTOP services	40%	46%	+6%	Designation of CTOP facilities is now a provincial responsibility. Consequently, there has been a decrease in the designation of facilities

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Accelerate the implementation of youth and adolescent friendly health services, (YFS) in all PHC facilities	% of PHC facilities implementing YFS	50%	47%	-3%	Not all provinces reported consis-tently
Finalise youth health strategy	Youth health strat-egy available	Youth health strategy finalised by March 2011	Strategy finalised in April 2010	None	None

Overview of performance

The sub-programme has the responsibility of ensuring that maternal, child, women's health and nutrition policies are developed, monitored and implemented. Additionally, the most significant Millennium Development Goals (MDGs) are the responsibilities of this programme particularly those relating to maternal and child mortality.

Diverse interventions were implemented during the financial year 2010/2011 to improve maternal, child and women's health. In keeping with the objective of accelerating progress towards MDGs 4 and 5. MDG 4 requires nations to achieve a two-third (66%) reduction in under-five mortality between 1990 and 2015; while MDG 5 calls for a reduction in the maternal mortality ratio by three quarters (75%) between 1990 and 2015. The NSDA of the health sector for 2010-2014 also requires similar levels of improvement in maternal and child health indicators.

Child health: A total of 89.4% South African children under the age of one were immunised to protect them against vaccine preventable diseases. Furthermore, 72.8% of targeted children were immunised with pneumococcal conjugate vaccine, and 72.2% with the rotavirus vaccine to reduce their susceptibility to pneumonia and diarrhoea respectively. These are amongst the leading causes of mortality amongst children globally and in South Africa. This was good performance as it exceeded the 2010/2011 target of 60%. It also reflected significant improvement from actual performance recorded in 2009/2010, where only 34.6% of eligible infants received the rotavirus vaccine, and 22.8% were immunized with the pneumococcal conjugate vaccine.

A national measles campaign was conducted during12-23 April 2010 and 24-28 May 2010 (mop up) whereby eight of the nine provinces (excluding Gauteng which conducted only a mop up) achieved

measles coverage of ≥95% for children aged 6 – 59 months. The overall coverage drops to 86% if other age groups are included. Seven of eight provinces reached ≥95% coverage among children aged 60 – 179 months. A polio immunisation campaign was also conducted. The campaign had two rounds - during the first polio campaign (first half 2010/11), eight of the nine provinces achieved an immunisation coverage of over 90%, and during the second round, only three of the nine provinces recorded >90% polio vaccination coverage.

With respect to HIV, during the reporting period, 69.1% of HIV exposed infants were initiated on Cotrimoxazole Prophylaxis Therapy (CPT) to reduce opportunistic infections. The target set for this indicator for the financial year was 60% and the programme surpassed it. This performance is a critical intervention as opportunistic infections can compromise the health of children and also result in recurrent hospital admissions at great cost to the State. Moreover, 83.1% of HIV-exposed infants were diagnosed early using the dried blood spot (DBS-PCR) test, which exceeded the target of 73%. This stellar performance demonstrates a marked improvement of the PMTCT programme. The department can now account on the programme effectiveness due to the ability to trace the infants - in contrast to the past when antibody testing at one year of age was used as an indicator with extremely limited ability to track the children and a significantly negative impact on programme performance. Remarkably, most HIV indicators for children in 2010/2011 demonstrate a better performance when compared with the previous year.

Breastfeeding is an important element of the child survival strategy, as part of the baby-friendly initiative. Facilities are urged to encourage breast feeding of infants where appropriate. While the target set for this indicator was 10%, data shows that about 25% of infants 0-6 months were exclusively breastfed, which exceeded the target for the financial year under review. The reported performance was based on data from the 2010 Human Sciences Research Council (HSRC). A total of 131 district hospitals implemented the World Health Organisation's *Ten Steps for the Management of Severe Malnutrition*, which exceeded the 2010/2011 target of 118 district hospitals.

The integrated management of childhood illnesses (IMCI) is another core element of child survival strategy. Data demonstrates that only 61% of primary level care facilities had trained IMCI healthcare providers that were managing children. This figure was lower than the set target of 75%, and lower than the 2009/2010 actual performance of 74%.

Maternal health: Efforts to improve maternal health were scaled up where a total of 72% of primary level health facilities provided basic antenatal care (BANC), which met and exceeded the set target of 60%. This also reflected an improvement from the 2009/2010 performance, where only 30% of

maternity facilities provided BANC. A total of 96.9% pregnant women agreed to be tested for HIV and underwent testing.

From the prevention of mother-to-child transmission (PTMCT) programme, there were major improvements. A total of 79.4% eligible HIV-positive pregnant women were placed on HAART, which exceeded the target of 70%. This also exceeded the 76.6% recorded in 2009/2010.

During the reporting period, the PMTCT programme reflected improved outcomes, including improved coverage and sustained declines in transmission rates. The number of PCR tests done on babies aged two months increased in all provinces between 2008 and 2010. At the same time, the HIV positivity rate amongst babies decreased in all provinces between 2008 and 2010, with major decreases in KwaZulu-Natal, Free State, Limpopo, Mpumalanga and the Northern Cape.

Sexual and reproductive health services are provided in the health facilities. These include family planning and contraception services and termination of pregnancy. The choice on termination of pregnancies (CTOP) services were implemented in 46% of designated healthcare facilities, which exceeded the target of 40%. In 2009/2010, this service was provided in only 25% of community health centres authorised to provide it.

Despite the significant progress made in certain areas, there were also areas of slow progress during the reporting period. Only 81% of maternity facilities reported that they conducted monthly maternal and perinatal morbidity and mortality meetings, against a target of 100%.

Only 29.9% of newborn babies and 27% of mothers were reviewed within six days post-natally (following discharge from health facilities). This will be enhanced in the next planning cycle. Strategies to achieve this will include the implementation of the new re-engineered PHC model for South Africa, which will encompass the deployment of PHC teams to community settings, as well as improving data collection and reporting on coverage.

To improve maternal and child health outcomes, the department conducted training for health workers in emergency obstetric care (EmOC) and comprehensive obstetric emergency care (CEmOC). EmOC refers to the care that is provided for parturient women in cases of emergency. This includes

the availability of skills for intervention such as having intravenous fluid lines, manual removal of the placenta and the provision of parenteral analgesia during labour. CEmOC refers to the above but includes the ability to give blood and to perform caesarean section in an emergency, as well as surgical interventions in cases of post-partum haemorrhage.

A systematic audit of healthcare providers trained in EMOC and CEMOC, as well as the health facilities in which they are located, will be completed in 2011/2012.

SUB PROGRAMME: HIV AND AIDS AND STI MANAGEMENT

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Providing quality and an appropriate package of treatment, care and support to 80% of HIV positive people and their families	New adults initiated on anti-retroviral treatment (ART) (>15yrs)	400 000 new adults	381 612	-18 388	The strike that took place around July and August 2010 affected service delivery
	New children (0 to <15yrs) initiated on ART	40 000 new children	37 065	-2 935	The strike that took place around July and August 2010 affected service delivery
Development of the standardised peer education training programme	Curriculum developed	Train 2 000 peer educators	1 603 trained	-397	Training not decentralised to districts, limited human and financial resources at NDoH to scale up training
Increase access to ART for TB/HIV co-infected patients	% of TB/HIV co-infected patients eligible for ART who start ART	60%	54%	-6%	Poor recording and reporting which impedes reporting to the next level
Provide CPT to co-infected patients	% of TB/HIV co-infected patients who start CPT	80%	99%	+19%	Target achieved due to training and supportive visits
Provide IPT to people living with HIV (PLWHIV)	% of TB/HIV co-infected patients who start IPT	40%	38%	- 2% (279 689)	Training and support visit help to improve the uptake of IPT. Clinicians are realising the importance of IPT to HIV infected people

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Preventing HIV in TB patients	% of TB patients tested for HIV	90%	67% (1 413 711 of 211 969)	-23%	Testing for HIV is voluntary and patients have the choice not to undergo a HIV test. There are challenges in the flow of information between the different levels of care resulting in under reporting
Facilitate the expansion of Step Down Care (SDC) facilities in district hospitals from 93 in 2009 to 117 by 2012/2013	Number of SDC facilities in districts	98	97	-1	SDC facility in Mpumalanga was not established due to the implementation of hospital revitalisation process
Improve access to quality male and female condoms	Number of male condoms distributed	1 billion	492 198 460	507 801 540	Funding for the procurement of an additional 500 million condoms to meet the demand generated by the HCT campaign was received late in December 2010
	Number of female condoms distributed	6 million	4 989 100	1 010 900	There was no national tender to procure female condoms. National Treasury did not approve the purchasing of condoms out of tender
Facilitate the payment of nationally determined stipend to 47 937 community care givers by 2012 (as determined by framework)	Number of community care givers receiving stipends	36 106	42 756	+6 650	The target of 36 106 was exceeded because all programmes which have community based projects and were funded from EPWP, conditional grants and equitables were included

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Review and finalise HCBC policy and guidelines to ensure access to comprehensive care by 2010/2011	Revised policy and guidelines approved and implemented	Approved policy and guidelines implemented in all 9 provinces	Final HCBC policy framework available but not approved because of PHC re-engineering process	None	The final approval and implementation of the policy was delayed due to the need to link it with the new model for PHC

Overview of performance

This sub-programme manages the comprehensive care management and treatment of HIV and AIDS as introduced by government in 2003. Furthermore, the sub-programme has the responsibility to keep up to date with the latest scientific evidence and evaluate the recommendations from multilateral institutions about new programs to be introduced within the health sector and provide advice regarding the need to fine-tune HIV and AIDS programmes on an ongoing basis. Finally, the sub-programme acts as a secretariat to the South African National AIDS Council (SANAC).

The South African government's approach to HIV and AIDS is a multipronged strategy comprising of prevention; treatment; care and support as outline in the comprehensive plan. Interventions under the prevention component include advocacy and social mobilisation, training peer educators, provision of male and female condoms and correct treatment of sexually transmitted infections. Treatment interventions consist of managing opportunistic infections through Cotrimoxazole and INH prophylaxis; providing ARTs and treating tuberculosis as part of co-infection with HIV. The final component is the care and support which has interventions ranging from providing nutrition for people living with HIV and AIDS; providing of home based care and sub-acute or step down care to minimise the cost of admitting patients at a higher level institution such as a regional or tertiary hospital when their conditions could be managed at a step down facility.

Prevention: During the reporting period, the NDoH used advocacy, social mobilisation and communication strategies in the fight against HIV and AIDS. In April 2010, the President of South Africa launched the largest HIV Counselling and Testing (HCT) campaign globally. This campaign provided an opportunity for community members to be tested for TB and chronic diseases such as diabetes and hypertension. At the end of the financial year, over 11.4 million South Africans had been counselled and more than 9.7 million people in the public sector alone had agreed to be tested. South Africans responded overwhelmingly to the call to go for testing to learn their HIV status and act responsibly. Additional interventions for the prevention component, particularly among the youth,

were peer education programmes. Peer education programmes have been shown to be a useful strategy for social mobilisation and advocacy. In 2010/2011 a total of 1 603 community-based peer educators was trained in reproductive health issues and HIV, against a target of 2 000.

Additional HIV prevention strategies are the provision of male and female condoms. To this end, a total of 492 198 460 male condoms was procured and distributed during 2010/2011, an increase from the 445 156 000 male condoms distributed in 2009/2010. This figure was, however, lower than the HCT target of distributing 1billion male condoms. If the HCT target is discounted, programmatic performance has improved based on year-on-year comparisons. For female condoms, a total of 4 989 000 was distributed during 2010/2011, against a target of 6 million. This was 17% less than the target of 6 million set for the financial year. Limited procurement and distribution of female condoms resulted from problems of limited supplies and delays in procurement processes. Performance during 2010/2011 reflects an increase of over 33% when compared with the 3.6 million female condoms procured and distributed in 2009/2010.

Treatment: Progress is being made towards improved access to ART for adult South Africans living with HIV and AIDS. During 2010/2011, a total of 418 677 patients were initiated on antiretroviral therapy (ART). Of these, 381 612 were new adult patients, a 91.5% performance against the 2010/2011 target of 400 000. This performance was lower than the 2009/2010 performance where 498 775 patients were placed on treatment. For children, a total of 37 065 new child patients were initiated on ART, against a set target of 40 000, which reflects a 92.7% performance. This reflects progress in access to ART. However, compared with 2009/10, where 45 044 new child patients were initiated on treatment, there was a decrease in 2010/2011.

Care and Support: Other interventions within the sub-programme focus on providing care and support to those living with HIV. For this programme component the department provided stipends to 42 756 community care givers (CCGs) supporting people living with AIDS and other debilitating conditions. This exceeded by 15% the 2010/2011 target of providing stipends to 36 106 CCGs. It also reflected an improvement of 40% from the 25 278 CCGs who received stipends in 2009/2010. While the actual amount of each stipend is modest, it nevertheless contributes to sustaining the high levels of commitment of these care givers. An additional intervention for the care and support component is availability of the step-down care (SDF) facilities in various provinces. A total of 97 SDC facilities were established during 2010/2011, against a target of 98. These facilities have contributed to improving quality of care for sub-acute patients. The SDCs have also increased from 91 in 2009/10.

TB-HIV co-infection: is extremely common in South Africa with latest research data putting co-infection rates at 73%. A total of 67% TB patients was tested for HIV, against a 2010/2011 target of 90%. Additionally, 54% TB/HIV co-infected patients who were eligible for ART started treatment during 2010/2011. This performance was slightly below the 2010/2011 target of 60%. However, it reflected an improvement from the 2009/10 actual performance of 47%.

A total of 99% of TB/HIV co-infected patients (86 203 out of 86 504) were initiated on cotrimoxazole prophylactic treatment (CPT) during 2010/2011, which exceeded the 2010/2011 target of 71%. Provision of cotrimozaxole has been shown to prevent morbidity and mortality due to invasive bacterial infections in patients with severe compromised immunity. To prevent activation of latent TB infection, 38% (170 311 out of 450 000) HIV-positive patients who were screened and found not to have active TB infection were provided with isoniazid prophylactic treatment (IPT), which was consistent with the target of 40%. The scaling up of the INH was highly successful when compared with the 2009/2010 actual performance, where only 1.8% HIV-positive patients were initiated on IPT.

Managing data: Monitoring the delivery services to people living with HIV and AIDS is essential. As a result, in March 2011, the NHC approved the adoption of a common three-tier strategy for monitoring the provision of ART in all provinces. This will create uniformity in reporting on service volumes as well as treatment outcomes. Tier 1, which is already in place, consists of paper-based ART registers. Tier 2 entails electronic registers, while Tier 3 is the most advanced, as it entails development of a patient information system. A national plan for the implementation of the three-tier monitoring and evaluation strategy has been produced. Provincial and district implementation plans will be produced in 2011. Over time this will significantly improve reporting on HIV and AIDS indicators, especially the provision of ART. We anticipate that year-to-year comparisons will become more stable as only one single source of reporting will be used and the multiple registers will be stopped to improve data accuracy and validity.

SUB-PROGRAMME: COMMUNICABLE DISEASE CONTROL

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement malaria elimination strategy	Malaria incidence per 1 000 population at risk (the number of persons at risk in the endemic provinces in South Africa which represents a figure of 4.9 million people)	0.66	0.60	None	None
Improve management of communicable diseases	IHR action plan in place	50% of the plan implemented (policy and guidelines on priority conditions developed)	% implementation of the plan was not determined The IHR core capacity assessment report was finalised and an action plan was developed	50% of the plan implemented	Delays in the implementation resulted from the time lag between the assessment process and finalisation of the assessment report
	Percentage implementation of the strategic plan for the FIFA 2010 World Cup	100% implemented during the World Cup	100% of the FIFA 2010 Strategic Plan for Communicable Disease Control was implemented	None	None

Overview of performance

The communicable diseases sub-programme is responsible for developing policy and guidelines for the prevention, management and control of communicable diseases. Malaria is a major cause of morbidity and mortality globally and particularly on the African continent. In South Africa however, it is not prevalent in all provinces but mainly in cross border provinces to our malaria endemic neighbours such as Mozambique. During the reporting period, the local malaria incidence reduced to 0.6 per 1 000 population, which was in line with the national target of 0.66 per 1 000 population. However, inclusive of imported cases, the malaria incidence rate was 1.65 per 1 000 population, which was inconsistent with the 2010/2011 target.

Some of the key interventions that contributed to a reduction in malaria cases included a robust indoor residual spraying programme which reached coverage of 90% of the 2 252 406 structures that were targeted. This was against the target of 80% set by the WHO. Other success factors included

effective case management by ensuring definitive diagnosis and treatment with combination malaria therapy and conducting malaria case management and epidemic preparedness workshops to foster a robust epidemic preparedness and response. Importation of malaria cases, especially during malaria prone seasons such as periods where there is flooding in the Southern African Development Corporation (SADC) region, remained a challenge.

A draft international health regulations (IHR) core capacity assessment report was finalised, and an action plan developed. The target for 2010/2011 was to implement 50% of the plan, focusing on the development of policy and guidelines on priority conditions. Due to the time lag between the assessment and finalisation of the report, less than 50% of the recommendations of the assessment were implemented.

SUB PROGRAMME: NON-COMMUNICABLE DISEASES

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Develop a health sector mini drug master plan.	Health sector mini drug master plan adopted by March 2011	Plan adopted by the NHC	Plan was adopted by the NHC in March 2011	None	None
Improve the management of diabetes as per the Diabetes Declaration and Strategy for Africa, 2006	Increase in the proportion of people with controlled diabetes	Commission a study to establish the baseline of people with controlled diabetes	The study was not commissioned	A study to establish the baseline of persons with controlled diabetes	The study is dependent on the application of the chronic disease management register, which has thus far failed to meet the requirements to undertake the study
Increase the proportion of primary schools implementing preventive school oral health service programmes	Percentage of primary schools in 9 of 18 health priority districts implementing preventive school oral health service programmes	40%	GP 80% WC 40% KZN 33% FS 7% NC 0% NW 10% LP 23% MP 11% EC 33%	GP +40% WC None KZN -7% FS -33% NC -40% NW -30% LP -17% MP -29% EC -7%	The schools were closed during the World Cup and the public sector strikes in August

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Decrease the turn-around times for blood alcohol, toxicology and food specimens	Turn-around times for blood alcohol, toxicology and food specimens	Turnaround times maintained: Blood alcohol: 8 weeks from receipt of sample by March 2011	Average turn-around time for all three labs was 36 weeks FCL PTA: 27 weeks FCL CT: turn-around time of 4 weeks for post-mortem samples and about 17 weeks for ante-mortem drunken driving samples FCL JHB : 71 weeks	Target achieved in CT regarding post-mortem samples, but all the other laboratories are behind with Jhb 63 weeks behind target	Lack of staff. Refurbishment at Johannesburg laboratory
		Toxicology: 6 months from receipt of samples by March 2011	Toxicology: 5 years from receipt	-4 years and 6 months	Lack of staff Refurbishment at Johannesburg laboratory
		Food: 10 working days from receipt of sample by March 2011	FCL CT : 74 working days FCL PTA : 170 working days	FCL CT : 64 working days FCL PTA : 180 working days	Lack of staff in both of the forensic laboratories
Strengthen Vision 2020 prevention of blindness programme – as per the global WHO initiative to eliminate avoidable blindness by 2020	Number of operations per 1 million population	1 500 operations per 1 million population	CSR for 12 months January - December 2010, is 1 061 per 1 million population	-30%	Achieving CSR is significantly impeded by poor financial and human resources in provinces

Overview of performance

Non-communicable diseases are part of the quadruple burden of disease (the other three are TB and HIV; violence and injury and high maternal and child mortality) that South Africa is facing. These include chronic conditions such as hypertension, diabetes and obesity. This sub-programme is responsible for developing policies and interventions to effectively deal with NCDs and their risk factors in order to reduce morbidity and mortality. Around 35% of all deaths in South Africa result from non-communicable conditions. Over the next 10 years deaths due to NCDs, notably cardiovascular diseases, cancer, diabetes and respiratory diseases, are projected to increase by 24%. The health sector in South Africa and globally has placed major significance on NCDs.

Diabetes is an important cause of mortality and morbidity. With the improvement in social conditions and the demographic transition it is becoming more prevalent. To improve the management of diabetes as per the Diabetes Declaration and Strategy for Africa (2006), the department aimed to commission a study to establish the baseline of people with controlled diabetes in 2010/2011. This was not achieved. However, a mini audit on the use of the chronic diseases management register (CDMR), which was rolled out in all districts and which was meant to provide the baseline information, indicated poor use, analysis and follow-up action. Prior to accurate information on diabetes control being extracted from the register, additional training on the use of the register is required and will be provided.

Loss of sight due to cataracts is a common condition among the elderly in the country. The department continued to implement the Vision 2020 prevention of blindness programme, which is part of the global WHO initiative to eliminate avoidable blindness by 2020. One of the key interventions of this strategy is to provide cataract surgery to restore vision to the elderly who have developed cataracts. A cataract surgery rate (CSR) of 1 061 operations per 1 million population was achieved. The set target was 1 500 operations per 1 million population. This contributed to sight restoration and improving the levels of independence for the elderly.

Curbing drug abuse among the population is an important priority for the government. The departments of health and social development has worked closely with international agencies and the United Nations to develop ways of managing substance use. One of the major achievements thus far has been the development of a government-wide coherent policy against drug abuse looking at both the supply and demand side. The health sector had set a target of developing a drug master plan known as “mini drug master plan”.

In keeping with the target for 2010/2011, the health sector mini drug master plan was adopted by the NHC in March 2011. Effective implementation of this plan across the country will contribute significantly to curbing drug abuse.

Forensic science has become an increasingly important element in criminal justice systems throughout the world. The requirement for forensic evidence has grown internationally, causing the caseload of many laboratories to double or treble in recent decades. There has also been rapid development of new techniques and methods giving improved possibilities to obtain forensic evidence. At the same time the demands on the laboratories from customers, mainly the police,

have increased drastically. There is pressure to improve turnaround times and provide more accurate reports. There is also increased recognition that forensic science should be an integral part of the investigation and criminal justice process. Thus there is a need to improve the co-operation between the forensic chemistry laboratory, forensic mortuaries, the police and justice. In South Africa medico-legal death investigation is an essential justice and health function whose professionals play an important role in determining the cause and manner of death. These functions are conducted by forensic pathologists and forensic analysts based in the department's forensic mortuaries and forensic chemistry laboratories.

The National Forensic Chemistry Laboratories (FCL) are divided into three primary sections – *toxicology section* to provide analytical support to forensic pathologists and other clients in cases involving toxic substances**,** *blood alcohol section* to provide scientific evidence in support of drunken driving prosecutions and to establish cause of death, and *food section* to analyse food samples to control compliance with legislation. The FCLs are situated in Cape Town, Johannesburg and Pretoria. These labs are supra-provincial as one lab is responsible for a wide geographical areas due to the limited skills available in the country. The FCL in Pretoria is responsible for the toxicology, blood alcohol and food analysis of Northern Gauteng, Limpopo, Mpumalanga and KwaZulu-Natal. It is also responsible for the food analysis of the Free State, North-West, Gauteng, Limpopo, Mpumalanga and KwaZulu-Natal. The FCL in Cape Town is responsible for the toxicology, blood alcohol and food analysis of Northern, Western and Eastern Cape. The FCL in Johannesburg is responsible for the toxicology and blood alcohol analysis of the Free State, North-West and Southern Gauteng.

With regard to FCL services, decreasing the turn-around times for blood alcohol, toxicology and food specimen proved to be a key challenge during the reporting period. The Forensic Chemistry Laboratory (FCL) in Pretoria achieved a turn-around time of 27 weeks for samples sent for processing. This figure is significantly different from the set target of eight weeks from the receipt of the sample to producing results. Other laboratories also had similar performances, for example the FCL in Johannesburg registered turnaround times of 71 weeks while the FCL in Cape Town registered a turnaround time of four weeks for post-mortem samples and 17 weeks for ante-mortem drunken driving samples.

The average turnaround times for toxicology samples were five years from receipt, against a 2010/2011 target of six months. Key impediments were lack of personnel at the FCLs, as well as the inappropriate infrastructure at the Johannesburg FCL.

To deal with the backlog in toxicology the Pretoria FCL is currently testing a rapid toxicology device that will allow for the screening of 54 samples in 180 minutes for 20 drugs, before confirming and testing for poisons afterwards. What is currently known about this device is that it can substantially decrease the screening time of toxicology cases. This device will decrease the time spent on finalising negative cases, and significantly increase the amount of samples screened monthly per analyst. It will be possible to indicate the results of this device by the end of March 2012. Currently only 10 toxicology samples can be screened within two days for 12 drugs, before following the rest of the procedures. It is intended to procure this device if it promises to provide the intended outputs for all the three FCLs.

SUB-PROGRAMME: TB CONTROL AND MANAGEMENT

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Strengthen the implementation of the DOTS strategy	Number of new TB cases reported	405 512	401 048	-4 464	The target was based on all TB cases instead of new cases
	Cure rate	70%	71.1%	+1.1%	Training of healthcare providers and support from TB co-ordinators ensured the use of appropriate guidelines, which resulted in this success
	Default rate	7	7.9%	None	None
	Percentage of patients successfully completing their treatment	80%	74%	-6%	Due to migration, some patients are lost to follow up. It has become difficult to evaluate treatment outcomes for patients lost to follow-up
	Percentage of PTB patients diagnosed with smear and culture	90%	82%	-8%	Access to laboratory service in remotely located facilities proved to be a challenge
	Number of DRTB facilities diagnosing and putting DR-TB patients on appropriate treatment regimen	15	19	+ 4	Training of healthcare providers and support from TB co-ordinators ensured the use of appropriate guidelines, which resulted in this success

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Increase the number of health professionals and non-professionals (community health workers) trained annually	Number of treated TB patients serving as ambassadors for TB	80	46	-34	Provinces were reporting individuals identified as TB ambassadors but not individuals who were contrated to undertake ambossadorship. When adjustments were done it was dscovered that the numbers were low against the target and corrective measures were implemented late
	Percentage of health facilities with turn-around-time of no more than 48 hours	75%	55.8%	-19.2%	Health systems challenges created delays in the delivery of TB results Introduction of GeneXpert technology will quicken the turn-around-times
	Number of health professionals trained in TB management control	3 500	11 379	+7 879	Development partners of the health sector assisted with the training of health professionals
	Number of non-professional workers trained	2 500	7 128	+4 628	Development partners of the health sector assisted with the training of non professional workers

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/11)	ACTUAL PERFOR-MANCE (2010/11)	VARIANCE	REASON FOR VARIANCE
Increase the number of district and sub-district TB co-ordinators	Number of district TB co-ordinators employed	52	43	-9	Resource con-straints
	Number of sub-district TB co-ordinators employed	135	143	+8	
Implement best practice model of collaboration on TB and HIV at PHC level	Percentage of TB and HIV co-infected patients with CD4 less than or equal to 350 started on ARVs	70%	31%	-39%	The calculation of this indicator was erratic since it was **not** only limited to individuals with CD4 ≤ 350 as a denominator, thus providing a low percentage. The correction to this error has since been factored in the algorithm
Initiate all eligible MDR and XDR patients on ARVs	Percentage of HIV positive MDR patients started on ARVs	100%	69%	-31%	There are chal-lenges in intro-ducing ARVs to patients with CD4 higher than 200. However, there has been a marked improvement from a baseline of 55% to 69%. There are plans to ensure further improve-ments

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/11)	ACTUAL PERFORMANCE (2010/11)	VARIANCE	REASON FOR VARIANCE
Initiate all eligible MDR and XDR patients on ARVs	Percentage of HIV positive XDR patients started on ARVs	100%	84%	-16%	There are challenges in introducing ARVs to patients with CD4 higher than 200. Generally, these patients are very sick and acceptance of ART is better than MDR-TB patients

Overview of performance

The national TB control programme has the responsibility of developing policies, plans and interventions to prevent and manage TB and multidrug resistant TB. Tuberculosis is a major public health problem and South Africa is one of the 12 tuberculosis (TB) high burden countries globally. This is exacerbated by the high proportion of TB-HIV co-morbidity in this country, which is currently estimated to be 73%.

Managing TB needs multipronged strategies that deal with personal health services and public health to prevent the spread. The strategies include: health education to raise awareness on how the disease is spread; social mobilisation and case finding to track those who might be defaulting on treatment and those exposed due to contact with an TB infected person; and treatment through the directly observed treatment strategy (DOTS) which is a WHO and NDoH health policy.

For social mobilisation, one of the key areas of success was in improving the TB treatment completion rate and decreasing the proportion of TB patients that default from treatment. During 2010/2011, 74% of patients successfully completed their treatment, against a target of 75%. Furthermore, only 7.9% TB patients defaulted from treatment, which was consistent with the 2010/2011 target. A total of 45 treated TB patients (against a target of 80) served as ambassadors responsible for communicating TB messages in their immediate communities and most importantly, being the “living proof” that TB can be cured, and that former patients are able to live full lives once cured.

Diagnosing and treating TB properly for the correct duration is part of the national TB guideline. This guideline has been developed to ensure that there is alignment across all provinces and sectors,

including both for profit and non-profit private sectors. Failure to follow these strict guidelines is one of the contributory causes to the development of drug resistant TB. A total of 401 048 new TB cases were reported in 2010/2011 against the set target of 405 512. Most health facilities implemented the national TB guidelines appropriately during 2010/2011. This resulted in 82% of PTB patients being diagnosed with smear and culture tests according to the guidelines. This reflected an upward trend from the 77.7% achieved in 2009/2010.

Drug resistant TB in the form of MDR and XDR TB is becoming more prevalent. The department has come up with a strategy for this public health problem through designating facilities specifically for the management of these types of TB. To this end a total of 19 facilities have been designated for drug resistant TB. The set target for designated drug resistant TB facilities was 15 and this represented an excellent performance in meeting and exceeding the set target for 2010/2011.

Efforts to improve the management and support skills amongst health professional and non-health professional workers have proved beneficial. A total of 11 379 health professionals were trained in TB management, which exceeded the 2010/2011 target of 3 500. A total of 7 128 non-health professionals was also trained, which exceeded the set target of 2 500. This performance exceeds by far the figures for 2009/2010, where 9 730 health professionals and 3 866 non-health professionals were trained in TB management and support. An area of under performance was that of appointing district co-ordinators, as only 68 sub-district TB co-ordinators were appointed, against a target of 135.

The cumulative effect of all these interventions was that the TB cure rate increased significantly from 63.4% in 2009 to 71.1% in 2010/2011. This performance also exceeded the 2010/2011 target of 70%.

Despite improvements that have been made, key challenges remain. Although the cure rate has steadily improved over the years, it has not reached the threshold of 85% required to significantly reduce the pool of TB infection in communities. Only 69% of HIV-positive MDR-TB patients and 84% HIV positive XDR-TB patients were started on ART during 2010/2011, against a target of 100% for 2010/2011 for both objectives.

Resultantly, South Africa now ranks third amongst the high burden countries in the world. In response, on World TB Day 24 March 2011, the minister announced three initiatives to strengthen the fight against TB. These included: intensive case finding by visiting homes of known TB patients; use of a new PCR based technology called GeneXpert to more rapidly diagnose drug susceptible patients as

well as rifampicin resistance; and the opening of nine facilities for in-patient treatment of multi-drug resistant TB.

Family members of known TB patients are being traced and screened for TB using teams comprising nurses, community health workers and lay counsellors. Intensified case finding began on 1 February 2011, and by the end of March 2011, more than 20 000 families had been visited, mainly in nine high-burden TB districts in the country. Where required, referrals for follow-up and management were made to the nearest appropriate health facility. The intervention is intended to find those with symptoms of TB early, confirm their status rapidly, and almost instantly, put them on treatment. This helps reduce the pool of infection in communities, and thereby minimises the risk of cross infection.

In order to reduce TB infection and ensure recovery from TB, people with the disease need to be identified quickly and provided with treatment almost instantly. Delays in detecting TB increases the risk of infection to the general public, and a deterioration in health, including possible death of those infected. Detecting TB is currently based on microscopy (for drug susceptible TB) and culture (for drug-resistant TB). Currently, TB culture results are available on average 35 days after the sputum is taken. Recently, the WHO endorsed new technology to diagnose TB with simultaneous detection of Rifampicin resistance (a good indicator of drug-resistant TB). This technology, called GeneXpert MTB/Rif, has high sensitivity in both smear-positive as well as smear-negative, culture-positive individuals. When compared with microscopy and culture, a single GeneXpert test detects 98% of smear-positive TB, whilst microscopy has sensitivity of around 72%. In addition to high levels of sensitivity a GeneXpert test result can be available within two hours.

The department has acquired 30 of these machines and an additional 17 will be procured over the next few months in order to achieve a target of at least one GeneXpert machine in each of the 52 health districts. A full roll out will be carried out over the next 18 months until current technology, mainly microscopy, will be fully replaced by the GeneXpert throughout the country. Already, 20 400 tests have been run on these machines, with TB detected in about 18% of suspected cases. This far exceeds detection rates of between 2% and 10%, using current technology, again demonstrating that we have been under detecting TB using current technology. Also, the tests that have been run show a 6.49% detection of resistance to Rifampicin (a good indicator of MDR-TB), well above current levels of just under 2%.

PROGRAMME 3: HEALTH PLANNING AND MONITORING

Purpose: This programme plans and monitors health services and co-ordinates health research programmes.

SUB-PROGRAMME: HEALTH INFORMATION, RESEARCH AND EVALUATION

The sub-programme is responsible for developing and maintaining a national health information system and commissioning and co-ordinating research for the department.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Prepare and submit South Africa's report to the United Nations General Assembly Session (UNGASS) on HIV and AIDS	UNGASS report submitted timeously	2008-2009 UNGASS country report submitted in 2010	The 2008-2009 UNGASS report was submitted	None	None
Conduct annual national antenatal HIV and syphilis prevalence survey	Annual national HIV prevalence estimates and trends report published. HIV incidence measuring tool developed	2010 national HIV and syphilis prevalence estimates and trends report published by March 2011	All 9 provinces were submitted the 2010 national HIV and syphilis data. The data for 32 198 records cleaned and validated	The final report was not published by March 2011	Funding constraints affected the appointment and payment of data capturers
Finalise and publish the HIV and AIDS notification strategy	HIV and AIDS notification strategy produced	HIV and AIDS notification strategy approved and implemented	HIV notification strategy has been drafted	HIV and AIDS notification strategy not approved and implemented	The legal and human rights issues around making the two conditions notifiable require extensive consultation with key stakeholders within the ambit of the South African National AIDS Council (SANAC)
Conduct the South African Demographic Health Survey (SADHS)	Conduct SADHS by 2011	Data collection and analysis for the third SADHS completed by March 2011	Agreement was reached with Human Sciences Research Council (HSRC) that modules of the SADHS will be incorporated into two household surveys of the HSRC	SADHS was not conducted	Budgetary constraints

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Establish an integrated national cancer registry	Annual report on the epidemiology of cancer in South Africa produced by March 2011	Mechanism established to co-ordinate and integrate all existing cancer registries in South Africa	Draft regulations on the cancer registry were produced, to guide reporting on different categories of cancers	Mechanism established to co-ordinate and integrate all existing cancer registries in South Africa	The cancer registry was not operational for several years. The draft regulations will facilitate reporting of both the private and public sector on different types of cancer
Support and monitor the functioning of the National Health Research Ethics Council (NHREC)	New NHREC and new National Health Research Council (NHRC) appointed according to National Health Act (NHA) and fully functional	NHREC and NHRC work plans and annual reports produced	New NHREC appointed and functional (4 annual meetings held 2010/2011). NHREC work plans and annual reports produced for 2010/2011	None	None
Commission diverse research projects in collaboration with the Department of Science and Technology (DST), HSRC, Health System Trust (HST) and academic institutions	Reports on the social determinants of health and nutrition and indigenous knowledge systems and traditional medicines produced	Report on the social determinants of health and nutrition produced by March 2012 in collaboration with research institutions	Four research reports were produced focusing on social determinants of health and nutrition	None	None
Establish the disease control hub that will enable the synthesis and analysis of existing and collected information from numerous data systems that currently operate separately	Disease control hub established and registered as a public entity	Governance boards, technical advisory forum and public entity established. Disease control hub established and registered as a public entity	Necessary documentation required for registration of the entity was produced	Entity was not established and registered	There was a policy change to rather invest in state entities i.e. National Institute for Communicable Diseases and stregthen it rather than setup a section 21 entity

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Conduct DHIS data quality assessment jointly with StatsSA	Report on the data quality assessment produced annually	Report on list of indicators meeting SASQAF criteria in 18 districts produced	Data quality assessment was conducted on a sample of 85 facilities in 17 districts	DHIS data was assessed in 17 of the target 18 districts	One district in the Eastern Cape was not visited during the reporting period. The team to conduct the assessment was reassigned to support the disease surveillance during the 2010 FIFA World Cup. It was decided that the assessment of the Alfred Nzo District would be postponed to the next financial year
Commission national, provincial and district level estimates for burden of disease	Final burden of disease report produced	Appointment of a South African national burden of disease (BoD) study group and national conceptual framework and methodology for BoD	A concept document was prepared with Health Development Africa for conducting a South African national BoD study	BoD study was not conducted	Resource constraints limited progress with the BoD study
Monitor and oversee the conduct of clinical trials and related activities	Availability of published reports on the number of clinical trials conducted and published bi-annually	Bi-annual report published on a number of clinical trials conducted	A report on clinical trials was produced 236 clinical trials were registered during the reporting period	Report was not published bi-annually	Resource constraints impliment-ed progress with this work
E-enablement of healthcare	Number of functional telemedicine sites	All 86 telemedicine sites fully functional	75 functional telemedicine sites A status report on functioning of the telemedicine sites was produced Site visits were conducted in 28 facilities in 5 provinces	-11	Capacity constraints at provincial level

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
E-enablement of healthcare	Number of hospitals with PAAB system	Two versions of PAAB consolidated and rollout strategy developed	A PAAB sub-committee was established Site visits of 3 provinces using PAAB system were done. Meetings with the two PAAB service providers were held and the PAAB source codes were obtained from the two service providers A draft strategy for PAAB consolidation was written. A draft outline document on proposed approach towards consolidation of the two PAAB versions was developed and presented to NHIS/ SA committee for inputs	The two separate versions of PAAB continued to be implemented in Mpumalanga, North West and Gauteng. The two versions have not been consolidated	The process was dependent on the PAAB sub-committee to develop user requirement specifications and strategy for consolidation of PAAB
	Number of facilities implementing the PHISC	PHISC consolidated and rollout strategy developed	The PHCIS is still deployed in the Western Cape. The Eastern Cape is intending to use the systems	The PHISC roll out strategy was not developed	Capacity constraints limited progress with this objective
Delivering health and management information	e-Health Agency established with the requisite staff and capacities	e-Health Agency structure established and staff recruited	e-Health Agency structure not established. Draft e-Health Strategy was produced and tabled at NHISA and served on NHC	e-Health Agency structure not established as planned	Establishment of the e-Health Agency was dependent on the finalisation of the e-Health Strategy

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Delivering health and management information	Approved ICT standards available	ICT standards developed and approved by March 2011	Standards documents for the Health Smart Card, which are part of the ICT standards, were developed by the South African Bureau of Standards (SABS) Draft documents on the general structure and data elements for the health smart card were developed	None Priority was placed on the develop-ment of the smart card, which is part of the ICT stan-dards	None
	ICD-10 unit standards implemented by March 2012	Implementa-tion of the registered unit standards	ICD10 unit standards were successfully reg-istered with the South African Qualifications Authority (SAQA)	Imple-mentation has not occurred compre-hensively across the health sec-tor. Training is needed to achieve this	Training needs to be conducted for key health workers on the implementation of the ICD10 unit standards
	Strategy for the development of the information hub finalised by March 2011	Strat-egy finalised . Business plan produced by the infor-mation hub	Strategy for the development of the information hub was finalised	None	None

Overview of performance

One of the key benchmarks for performance during this period was the finalisation of the country's progress report on efforts to combat HIV and AIDS during 2008-2009. This report was submitted to the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS as planned in the targets for 2010/2011.

Additional mandatory reports that were finalised were the National Antenatal Sentinel HIV and Syphilis Prevalence Survey for 2009 launched in November 2010. This survey indicated that HIV prevalence amongst pregnant women in the country has remained stable at 29.4% in 2009, compared with 29.3% in 2008. HIV prevalence amongst pregnant women in the 15-24 year old age group also stabilised at 21.7% during both 2008 and 2009. HIV prevalence amongst this age group is monitored globally as part of tracking progress towards MDG 6, which is about combating HIV and AIDS, TB

and malaria. Data collection for the 2010 annual national HIV prevalence survey was also completed as all provinces submitted data for the survey. The target for 2010/11 was to publish the 2010 annual national HIV prevalence estimates and trends report by March 2011.

Improving management and decision making is a key priority for the department for improving performance. In order to improve the quality of routine data collected through the District Health Information System (DHIS), data quality assessments were conducted in 17 of 18 districts targeted for 2010/2011, and reports with recommendations were compiled.

Co-ordination of research and oversight is the responsibility of the department. Through the two committees: National Health Research Committee (NHRC) and the National Health Research Ethics Council (NHREC), the department exercises this function. For the year under review, the committees were fully functional as the NHREC produced its annual report for 2010/2011 and the work plan for 2011/2012. In keeping with the set target, a report on the social determinants of health and nutrition was conducted, and a report produced, in collaboration with research institutions. A total of 236 clinical trials was registered during 2010/2011. The major performance indicator and target for 2010/2011 was to publish a report on the number of clinical trials conducted, and this has been met.

There were also areas of slow progress during the reporting period such as the HIV notification strategy which was drafted but not finalised due to legal and human rights issues that still have to be incorporated into the strategy. Furthermore, data collection and analysis of the third South African Demographic and Health Survey (SADHS) was not completed according to plan. However, agreement was reached with the Human Sciences Research Council (HSRC) that modules of the SADHS will be incorporated into two household surveys of the HSRC.

The objective of producing an annual report on the epidemiology of cancer in South Africa was not achieved. The target for 2010/2011 was to establish a mechanism to co-ordinate and integrate all existing cancer registries in South Africa. The department has no access to cancer databases that reside and are owned by institutions outside the NDoH hence the epidemiology of cancer in South Africa has not been published. To address the issue, the Non-communicable Diseases Cluster has developed a regulation for compulsory cancer reporting, which will enable the directorate to access the cancer data from NHLS, CANSA, MRC and others in the future.

The department used the 2010 FIFA World Cup experience as an opportunity for developing an accountability framework for the public and private sector hospitals and laboratories together with the WHO to strengthen public health surveillance systems. The ultimate goal was to use the 2010 World Cup as an opportunity for collaboration with the private sector and come up with demonstrable projects that could be used as models of working together in the future.

The department developed and established the web-based disease notification surveillance system for the FIFA 2010 World Cup. The system collated data as a back–up for public health early warning web-based disease notification surveillance systems at all FIFA dedicated hospitals, private hospital groups (Lifecare, Netcare, Mediclinic and independent hospital groups), main airports including Lanseria, three main harbours, eight public viewing areas and 10 stadia. This collaboration has strengthened the country's ability to detect epidemic-prone diseases and respond on time. Additional spin offs from the project demonstrated the feasibility of the public and private health sectors to jointly implement the National Health Act 61 of 2003 and the International Health Regulations on Priority Health Notifiable Conditions specific to the World Cup, and to ensure that all data to was sent to a single repository at the J9 surveillance desk at the SAMHS head quarters.

The legacy left by this project is the ability to establish an early warning system to detect outbreaks or epidemic-prone diseases outbreaks occurring in the health sector. The staff trained during the project were from the DoH, e.g. infection control, informatics, surveillance data capturers, emergency medical services, health inspectors, port health officials, retired nurses and doctors. These categories of staff were all trained in the implementation of the web-based notification system and active surveillance during mass gatherings and the skills base has remained within the health sector.

A business plan for the disease control hub was produced, in keeping with the set target. Documentation for the registration of the hub was also produced. The target for 2010/2011 was to establish governance boards, a technical advisory forum and register the disease control hub as a public entity. However, the hub was not established and registered as a public entity. This process was halted due to a paradigm shift of the health sector during 2010/2011 which placed more emphasis on using public funds to strengthen state institutions i.e. the National Institute for Communicable Diseases (NICD) instead of establishing a private entity using public sector funds.

A South African national burden of disease (BoD) study group was not established, due to resource constraints. Two versions of the patient administration and billing system (PAAB) continued to be

implemented in three provinces - Gauteng, Mpumalanga and North West. The target for 2010/2011 was to consolidate these into one version and develop a roll out strategy. A PAAB sub-committee was established in the National Health Information Systems Committee of South Africa (NHISSA), and site visits were conducted to three provinces using PAAB. A draft strategy for the consolidation of PAAB was produced.

SUB-PROGRAMME: OFFICE OF STANDARDS COMPLIANCE

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Establish ministerial advisory committee for quality	Ministerial advisory committee established	Ministerial advisory committee established	Proposal for ministerial advisory committee or NHC quality sub-committee was prepared	Ministerial advisory committee was not established	Establishment of the ministerial advisory committee was placed on hold
Provide the legislative framework for the establishment of an independent accreditation body	NHA of 2003 amended	NHA amended regulations published for public comment	The National Health Act Amendment Bill, 2011 gazetted in January 2011 for public comment	Following Parlimentary schedual	Lead times in preparation of Amendment Bill
Conduct an audit of all health establishments to determine if they meet core standards	Percentage of health establishments audited annually	20% of 4 210 health establishments audited	Self assessments were conducted in 199 public facilities	External audits of health facilities were not conducted	External audits will be conducted once the legislative framework is finalised
Conduct accreditation of health establishments (public and private)	Percentage of health establishments (public and private) accredited	10% of 4 500 health establishments audited	No accreditation (visits) of health establishments were conducted	Accreditation of facilities did not take place	The independent body responsible for external audits has not been established

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Develop national core standards for non-health establishments and EMRS	National core standards for non-health establishments and EMRS	National core standards for non-health establishments and EMRS drafted	Standards for non-health establishments and EMRS were not produced	Standards for non-health establishments and EMRS were not produced	Process of developing accreditation standards has been placed on hold until the establishment of an independent audit structure, as part of the Office of Health Standards Compliance
	Percentage of facilities supported for national core standards	20% of 4 210 public health facilities establishments supported	1 575 public service managers received orientation on the use of self-assessment methods for compliance with core standards 740 managers received further training	Assessment of the facilities in which the managers are located will enable accurate estimation of the variance	Assessment of the facilities in which the managers are located will enable accurate estimation of the variance
Implement a national adverse event reporting and response system	Percentage of public hospitals reporting on and responding to adverse events	35% of 400 hospitals	Guidelines on how to manage and respond to adverse events was prepared	No national adverse event reporting system in place	Provincial health departments have different adverse events reporting systems whose consolidation into a national paper-based or electronic system is still underway
Facilitate the development and implementation of Quality Improvement Plans (QIPs) covering patient safety, infection prevention and control, waiting times, positive and caring attitudes, cleanliness, and availability of medicines	Percentage of public health facilities with QIPs being implemented	50% of 4 210 facilities	0% Priority areas a central component of the national core standards Many improvement efforts in these 6 areas underway	50% of 4 210 facilities No formal reporting system to provide data	Data to be obtained from core standards assessment reports as these become available

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Establish and manage a national customer care programme	Average waiting time per key area	National survey to establish baseline and targets commissioned	The average waiting time in key areas (e.g. pharmacy and reception) was measured in 18 hospitals as part of improvement efforts	National survey was not conducted	National survey costs were considered too high. Slower process is combining measurement with improvement
	Percentage of complaints resolved within 25 days	40%	60%	+20%	Greater focus on the resolutions of complaints from users of health services
	National Ombuds Office established	Ombuds Office established	Provision for the establishment of the Ombuds Office was made in the National Health Act Amendment Bill, 2011 gazetted in January 2011 for public comment	Ombuds Office not established	This office will be part of the future Office of Health Standards Compliance, thus its establishment is dependent on the promulgation of the Bill
	Percentage of public sector hospitals conducting at least one satisfaction survey per annum	30% of 400 public sector hospitals	A revised client satisfaction tool for hospitals and PHC settings was prepared and field-tested	No assessment of hospitals conducting at least one satisfaction survey per annum was conducted	No accurate data yet exists on DHIS, because facilities do not all use the DHIS module to capture satisfaction survey data

Overview of performance

This sub-programme is mandated to deal with quality assurance; the licensing and provision of certificates of need as required in terms of the National Health Act 2003 and to develop policy and interventions on radiation control.

During the period under review, the NDoH recorded a number of achievements in setting the basis for institutionalising quality of care, the most important of which is the release for public comment of the draft National Health Amendment (NHA) Bill following its approval by the National Health Council and Cabinet. This Bill was gazetted for public comment in January 2011, and provides for the establishment of an independent Office of Health Standards Compliance (OHSC), creating a regulatory or audit framework for the inspection and certification of health establishments as compliant with mandatory standards and norms. The National Ombuds Office will be part of a future

independent Office of Health Standards Compliance.

As a basis for ensuring that safe and decent care is provided for South Africans, the National Core Standards (NCS) were developed through a process of wide consultation and expert technical inputs from both public and private sectors as well as professional bodies to reflect the specific policy context. They have now been published and are being widely distributed, providing a guide to managers on expected practice.

A measurement tool to enable self-assessment by managers of their level of compliance was also developed and field-tested and its use was initiated in the second half of the reporting period. Initial orientation sessions on the structure and use of the NCS were attended by 1 575 public service managers from provincial, district, hospital and primary healthcare levels. Further practical training in the methodology was provided to 740 managers and data capturers (although in neither case were the facilities they came from recorded to enable calculation of support). The target for support to health establishments for the implementation of the NCS was 20% of 4 333 public health facilities.

Self-assessments of compliance with the standards had covered 199 public facilities by end March 2011 (155 on the full set of standards, 44 using partial or adapted versions). Improvement projects in relation to identified gaps were put in place in preparation for future external inspection. (The 2010/2011 target was to audit 20% of 4 333 health establishments, but this would require the establishment of the external occupational health and safety committee (OHSC).

The inclusion of a sub-set of the NCS as part of the baseline audit protocol that will cover all hospitals and PHC facilities reflected the progress made in achieving acceptance of the standards (and will enhance staff knowledge and expand coverage in the coming financial year). The implementation plan and indicators have been approved by the NHC and will enable the formal reporting of self-assessments and of the many examples of significant quality improvements realised around the country.

Average waiting times were measured in various key areas in 18 hospitals, with the assistance of an external service provider, the Lean Institute, and corrective measures resulted in a reduction of 50-80% in several areas such as pharmacies and outpatient departments. Next steps entail expanding the measuring of waiting times in more hospitals with a view of setting national targets and ensuring

that effective improvement methods are spread among managers. The 2010/2011 target was to commission a national survey to establish baseline and realistic target waiting times.

As a starting point in improving infection prevention and control, an audit was carried out of current infection control nurses and their training, and a list of mandatory cleaning materials and equipment was approved by the NHC to reduce the weaknesses and shortages encountered. Competitions for “the cleanest hospital” were run in 88 hospitals covering four provinces with private sector sponsorship. In the process 170 health workers were trained and significant improvements achieved.

There were also several areas of slow progress during the reporting period. A number of targets were not achieved due to a policy decision to include these outputs as part of the future Office of Health Standards Compliance once established. Wider processes underway within government to improve efficiency and accountability also resulted in some modification of plans and reporting systems. A proposal for the establishment of a ministerial advisory committee (MAC) on quality, or a NHC quality sub-committee was prepared. However, this did not occur, although a major consultation meeting was called by the minister where national and international experts gave critical insights into their programmes. The establishment of the advisory committee or NHC quality sub-committee was placed on hold pending a general review of such committees.

No accreditation of health establishments meeting core standards was conducted as this requires the establishment of the external OHSC. The 2010/2011 target was to accredit 10% of 4 500 health establishments. Limited progress was made with procurement processes for in-sourcing service providers to support health establishments for the implementation of NCSs. The target for 2010/2011 was to support 20% of 4 333 public health facilities.

A guideline for managing or responding to adverse events was prepared. However, a national adverse event reporting system was not established. The target for 2010/2011 was for 35% of 400 hospitals to report on and respond to adverse events.

The process of formulating NCSs for non-health establishments and Emergency Medical Rescue Services (EMRS) did not commence. The department placed on hold the development of further standards pending the establishment of the independent body.

No formal reporting system was established to track the implementation of quality improvement plans (QIPs) during 2010/2011. The target for 2010/2011 was that 50% of 4 210 facilities would implement QIPs. Data will be obtained from core standards assessment reports as these become available.

SUB-PROGRAMME: HEALTH FINANCIAL PLANNING AND ECONOMICS

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
The establishment of a National Health (NHI) Insurance Fund	A NHI Fund established	Detailed implementation plan for the introduction of the a national insurance system developed	Draft policy was tabled at Cabinet	The draft policy document on NHI and the establishment of the NHI Fund have been approved by Cabinet	The draft policy document on NHI has been tabled before Cabinet for approval
Investigate and develop alternative reimbursement structures for use in the implementation of the NHI	DRG algorithm suitable for use as a reporting tool and for the reimbursement of hospitals produced	Options for the DRG algorithm for South Africa investigated by March 2011	Scope of work for an external service provider for the DRG algorithm for South Africa was produced	Investigations for the DRG algorithm did not commence	Delays occurred in the procurement of an appropriate service provider
Publish a reference price list (RPL) for all healthcare providers in the private healthcare sector annually within the regulated timelines	Reference price list that guide prices for medical services	Publish RPL 2011	RPL published	Could not be implemented	Court case prevented implementation
Implement a turnaround strategy for improving the management of tertiary services	Draft customised business plan	Business plan finalised by January 2011 and accepted by NDoH and Treasury	Business plan developed and approved by the director-general in November 2010	None	None
	Grant schedule of national tertiary service grant (NTSG) as per the DORA	NTSG is re-scheduled to schedule 5 grant	Modified schedule 5 conditions for the NTSG were approved by National Treasury	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Develop a sustainable revenue model which includes tariffs, collection and debt management	Number of provinces that comply with a national revenue model	National revenue model developed Revenue model implemented in 3 provinces	Draft revenue policy was produced, and shared with provinces for inputs	National revenue model was developed Revenue model was not implemented in 3 provinces	During the consultation process for the developments of the revenue model it was agreed with provinces that the model should be implemented in a phased approach. Phase 1: Addressing patient tariffs for funded patients has been completed

Overview of performance

This sub-programme is responsible for conducting or commissioning health economics research; develops policy on revenue collection and national health insurance; regulates the prices of medicine in the private sector; manages the national tertiary services grant and monitors public private partnerships.

During the reporting period, the department continued to refine the policy proposals for the implementation of the NHI, taking account of inputs from various government departments. A detailed implementation plan for the NHI was not produced as the policy document was still under consideration by Cabinet. A task team involving the NDoH and National Treasury reviewed the health component of the provincial equitable share and proposed an alternative formula based on the provincial burden of disease and health service utilisation in a province. The formula will be refined on an annual basis as the quality of the healthcare data improves.

During the reporting period, the minister on the recommendation of the pricing committee:

- Published a maximum dispensing fee for pharmacists
- Published a maximum dispensing fee for other health professionals
- Determined that there shall be no increase in the single exit price for 2011 due to the favourable exchange rates and consumer price indices
- Published draft regulations for the benchmarking of originator medicines

- Published draft regulations on the maximum logistics fees that may be charged by wholesalers
- Published draft guidelines on the submission of pharmacoeconomic analyses.

These interventions serve to improve transparency in the pricing of medicines and improve affordability of medicines.

In pursuit of improved revenue collection at facilities:

- a revised uniform patient fee schedule was published for implementation in 2011
- provincial health officials were trained in the submissions of claims to medical schemes
- draft regulations relating to the retention of revenue at public health facilities was approved for publication
- contracts between provincial health departments and medical schemes were facilitated
- provincial health departments were supported with the introduction of electronic claims submission to minimise rejections by schemes.

There were several public private partnerships over the reporting period:

- Five flagship hospitals were identified – they will be funded through public private partnership. Joint agreements between the national and provincial departments of health, National Treasury and the Development Bank of Southern Africa were signed.
- Transaction advisors were appointed for the Chris Hani Baragwanath project and the Limpopo Academic project.
- Management structures were established at four of the hospital PPP projects – Chris Hani Baragwanath, Limpopo Academic, King Edward, and Nelson Mandela Academic.
- The infrastructure PPP for Phalaborwa Hospital was finalised.
- The PPP with BIOVAC as reviewed with a view to an extension of the contract.

In keeping with the target for 2010/2011, a proposed reference price list (RPL) for 2011 was produced.

However, this was challenged by the private sector in the High Court resulting in the RPL regulations being struck down. In an effort to address the lacuna created by the RPL judgment a draft policy document to determine tariffs was published for comment.

Proposals were requested from service providers to commence with the development of a DRG Algorithm suitable for use as a reporting tool and for the reimbursement of hospitals. The target for 2010/2011 was for options for the DRG Algorithm for South Africa to be investigated by March 2011.

In an effort to improve the management and accountability for the National Tertiary Services Grant, a more detailed reporting framework was implemented.

SUB-PROGRAMME: PHARMACEUTICAL POLICY AND PLANNING

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Management of procurement and distribution of medicines and medical related items on contract (drug supply management)	Reported % stock-outs out of total number of antiretroviral medicines on tender (45) measured in 9 provinces (405)	< 5%	Total: 2.4% EC: 4.4% FS: 2.2% GT: 4.4% KZN: 0% LP: 4.4% MP: 2.2% NC: 2.2% NW: 2.2% WC: 0%	+2.6%	Improved monitoring and effective management to bring medicine stock-outs down from 42% in 1st quarter to 2.4% in 4th quarter
	Reported % stock-outs out of total number of TB medicines on tender (35) measured in 9 provinces (315)	< 5%	Total: 5% EC: 5.7% FS: 5.7% GT: 5.7% KZN: 5.7% LP: 5.7% MP: 2.8% NC: 8.6% NW: 5.7% WC: 0%	None	Improved monitoring and effective management to bring medicine stock-outs down from 42% in 1st quarter to 2.4% in 4th quarter

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Review of standard treatment guidelines	% of book reviewed	80%	60%	-20%	Vacancy rate of pharmacists. Cancelation of meetings due to World Cup. Less meeting time due to meetings being held at Civitas Building. (2 hours less per meeting)
Review the essential medicines lists	% of book reviewed (hospital level STG/EML)	80%	80%	None	None
	% of drugs reviewed out of a total number of motivations received (Tetiary and quaternary EML list)	75%	80%	+5%	
	% of book reviewed (PHC STG/EML 5th edition)	0%	0%	None	None
Licensing of premises for pharmacies in terms of the Pharmacy Act of 1974	Percentage of pharmacy license applications finalised out of total number of applications that meet requirements for licensing received in a quarter, (compliant with legislation)	80%	84%	+4%	
Licensing of public and private sector authorised prescribers to dispense medicines in terms of Section 22C of the Medicines and Related Substances Act of 1965	Percentage of dispensing licence applications finalised out of total number of applications that meet requirements for licensing received in a quarter (compliantto legislation)	90%	91.5%	+1.5%	

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Inspection in terms of legislation of the premises of licensed authorised prescribers to determine compliance to legislation	Percentage of premises of licensed dispensers inspected	5%	0%	-5%	No pharmacist inspectors to carry out these inspections
Institutionalisation of African traditional medicine (ATM) into the national healthcare system	Signed policy on ATM	Publication of ATM policy	Final ATM policy submitted for approval by TAC of NHC	0%	Delays in tabling of ATM policy at TAC of NHC

PROGRAMME 4: HUMAN RESOURCE MANAGEMENT and DEVELOPMENT

PURPOSE: This programme plans and co-ordinates human resources for the health sector.

SUB-PROGRAMME: HUMAN RESOURCE (HR) POLICY RESEARCH AND PLANNING

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Co-ordinate the review of the national human resource for health (HRH) plan and ensure alignment with the 10 Point Plan	Revised national HRH plan produced and implemented	Revised national HRH plan drafted by 2010	A draft workforce strategy was compiled and presented to the TAC of the NHC	The target for 2010/2011 was to produce a revised HRH (workforce) plan	None
Increase annual enrolment of chief executive officers (CEOs) into hospital management training programme	Number of hospital managers enrolled for a hospital management training programme	150/400	143/400 hospital managers were enrolled for a hospital management training programme	-7 or (-4.66%)	The intake of students was reduced by both the Universities of KwaZulu-Natal and WITS to address the research backlog

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Commission audit of public and private nursing colleges and schools in the country	Audit reports finalised	Business plans developed for the revitalisation of public sector nursing colleges	A business plan for the revitalisation of public sector nursing colleges was developed	A business plan was developed, in keeping with the 2010/2011 target	None
Establish a management and leadership academy for health managers	Management and leadership academy established and students enrolled	Feasibility study for the management and leadership academy completed by March 2011 . Business plan for the management and leadership academy produced and costed by March 2011, and used to mobilise resources	No progress was made with conducting a feasibility study for the management and leadership academy	-100%	There was no funding for such a feasibility study for the reporting period

Overview of performance

The sub-programme is responsible for developing and implementing the department's medium to long term human resource planns and implementation.

HR for health plan: Health workers are the tipping point of health service delivery, given the labour intensive nature of this sector. Significant strides were made in improving human resource planning, development and management during the reporting period. A draft workforce strategy was developed, with external technical expertise, and presented to the technical advisory committee of the NHC. A strong focus of the strategy is on increasing the production of health professionals and enhancing their retention in the public health sector. The target for 2010/2011 was to produce a revised human resource for health workforce plan however this was not achieved and has been moved to the following financial year.

Nursing colleges: Following completion of the audit of 126 nursing colleges during 2009/2010, a

business plan for the revitalisation of public sector nursing colleges was developed in 2010/2011, in keeping with the set target. Nursing education and training institutions provide a critical resource for the national health system in the country. The objectives of the audit were to:

- Obtain a comprehensive data set that would provide a clear picture of the nursing education landscape, from the state and condition of infrastructure to the size of student enrolments, the nature of programmes provided and the number of educators
- Create a database for nursing education in public colleges and schools, which will serve as a basis for a nursing education management information system
- Inform human resource planning
- Develop a register of infrastructural needs in preparation for an anticipated revitalisation programme.

The scope of the audit covered student enrolment patterns, programme information, the status and condition of infrastructure at the facilities of institutions, and the profile of nursing educators and other staff. The infrastructure chapter of the audit was also driven by an additional imperative of providing cost estimates for the revitalisation of the institutions, particularly those institutions that were in a state of disrepair and degradation.

The audit was finalised in May 2010, and a draft report produced. Based on feedback from the DoH on 2 June 2010, the report is being refined for submission at the end of June 2011. The audit was used in provincial workshops which involved around 3 000 nurses countrywide to prepare for a national nursing summit which aimed to produce a nursing compact in order to strengthen the contribution of nursing as a profession to improving health outcomes.

Hospital management training: A total of 143 of the 400 existing hospital managers was enrolled for a hospital management training programme, against a target of 150/400. The intake of students was reduced by both the Universities of KwaZulu-Natal and WITS to address the research backlog.

Leadership academy: No progress was made with conducting a feasibility study for the management and leadership academy for health managers. The set target was to complete the study by March 2011.

SUB-PROGRAMME: HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Strengthen human resource capacity in district hospitals	Number of clinical associates enrolled within the degree programme	125	183	+58	Two universities increased their annual intake of students for 2010 resulting in the increase of 58 students in the programme
Strengthen human resource capacity for the delivery of emergency care services	Number of colleges offering the emergency care technician (ECT) programme	5 additional colleges	6 additional colleges	+1	Due to the continuous efforts one additional EMS college was able to obtain the strigent requirements of the HPCSA to present the ECT programme
Finalise and implement Occupation Specific Dispensation (OSD) for therapeutic, diagnostic and allied health professionals	OSD agreement for diagnostic, therapeutic and related allied health professionals signed in the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC)	OSD agreement signed by government and organised labour, and implemented by March 2011	The OSD agreement for therapeutic, diagnostic and related allied health professionals was concluded and signed as an agreement on 5 November 2011 in the PHSDSBC	None	None

Overview of performance

This sub-programme has the responsibility of ensuring that there are HR policies, norms and standards which would allow for the efficient management of human resource.

Training: A total of 183 clinical associates was enrolled within the degree programme. This exceeded the 2010/2011 target of enrolling 125 clinical associates. From the first cohort group, 23 students completed the programme in December 2010 at Walter Sisulu University. A total of 56 students will

complete the programme at the end of 2011, 33 at the University of Pretoria and 23 at the University of Witwatersrand. This cadre of health workers will enhance the availability of medical support in public health facilities.

ECT: Six additional colleges offered the emergency care technician (ECT) training programme. This exceeded the 2010/2011 target of five additional colleges offering ECT.

OSD: The department fortified its efforts to improve the conditions of service for healthcare workers. The Occupation Specific Dispensation (OSD) was introduced as an integrated career development framework comprising remuneration, career progression and pathing, and performance management of the professional or clinical workforce based on roles and function. The main focus of the system so far has been on remuneration. However, the performance management aspects of the OSD will be refined and elaborated as the roll out of the OSD intensifies. In keeping with the 2010/2011 target, the OSD agreement for diagnostic, therapeutic and related allied health professionals was signed in the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) during November 2011. The department also conducted a 5% sampling in all nine provinces to ensure correct interpretation and application of Resolution 2.

SUB-PROGRAMME: SECTOR LABOUR RELATIONS AND PLANNING

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Manage disputes between organised labour and the employer in the PHSDSB	Percentage of mutual interest disputes lodged at the PHSDSBC managed and finalised	75% by March 2011	No dispute relevant to the NDoH was declared in the PHSDSBC	None	None
	Number of collective agreements tabled for negotiation over 3 years	2 collective agreements tabled for negotiation	2	None	None
	Number of progress reports produced on implementation of collective agreements concluded at PHSDSBC and PSCBC	4 quarterly reports	4 quarterly reports	None	None
Manage disputes between organised labour and the employer in the PHSDSB	12 PHSDSBC collective agreements reviewed and their efficacy assessed for amendment	4 PHSDSBC collective agreements reviewed, their efficacy assessed for amendment	Review of 3 collective agreements commenced	1 collective agreement not reviewed	Public sector strike during the reporting period required that more attention be devoted to the negotiations

Overview of performance

The sub-programme provides the resources and expertise for bargaining in the PNSDSBC. Additional responsibilities include maintaining good relationships with public sector unions and settling of health sector grievances.

During 2010/2011, health service delivery was affected by the protracted public sector strike over wage increases, which affected all government departments. Access to critical services, such as antiretroviral treatment for people living with HIV and AIDS, was curtailed. The department implemented various contingency measures during the industrial action, including deploying officials with a health background to the coalface of service delivery, and encouraging other officials to volunteer in providing administrative and other support services. The department also produced a detailed contingency plan (or strike management plan) for the future.

During the reporting period, no dispute relevant to the NDoH was declared in the PHSDSBC. The target for 2010/2011 was to manage and finalise 75% of mutual interest disputes lodged at the PHSDSBC by March 2011.

In keeping with the 2010/2011 target, two OSD agreements were signed during the reporting period, namely: PHSDSBC *Resolution 1 of 2010: Agreement on the addendum to PHSDSBC Resolution 3 of 2009: Implementation of an OSD for doctors, medical specialists, dentists, dental specialists, pharmacists, pharmacologists and emergency care personnel*; and *PHSDSBC Resolution 2 of 2010: Agreement on the OSD for therapeutic, diagnostic and allied health professionals*. National implementation workshops were held with provincial health departments and the trade unions in the PHSDSBC in preparation for implementation of the agreement.

Progress reports on the implementation of signed collective agreements were provided to the trade unions at each PHSDSBC meeting following their signing. Reports on implementation of OSD were also provided at each meeting of the NHC as required. This was consistent with the set target of consistently providing quarterly reports on signed collective agreements.

A review of three collective agreements commenced in the PHSDSB during the reporting period, namely: *PHWSBC Resolution 1 of 2003 as amended: Agreement on the appointment of full-time shop-stewards; PHWSBC Resolution 1 of 2004: Agreement on the payment of a scarce skills allowance (to be repealed following the signing of all health OSDs); PHWSBC Resolution 1 of 2005 as amended: Agreement on the payment of a uniform allowance to nurses;* and *PHSDSBC Resolution 2 of 2006 as amended: Constitution of the PHSDSBC.* The target for 2010/2011 was to review four PHSDSBC collective agreements and to assess their efficacy. The public sector strike that occurred during the reporting period required that more attention be devoted to the negotiations.

PROGRAMME 5: HEALTH SERVICES

PURPOSE: This programme supports the delivery of health services in provinces including primary healthcare, hospitals, emergency medical services and occupational health.

SUB-PROGRAMME: DISTRICT HEALTH SERVICES

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement appropriately decentralised and accountable operational management model	PHC package revised	Review of PHC package commissioned	Revised PHC package produced	None	None
	PHC team strategy developed	PHC team strategy produced and approved by the NHC	PHC multidisciplinary team outreach strategy developed and approved by the NHC	None	None
	PHC service delivery model developed	PHC service delivery model developed	PHC service delivery model developed and approved by NHC The model focuses on three streams being school health, PHC teams, and specialist teams at district level	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement appropriately decentralised and accountable operational management model	Number of provinces where PHC audit was conducted	6	Service provider appointed and started with the audit	-6	The process for conducting the audit was reviewed and an integrated approach covering facility profile, HR, infrastructure, healthcare technology services and compliance with core standards was developed The service provider was only appointed in February 2011. The audit will be completed by March 2012
	PHC utilisation rate	2.6 visits per person per capita	2.4	-0.2	A need exists to enhance public confidence in PHC services. This will be achieved through the re-engineered PHC model, which will strengthen both community-based and facility based services
	Number of districts with full complement of DMT	52	Total districts with DMT=40 GP: 5 out of 6 districts NC: 2 out of 5 districts FS: 4 out of 5 districts WC: 5 out of 6 districts LP: 5 out of 5 districts NW: 4 out of 4 districts EC: 6 out of 7 districts MP: 3 out of 3 districts KZN: 6 out of 11 districts	-12	Full complement of DMT includes the following posts: District manager, head of PHC including programmes, head of finance, head of human resource, and head of health information. This includes those managers who are in acting positions, who ensure the work gets done and are accountable for it

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement appropriately decentralised and accountable operational management model	Number of DMTs with written delegations	52	Only 40 districts had DMTs • Human Resources delegations=32 • Financial delegations=11 • Supply chain Management delegations=7	DMT without: • human resource delegations= 8 • financial delegations= 29 • supply chain management delegations= 33	**General comments**: Provinces such as Mpumalanga and Northern Cape have centralised finance, human resource and supply chain management (SCM) **Human resource delegations:** North West's delegations are dated 2002 and there have not been any delegations subsequently **Finance delegations:** Finance delegations were not provided from Eastern Cape. Delegations for district managers in the Eastern Cape have not been submitted for verification. Limpopo submitted only for 2 district managers out of 5. (3 were not submitted for verifications) **SCM delegations:** Delegations for districts in Limpopo and Western Cape were not provided for verification. KwaZulu-Natal submitted individualised letters for finance delegations that were sent to managers. These letters have different dates which show that although they have the same content, they are specific to the managers to whom the delegations are given. With regards to SCM delegation KZN has a generic set of delegations
	Number of districts where management teams are trained in district management programmes	20	0	-20	DBSA was commissioned by the NDoH to review and assess the competencies and functions of district managers. The further training of district managers was halted pending the outcome of this assessment which is not available yet

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement appropriately decentralised and accountable operational management model	Number of districts with district health plans (DHPs) received from provinces	52	Total = 46 GP: all 6 districts submitted WC: no DHP received for verification NC: all 5 districts submitted LP: all 5 districts submitted FS: all 5 districts submitted NW: all 4 districts submitted EC all 7 districts submitted MP: all 3 districts submitted KZN: all 11 districts submitted for verification	-6 DHPs	DHPs from the 6 districts in the Western Cape were not received
	Number of provinces where PPHC services has been provincialised	7	5 (FS; LP; NW; MP and NC)	-2 provinces	This work is dependent on collaboration with the South African Local Government Association (SALGA) as well as organised labour. Those provinces that made progress are where the matters have been finalised between SALGA, unions and the province

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PER-FORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement appropriately decentralised and accountable operational management model	Number of quarterly performance reports received from districts	18 priority districts	18	None	This project has been closed. Those districts that have improved performance were recognised through awarding of certificates
	Number of district health councils (DHCs) established and functional	52	DHCs established = 32 GP: All 6 districts NC: All 5 districts FS: All 5 districts WC: No district Health Councils LP: All 5 districts NW: All 4 districts EC: All 7 districts MP: No District Health Councils KZN: No District	-20	Mpumalanga, KwaZulu-Natal and the Western Cape reported that no DHCs were established
	Number of district health councils trained	52	0	-52	Status quo for 2009/2010 remains where 43 DHCs were reported as trained. For 2010/2011 no training took place. Training is conducted after the establishment of the District Health Councils. It is not done annually but once per term of office. Training is thus reported once for the duration of the term of office

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement appropriately decentralised and accountable operational management model	Number of districts with PHC facilities where committees are established and functional	52	GP: All 6 districts NC: All 5 districts FS: All 5 districts WC: 2 out of 6 districts LP: 4 out of 5 districts NW: All 4 districts EC:6 out of 7 districts MP: All 3 districts KZN: 8 out of 11 districts Total Districts with DMT = 43	-9	The remaining ones are due to resignations of members and delays in the formal appointment of the new members
	Number of districts where committees have been trained	52	0	52	Status quo for 2009/2010. For 2010/2011 no training took place. Training is conducted after the establishment of the committees. It is not done annually but once per term of office. Training is thus reported once for the duration of the term of office
	% of PHC facilities visited by a supervisor once a month	80%	68.4%	-11.6%	There are still districts without dedicated PHC supervisors, where supervision is provided by health programme co-ordinators, who are also expected to do other jobs involving their programmes. The other challenge is that supervisors are not provided with vehicles thus leaving them to use pool vehicles which are not reliable in terms of availability and roadworthiness
	PHC per capita expenditure per district	R350	R390	+ R40 Data on PHC per capita expenditure per district were not available during the reporting period	This is a calculated value. PHC expenditure needs to be reviewed through an institutionalised district health expenditure review (DHER) per district. The information per district will only be available once the 2010/2011 DHER is completed in August 2011

Overview of performance

The sub-programme promotes and co-ordinates the development of the district health system and monitors the implementation of primary healthcare. In keeping with the set target, the PHC package developed in 2000 was reviewed and a revised and updated package produced.

PHC revitalisation: Key milestones were achieved in the revitalisation of health service delivery through the PHC approach. During 2010/2011 a new PHC model for the country was produced and endorsed by the NHC. The new PHC model places greater emphasis on both the individual and the family, and focuses on promotion and prevention, rehabilitative and referral services, rather than exclusively on curative services. It avoids fragmentation that results in multiple healthcare providers visiting families, and ensures that a single integrated team establishes relations with families in the catchment area. It accentuates strong community participation as well as multi-sectoral collaboration. Three pillars of the new PHC model are: deployment of PHC outreach teams consisting of professional nurses, enrolled nurses and community health workers in different wards across the country; establishment of medical specialist teams to support the PHC teams; and strengthening school health services. This will contribute significantly to enhancing health outcomes in the country. As part of strengthening communication and raising awareness on revitalisation of PHC in the country, a non-profit organisation was commissioned to produce a communication strategy. A draft communication strategy was produced, reviewed and refined.

To strengthen planning processes at district level, 46 districts produced and submitted draft district health plans (DHPs) for 2011/2012 to the NDoH. Feedback was provided to districts on their DHPs. The performance reflects significant improvement from the 20 DHPs produced and submitted in 2009/2010. Quarterly performance reports were received from 18 priority districts, in keeping with the 2010/11 target. Progress was made with improving the supervision of primary level facilities and 68.4% of these facilities were visited by a supervisor once a month, against a 2010/2011 target of 80%. District health councils (DHCs) were established and are functional in 32 of the 52 districts - the target for 2010/2011 was 52. Primary level facility committees were established in 43 of the 52 districts. The 2010/2011 target was to establish these committees in all 52 districts.

The objective of implementing a two-fold approach for overhauling the healthcare system, which consists of re-invigorating the PHC approach to healthcare delivery and improving the functionality and management of the health system, was achieved. The DBSA completed its assessment of the

appropriateness of the organisational environment in which health district managers and hospital CEOs function. A report with recommendations was compiled by the DBSA.

There were also areas of slow progress during the reporting period. A service provider was appointed to conduct an integrated audit of health facilities. The target for 2010/11, which was to produce PHC audit reports of six provinces by the end of March 2011, was not achieved. The PHC utilisation rate for 2010/2011 was 2.4 visits per capita, against a 2010/2011 target of 2.6 visits per person per annum. The PHC per capita expenditure per district was estimated at R390, against a 2010/2011 target of R350. Personal PHC services were provincialised in only five of the seven provinces targeted for 2010/2011.

A strong district health system is essential for the implementation of the PHC strategy. District health system development will continue to be accelerated in the next planning cycle.

SUB-PROGRAMME: HOSPITAL SERVICES AND HEALTH FACILITIES MANAGEMENT

The sub-programme is responsible for developing policy on health facility infrastructure, health technology and emergency medical services and hospital governance.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Accelerate revitalisation of health facilities	Number of health facilities accepted in the programme per financial year	18 additional hospitals to be accepted (5 tertiary hospitals constructed or refurbished through PPPs namely Nelson Mandela Academic Hospital in the Eastern Cape, Dr George Mukhari Hospital in Gauteng, King George VIII Hospital in KwaZulu- Natal, Limpopo Academic Hospital and New Nelspruit Hospital in Mpumalanga, and 13 from the hospital revitalisation project)	Construction of 4 hospitals commenced (i.e. Cecilia Makiwane, Ladybrand, Trompsburg and De Aar) and the remaining 7 are in various planning stages Regarding the 5 PPP flagship projects, the target was to complete planning in 2011/2012 financial year and be in construction in 2012/2013. Currently Chris Hani Baragwanath and Limpopo Academic Hospitals are about to finalise the feasibility study. The remaining 3 are in the process of appointing transactional advisors to conduct the feasibility study.	EC:Madwaleni Hospital was delayed because the business case was reviewed following changes in the number of beds by the province. The NDoH granted approval of the revised business case KZN: Dr P. ka Seme hospital was delayed in the design phase because the province recommended that the hospital should render regional services instead of district services as was previously requested. Edendale hospital was delayed because the submitted project brief was not correct and the national peer review comments were not incorporated into the project brief. LP: Musina hospital was delayed because the province could not provide a site of the hospital. MP: the new Mpumalanga tertiary hospital planning was stopped following the withdrawal of approval of the business case for the hospital by the NDoH NW: Bophelong psychiatric hospital was stopped by the NDoH in the tender stage following the concern raised by the NDoH mental health unit that the size of the new facility was against the Mental Health Act and WHO psychiatric norms and standards. The planning of Lichtenburg is still in the design phase. WC: Valkenburg psychiatric hospital was delayed because of delays in incorporating into the business case the comments by the national peer review team Tygerberg Tertiary Hospital: The facility was in the process of establishing a project office that will handle the development of a feasibility study, projects brief and design. The facility was registered as a PPP with National Treasury. The reason why there was a delay is that the funding was split into two. Some of the money was coming from HRG and the other portion from NT PPP Unit. The province prefers the budget from one source of funding which is HRG. This request was approved by the department.	The NDOH challenge was that the team that evaluated the planning documents was the same team that was supposed to oversee the implementation of projects on site. A dedicated team to oversee planning of infrastructure is needed to ensure better planning and speed up infrastructure delivery

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Determine infrastructure area and cost norms for health facilities based on approved national policies	NHC approved area and cost norms policy document	Draft cost norms policy document submitted to NHC for approval, (based on NHC approved norms policy document)	The cost norms policy document was not submitted to NHC for approval The first phase which is consultation with various stakeholders including provinces and gathering available norms and standard has been completed	Cost norms policy document submitted to NHC for approval	The assessment on the capacity to deliver this project on time shows that external capacity is required to fast track the process. To achieve this the NDoH contracted CSIR to drive this process
	Provinces target 3-5% of health operational budget for preventative maintenance by 2013	Implementation on plans of preventative maintenance developed by the provinces based on set target of 3-5%	Implementation on plans of preventative maintenance developed by the provinces based on set target of 3-5% was not achieved	Implementation on plans of preventative maintenance developed by the provinces based on set target of 3-5%	The maintenance budget is part of infrastructure grant and provincial equitable share. The report from the infrastructure reporting model (IRM) from National Treasury shows that all provinces are far away from the set target
Strengthen health infrastructure delivery capacity in provinces	Number of provincial health departments implementing infrastructure delivery model	Develop, approve and pilot the infrastructure delivery model in 3 provincial health departments	All 9 provinces have one technical assistant appointed through IDIP. The NDoH receive 2 technical assistants. The department is also in the process of appointing engineers to enhance the existing capacity in the provinces. Only KZN, WC and EC managed to get the resident engineer/ architect	The remaining provinces are in the process of getting engineers as approved by the NHC	Inadequate capacity, which is being addressed through the appointment of engineers
Develop and implement disaster management policy	Number of provinces implementing disaster management policy	3	0	-3	There was a delay in the development of the disaster management policy

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement hospital emergency preparedness plan	% of hospitals implementing hospital emergency preparedness plan	15%	(62/381) 16.2%	+1.2%	Focus was on hospitals that were part of the preparation for the FIFA Soccer World Cup 2010
Development and implementation of a national information management system	Number of provinces implementing a standardised (uniform) data management system	4	0	-4	The EMS unit was depleted during the FIFA 2010 World Cup event. Budgetary constraints are hindering provinces from acquiring correct systems to implement information management systems
Provide strategic and technical support to emergency services	Number of provinces complying with emergency medical services norms and standards	4	0	-4	Unavailability of EMS norms and standards Shortage of resources (ambulances, trained staff, equipment)
Development of the health technology planning system	Planning standards and relevant tools % provinces complying with the standards	Health technology planning structures established at district, provincial and national levels of the health system essential health technology packages (EHTP) updated	Health technology committees were created at provincial and district/ hospital levels for planning Essential equipment lists were developed and are being ratified by stakeholders before final adopting by NHC	% of hospitals with health technology management committee not yet known but not all hospitals have health technology management committees	Due to budget constraints, the process to develop EEL only started when WHO offered funding

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Development of a national health technology acquisition system	Restructured health technology acquisition system in place	Health technology value chain analysis (including pricing and/ or cost drivers, supply and demand) completed and report produced	Information analysed for 1 province	Only 1 out of 9 provinces	Lack of health technology asset management systems as well as insufficient data provided by hospitals, made it impossible to have proper supply and demand analysis. The work to obtain further information is continuing
Develop a national health technology management system	% of hospitals complying to the standards	GMTP standards developed by March 2011	70% complete	-30%	Inadequate internal capacity affected progress with the development of standards
Establishment of a national health technology assessment (HTA) system	Numberof provinces that have institutionalised HTA	HTA strategy approved by the NHC	Draft strategy produced	80% complete	Draft strategy to be presented to the ministerial advisory committee on health technology before being presented to the NHC

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement health technology regulations	Health technology regulations finalised	Final health technology regulations published for public comment	Health technology regulations finalised	80% complete	Health technology regulations are awaiting MCC approval
Support the implementation of hospital improvement plan	% of hospitals implementing the hospital improvement plan	20% of hospitals implementing the hospital improvement plan	26 % of hospitals implemented the hospital improvement plan	Target exceeded by 6%	Even though the target was exceeded the department needs more staff to cover more facilities in the financial year
Improve the capacity of hospital board members through the development of a national training manual	Percentage of hospital boards trained	80%	55.5% of the hospital boards have been trained. This was a joint effort between the NDoH, DHS and the HST There is a draft training manual. The unit is working closely with the district health system (DHS) and the Health System Trust (HST) in ensuring the manual will incorporate all relevant aspects	-24.5%	Some of the provinces had no duly constituted boards as stipulated in the NHA, for example Limpopo (period 2008 -2011) The boards were appointed in February 2011 and training was conducted in March 2011
Develop framework for the delegation of authorities to CEOs	Percentage of CEOs who have signed delegation of authorities	100%	There is a draft framework. 67% of the hospital CEOs have signed delegations of authority	-33%	Some of the provinces have withdrawn their delegations to hospital managers, for example MP, NC and EC

Overview of performance

During 2010/2011, the NDoH employed two broad strategies for improving health facility infrastructure to enhance quality of care, namely construction or refurbishment of five tertiary hospitals (known as flagship projects) through PPPs, and construction or refurbishment of 13 additional hospitals through the hospital revitalisation programme. The five flagship tertiary hospitals, namely Nelson Mandela Academic (Eastern Cape), Chris Hani Baragwanath and Dr George Mukhari (Gauteng Province),

King Edward VIII (KwaZulu-Natal) and Limpopo Academic Hospital (Limpopo), were registered with National Treasury which opened the way for feasibility studies to be conducted.

Transaction advisors for Chris Hani and Limpopo Academic Hospitals were appointed. The process of appointment of transaction advisors for the other three flagship projects also commenced. The report on the feasibility study for the Chris Hani Baragwanath PPP project was completed by the transaction advisor and submitted to the JIC, which consists of NDoH, National Treasury PPP Unit, the DBSA and each of the four provinces with PPP projects.

Construction of four hospitals through the hospital revitalisation programme commenced during 2010/2011. These were: Cecilia Makiwane (Eastern Cape), Trompsburg and Ladybrand (Free State), and De Aar (Northern Cape).

There has been a paradigm shift from infrastructure delivery to health facility planning and development. This means that all key aspects of a facility should be considered before a project is signed off as complete. For example, equipment, staff and consumables have to be factored in to avoid having a facility non-operational due to non delivery of equipment or similar reasons.

Significant progress was made with the implementation of the new infrastructure delivery model in provincial health departments. The NDoH, in unison with National Treasury, appointed technical assistants (TA) in all nine provinces. The capacity of the provinces was reviewed and it was found that each province needed to appoint a resident engineer to enhance capacity for infrastructure delivery. Three provinces, Eastern Cape, KwaZulu-Natal and the Western Cape, appointed engineers during the reporting period. Similar processes are underway in other provinces.

There has been a stabilisation of the expenditure on the revitalisation grant and infrastructure grants over the past financial year.The total expenditure for 2010/2011 was R3.2 billion, constituting 80% of the allocated budget for the financial year. This reflects improvement from 2009/2010 where expenditure on infrastructure grants was R2.68 billion (77% of the allocated budget). The amount of under expenditure decreased from R813 million in 2009/2010 to R802 million in 2010/2011. Both these figures confirm that the under expenditure pattern has stabilised and minimally improved in the year under discussion.

Some strides were made in strengthening hospital management. About 26% of hospitals implemented hospital improvement plans, which exceeded the 2010/2011 target of 20%. With the aid of a hospital board training manual, over 55% of hospital boards were trained on their governance roles and functions. This was inconsistent with the target of 80%. About 67% of hospital CEOs signed delegations of authority, against a 2010/2011 target of 100%.

Hospital emergency preparedness plans were implemented in 16.3% of hospitals (62 out of 381) which were the hospitals that were identified for the FIFA World Cup 2010. This was consistent with the 2010/2011 target of implementing these plans in 15% of hospitals. There were also areas of slow progress during the reporting period.

Delays occurred in the planning processes for the construction of hospitals. These included Madwaleni Hospital (Eastern Cape), Dr Pixley kaSeme (KwaZulu-Natal), Edendale Hospital (KwaZulu-Natal), Bophelong Psychiatric Hospital (North West), and Valkenburg Psychiatric Hospital (Western Cape). The design of psychiatric hospitals was affected by non-compliance with the Mental Health Act and the WHO Psychiatric Norms and Standards. Inability to locate land delayed the planning processes for the Musina Hospital (Limpopo).

During the planning and design stages, the following activities need to be addressed to avoid delays and under expenditure on infrastructure service delivery: project identification, justification, preparation of business cases, and project definition and preparation of project briefs. These activities could be undertaken internally by health departments, or externally with technical support from the private sector. In the case of the hospitals enumerated above, delays resulted from diverse factors - these were mainly changes in the original business cases of the hospitals, such as amendments to the size of the hospitals (number of beds), and the level of services that the hospitals were planned to provide.

Provincial progress review committee meetings, as sanctioned by the NHC comprise a management and co-ordinating structure consisting of provincial health departments, their implementing agents and principal agents. The characteristics of the committee are also reflected hereunder. It is advisable to have one progress review committee meeting per implementing agent and NDoH infrastructure unit to officially participate in all the meetings.

Provincial health departments did not achieve the target of spending 3-5% of their operational budget on preventative maintenance. Reports from the infrastructure reporting model indicated that all provinces were not achieving the targeted level of spending on preventative maintenance.

The disaster management policy was not finalised for adoption and implementation. The 2010/2011 target was to implement the policy in three provinces. Emergency medical services (EMS) norms and standards were not finalised due to the shortage of resources. The target for 2010/11 was that at least four provinces should comply with the EMS norms and standards.

Draft health technology regulations were developed and submitted to the Medicines Control Council (MCC) for approval. Essential equipments lists were developed to guide the health sector in the acquisition of appropriate technology for healthcare delivery. A draft health technology assessment strategy was produced, and was almost finalised at the end of the reporting period. The target for 2010/2011 was to have the strategy approved by the NHC.

Due to capacity constraints, health technology planning structures were not established at district, provincial and national levels of the health system as planned. An analysis of the health technology value chain was not completed due to lack of health technology asset management systems and insufficient data provided by hospitals. An effort to obtain further information is continuing to inform a proper supply and demand analysis. These areas will be prioritised in the next planning cycle.

SUB-PROGRAMME: ENVIRONMENTAL HEALTH, HEALTH PROMOTION AND NUTRITION

This sub-programme is responsible for policy development and monitoring of environmental health, health promotion and nutrition issues.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Strengthen environmental and municipal health services	Number of district and metro municipalities rendering municipal health services	100%	20 %	-80 %	Delays occurred with the devolution of the municipal health services
Strengthen port health management	Number of provinces implementing the international health regulations (IHR)	3	9	+6	All provinces implemented IHR in the priorities points of entries including North West and Northern Cape who have employed permanent staff during the first quarter of 2010
Implementation of National Environmental Management Act (NEMA)	Number of provinces implementing the NEMA	3	9	+6	All provinces dedicated resources to the implementation of the NEMA
Strengthen human resource capacity	Number of municipalities accepting community service environmental health practitioners (EHPs)	27 (metropolitan and district municipalities)	4 1 metropolitan municipality (City of Cape Town) and 3 district municipalities (Cape Winelands, West Coast and Eden) and KwaZulu-Natal	-23	Slow progress was made with the placement of community service EHPs in municipalities. The department initiated amendments to the community service regulations for municipalities to start accommodating community service EHPs
Support districts in the implementation of the health promotion strategy with (special focus on the 5 pillars of the healthy lifestyles programme)	Number of districts implementing the 5 pillars of the healthy lifestyles programme	52 districts	37 of the 52 districts	-15 districts	Some provinces have limited dedicated health promotion staff. Formal reporting system initiated in last quarter

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implement an integrated strategy on the management of severe malnutrition in district hospitals	Number of district hospitals implementing the WHO ten steps for the management of severe malnutrition	118 district hospitals	131 district hospitals	+13 additional hospitals	Development partners of the department contributed training in additional hospitals
Improve infant feeding practices for infants younger than 6 months	Percentage of infants 0-6 months who are exclusively breastfed	10%	25%	+15%	Implementation of the baby friendly hospital initiative has contributed to the increase in the rate of exclusive breastfeeding. Advocacy, social mobilisation and communication strategies were used to promote exclusive breastfeeding
Provide nutritional care and support to people living with HIV, AIDS and TB	Percentage of primary healthcare facilities providing nutritional care and support to people living with HIV, AIDS and TB	65%	79%	+14%	Data collection for this indicator improved during the reporting period, through collaboration with the HIV and AIDS programme
Improve quality of care of HIV exposed infants younger than 6 months by increasing the proportion of primary care level facilities with healthcare providers trained in infant and young child feeding in the context of HIV and AIDS	Percentage of primary care level facilities with healthcare providers trained on infant and young child feeding in the context of HIV and AIDS	60%	57.4%	-2.6%	Due to difficulty in collecting data from provinces on training that took place at provincial DoH level, the NDoH was only able to report on training that was conducted by the NDoH itself or by partners working with the NDoH
Increase routine coverage of Vitamin A supplementation among children 12-59 months	% coverage of Vitamin A supplementation in children aged 12 – 59 months	60% of children 12-59 months receiving 2 doses of Vitamin A	32.9%	-27.1%	This figure reflects only routine Vitamin A supplementation During the Vitamin A campaign conducted in May 2010, 81% of children in this age group was reached

Overview of performance

Environmental health: The goal is to ensure the delivery of effective, efficient and sustainable environmental health services. The objective is to ensure the implementation, monitoring and evaluation of environmental health services, provision of strategic leadership for the development of policies, procedures, norms and standards for the prevention, management and control of environmental health risks, and to provide support to provinces, municipalities and other stakeholders.

For the period under review, the Environmental Health Directorate managed to finalise the draft environmental health policy and port health policy documents which were adopted by the interprovincial meeting for approval. Additional accomplishments were standardisation of the environmental health indicator data set for use by provinces and municipalities.

Managing hazardous substances is a primary activity for the directorate. To this end training was conducted in all nine provinces on healthcare waste management and hazardous substances. A total number of 604 environmental health practitioners was trained. Authorisation letters were made out for six provinces appointing environmental health practitioners as inspectors in terms of Section 8(1)(2) of the Hazardous Substances Act 1973 15 of 1973 for Group I and Group II hazardous substances.

The health and hygiene strategy (H&HE) was rolled out in all nine provinces, wherein 489 environmental health practitioners and 29 councillors were reached. The roll out also incorporated a workshop on H&HE implementation and development of provincial work plans. As a result six provinces managed to compile and submit H&HE work plans. The provinces included KwaZulu-Natal, Free State, North West, Eastern Cape, Western Cape and Northern Cape.

Training of environmental health practitioners took place across all nine provinces. A total of 521 environmental health practitioners was trained on health-related water quality management which acquired 15 continual educational units (CEU) from the HPCSA. Environmental health practitioners in all nine provinces were trained on the *Environmental Health impact Assessment Guideline* (EHIAG) and 579 EHPs were reached.

Areas of slow progress: Only 20% of district and metro municipalities fully rendered municipal health

services, against a 2010/2011 target of 100%. All others partially rendered the services. A task team comprising the Environmental Health Directorate, the South African Local Government Association (SALGA) and the Department of Cooperative Governance and Traditional Affairs (CoGTA) was established in order to monitor the situation and bring this process to fruition. Guidelines on devolution of municipal health services were developed to assist provinces and municipalities in finalising the process.

Only four municipalities accepted community service environmental health practitioners during the 2010/2011 financial year, against a target of 27. This included one metropolitan municipality (City of Cape Town), and three district municipalities (Cape Winelands, West Coast and Eden). The department initiated the process of amending the *Community Service Regulations* in order to accommodate municipalities and they were published for public comments.

During the reporting period all provinces implemented the international health regulations in their priority points of entries. This exceeded the set target of three provinces. Furthermore, all nine provinces implemented the National Environmental Management Act (NEMA), which was in keeping with the 2010/2011 target. An assessment report for municipal health services was compiled, with recommendations for strengthening the outcome.

Nutrition: A total of 131 district hospitals implemented the *WHO's Ten Steps for the Management of Severe Malnutrition*, which exceeded the 2010/2011 target of 118. About 25% of infants 0-6 months were exclusively breastfed, which exceeded the target of 10%. The reported performance was based on survey data from the HSRC 2010 survey. Also, during the reporting period, 79% of primary care level facilities provided nutritional care and support to people living with HIV, AIDS and TB, which exceeded the 2010/2011 target of 65%. A total of 57.4% PHC facilities had healthcare providers trained on infant and young child feeding in the context of HIV and AIDS, against a target of 60%. By the end of December 2010, Vitamin A supplementation to children aged 12 – 59 months was at 32.9% coverage, against a target of 60%. Only 37 of the targeted 52 districts implemented the five pillars of the healthy lifestyles programme. Limited availability of dedicated health promotion staff served as a key impediment.

SUB-PROGRAMME: OCCUPATIONAL HEALTH SERVICES

The sub-programme promotes occupational health and safety in public health institutions and ensures the training of occupational health practitioners in risk assessment. The programme also provides benefit medical examinations to ex-mine workers to assess if they acquired any diseases that render them eligible for compensation from the mines where they previously worked.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFOR-MANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Increase numbers of ex-mine workers who undergo benefit medical examinations (BMEs)	Number of ex-mine workers who undergo BMEs	23 000	12 710	-10 290	Capacity constraints impacted on the ability to examine a higher number of ex-mine workers
Expand comprehensive occupational health units (OHUs) in district hospitals	Number of district hospitals with comprehensive OHUs	70/264	72/264	+2	More provinces established DHIS at district level during the reporting period

Overview of performance

A total of 12 710 ex-mine workers underwent benefit medical examinations during 2010/2011, against a target of 23 000. Capacity constraints militated against achievement of this target. Additional medical personnel have since been appointed at the Medical Bureau for Occupational Diseases (MBOD) to enhance the capacity to conduct these examinations.

A total of 72 district hospitals established occupational health units (OHUs), which exceeded the 2010/2011 target of 70.

PROGRAMME 6: INTERNATIONAL RELATIONS, HEALTH TRADE AND HEALTH PRODUCT REGULATION

PURPOSE: This programme co-ordinates bilateral and multilateral international health relations including donor support, regulations of procurement of medicines and pharmaceutical supplies and regulation and oversight of trade in health products.

SUB-PROGRAMME: MULTILATERAL RELATIONS

This sub-programme is tasked with developing and implementing bilateral and multilateral agreements with other countries and agencies to strengthen the health system. Additional responsibility includes agreements with other states on recruitment of health workers from other countries and mobilises international resources for priority health programmes.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Contribute towards post conflict reconstruction and development	Number of Cuban health professionals recruited to work in Rwanda and Sierra Leone under the trilateral arrangements	10	32 Cuban healthcare workers were recruited and started working in Rwanda An oversight committee meeting for the SA-Cuba-Rwanda trilateral project was held in Rwanda 14-18 March 2011 and an evaluation report developed	No healthcare workers were recruited to work in Sierra Leone	There was a delay in signing transfer of funds to Sierra Leone for the implementation of the trilateral project Delays in the finalisation of the Memorandum of Understanding (MOU) between Cuba and Sierra Leone on recruitment of Cuban doctors delayed implementation
Strengthening bilateral relations with Africa and South-South countries	Number of South African students recruited and retained in the SA-Cuba programme	80	80	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Strengthening bilateral relations and SADC integration agenda	Number of cross border initiatives facilitated to manage communicable diseases along border areas	2	6 • Lubombo Spatial Development Initiative (LSDI) for the control of malaria along the borders of South Africa and Mozambique • Mozambique-Zimbabwe-SA (MOZIZA) cross-border malaria initiative • Global Fund approved the transfer of $455 000 • (R3 444 350) towards the SADC HIV and AIDS special fund for 2010/2011 for 4 cross border projects	+4 projects	Global Fund approved the transfer of US$455 000 (R3 444 350) towards the SADC HIV and AIDS special fund for 2010/2011 for 4 cross border projects.
Contribute towards post conflict reconstruction and development	Number of technical assistance programmes facilitated for the reconstruction and development of DRC, Zimbabwe, Sierra Leone, Rwanda and Burundi	3	2 • Referral systems were established between South Africa and the Democratic Republic of Congo, Zimbabwe, Burundi and Rwanda, for patients from these countries to be referred to South African hospitals • Training of graduate and post-graduate health professionals students from the DRC, Zimbabwe, Burundi and Rwanda at South African universities continued during the reporting period	- 1	Due to the changing political situations in the DRC and Zimbabwe, follow-ups were not done as planned

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Strengthening multilateral relations (IBSA and SADC)	Number of initiatives facilitated to strengthen health systems	6	6 initiatives • SADC health ministers meeting from 21-22 April 2010 • SADC sexual and reproductive health managers' workshop from 14-16 September 2010 • Malaria consensus workshop held in Tanzania from 20-22 September 2010 • SADC technical conference on sustaining HIV and AIDS responses in the context of shrinking resources from 24-26 August 2010 • SADC health ministers' meeting in the DRC, Nov 2010 • SADC validation workshop on the documentation of the draft regional database for HIV and AIDS, tuberculosis and malaria, Johannesburg, 7-8 December 2010	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Facilitate the implementation of the African Union (AU) campaign on accelerated reduction on maternal mortality in Africa (CARMMA)-towards meeting the Millennium Development Goal (MDG) 5	Number of reports on structured interventions essential for the promotion of the AU campaign on accelerated reduction on maternal mortality in Africa (CARMMA)	2	2 • South Africa's progress report on the implementation of the Maputo action plan for the continental policy framework on sexual and reproductive health rights (2007-2010). This report was integrated into the AU progress report. The cluster further reported that it collaborated with SADC in hosting planning sessions for the regional meeting for national managers on MDGs 4, 5 and 6 • Ministerial report on health related decisions taken at the Fifteenth Ordinary Session of the Assembly of the African Union held in Kampala, Uganda on 25 to 27 July 2010	None	None

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Mobilised ODA resources (technical and financial assistance) for the implementation of the 10 Point Plan	Number of agreements signed and implemented	7	7 • USAID Mega Assistance Agreement signed in September 2010 • Operation Smile South Africa Memorandum of Understanding signed in December 2010 • Annual Bilateral Forum between South Africa and United Sates of America held in May 2010 • Annual consultation held between South Africa and Canada in September 2010 • PEPFAR / SA partnership framework signed Belgium/NDoH agreement signed • Aid Effectiveness Framework for Health signed by minister and development partners • EU/SA financing agreement for health signed EU/SA JCC meeting facilitated and coordinated	None	None

Overview of performance

During the reporting period the department contributed to the post-conflict reconstruction and development in SADC countries, particularly Rwanda. A total of 32 Cuban health professionals were recruited to work in Rwanda under the trilateral arrangement. The 2010/2011 target was to recruit 10 Cuban health professionals to work in Rwanda and Sierra Leone under the trilateral arrangement.

Cuba is an important partner. South Africans are sent there to train for their medical degrees. In keeping with the 2010/2011 target, a total of 80 South African students was recruited into the SA-Cuba programme. The last group departed for Cuba on 25 October 2010.

Cross border referrals and assistance to our neighbours have continued. During the financial year, patients from the Democratic Republic of Congo (DRC), Zimbabwe, Burundi and Rwanda were formally referred to South African hospitals to access healthcare. Training of graduate and post-graduate health professionals from the DRC, Zimbabwe, Burundi and Rwanda at South African universities continued during the reporting period. The target for 2010/2011 was to establish three technical assistance programmes for the post-conflict reconstruction and development in SADC countries.

The department continued to participate in cross-border initiatives to manage communicable diseases along border areas. One such initiative was the Lubombo spatial development initiative (LSDI) for the control of malaria along the borders of South Africa, Swaziland and Mozambique.

A Mozambique/Zimbabwe/South Africa (MOZIZA) cross-border malaria initiative was also developed in July 2010. In December 2010, four HIV and AIDS cross-border initiatives were approved for implementation, with funding from the Global Fund. An amount of $455 000 (R3 444 350) was transferred to the SADC HIV and AIDS special fund for the year 2010/2011 to implement cross-border projects. This performance was consistent with the 2010/2011 target of facilitating two cross-border initiatives.

The department signed six agreements with development partners to leverage technical and financial assistance for the implementation of national health systems priorities such as the 10 Point Plan 2009-2014, and the NSDA 2010-2014. The 2010/2011 target was to sign seven agreements with international development partners. The following agreements were signed: the USAID Mega Assistance Agreement (September 2010); Memorandum of Understanding with Operation Smile South Africa (December 2010); PEPFAR/SA Partnership Framework; European Union (EU)/SA Financing Agreement; Belgium/NDOH Agreement and the Aid Effectiveness Framework for Health.

SUB-PROGRAMME: PHARMACEUTICAL AND RELATED PRODUCT REGULATION AND MANAGEMENT (MRA)

The sub-programme is responsible for registration of human and animal medicines on the basis of efficacy, safety and quality. It is also responsible for the approval and monitoring of clinical trials, post marketing surveillance and continuously assessing and ensuring the safety of all registered medicines. The unit is also responsible for licensing manufacturers, distributors and wholesalers on the basis of meeting good manufacturing practice, good distribution practice and good wholesaling practice. The unit has a law enforcement arm that monitors adherence to the Medicines and Related Substances Act and liaises closely with other law enforcement structures to ensure that medicines used in the country are safe. These officers also work closely with officials at ports of entry.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Improve the registration of medicines and implement a shorter time to market for medicine, by reducing the backlog on medicine registrations, build in house capacity, training and aggressive recruitment of evaluators, clinical trials management, and performing inspections	Registration timelines for NCE and generics	Registration timelines of 24 months for NCE and 18 months for generics achieved. Backlog of safety updates eliminated	Average time for registration of NCEs was 32 months and 30 months for generics. These timelines include up to 9/12 months of applicant's time to respond to committee resolutions. Hence actual average evaluation time by the authority is 23 months for NCEs and 21 months for generics. 1 473 (49%) of 2 981 safety update backlog was reviewed	8 months for NCEs 12 months for generics	Some applicants take up to 9/12 months to respond to committee resolutions Shortage of evaluators Delayed implementation of OSD at national level hampered recruitment of technical staff and retention efforts The moratorium on recruitment of personnel hampered plans for building in-house capacity

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Implementation of electronic document management system (EDMS) as an improved tracking system for medicine applications	EDMS live and fully operational	EDMS piloted and EDMS goes live	EDMS configured and ready	Pilot could not be completed due to move to Civitas Building and go-live therefore delayed	Move to Civitas Building resulted in problems with access to server where EDMS is to run from. Insufficient IT support
Establish the South African Pharmaceutical and Related Product Regulation and Management Authority (SAHPRA)	SAHPRA appointed by the minister	Legislation developed to support the establishment of SAHPRA	Draft legislation to support establishment of new authority has been developed and is at consultation stage. Authorisation for new fee structure has been approved. A high-level organisational structure has been developed Regulations for the regulation of CAMs are at a legal drafting stage in order to be gazetted for comment. Medical device regulations are at consultations stage	The variance in terms of finalising the legislation was caused by parliamentary processes which could not accommodate consequential amendments to the statute	The variance in terms of finalising the legislation was caused by parliamentary processes which could not accommodate consequential amendments to the statute

Overview of performance

For the financial year under review, the timeframes for the registration of new chemical entities (NCE) was, on average, 32 months and the time rames for generics was 30 months. The department aimed to eliminate the backlog of safety updates. By the end of 2010/2011, 49% (1 473) of 2 981 safety update backlogs had been reviewed. A backlog of 51% remained which will be cleared in the next planning cycle. The registration of medicines has improved significantly since the backlog project was initiated. The registration of ARVs has significantly increased from 22 in 2009/2010 to 101 in 2010/2011. Consequently South Africa was able to put together a competitive ARV tender which resulted in a price reduction of 53%. This price reduction, due to efficiency gains in the system, can be directly translated into tangible results as more patients will be put on ARVs.

With regard to clinical trials, the turnaround time for review of applications is eight weeks. The main areas of applications for clinical trials are: HIV, oncology, particularly bio-therapeutics and endocrinology on the main composed of clinical trials related to finding better ways to manage diabetes. Other areas less prominent than the above three are: psychiatry, neurology, cardiology and pulmonology (asthma and COPD). This is a promising trend as most of the clinical trials conducted in South Africa could provide a solution to some of the health problems the country is facing.

The electronic document management system (EDMS) was configured and prepared to go live. The target for 2010/2011 was to pilot and to go live with the EDMS.

In keeping with the target for 2010/2011, the legislation to support the establishment of the South African Pharmaceutical and Related Product Regulation and Management Authority (SAHPRA) was developed.

SUBPROGRAMME: FOOD CONTROL AND NON-MEDICAL HEALTH PRODUCT REGULATION

The food control sub-programme is tasked with ensuring food safety through the development and implementation of food control policies, regulations and norms and standards.

MEASURABLE OBJECTIVE	INDICATOR	TARGET (2010/2011)	ACTUAL PERFORMANCE (2010/2011)	VARIANCE	REASON FOR VARIANCE
Strengthening food control risk management measures related to development/ publication/implementation of relevant national legislation, based on international standards adopted by the FAO/ WHO Codex Alimentarius, where applicable	Nutrient profiling model available and implemented to evaluate health claims and non essential foodstuffs for listing in regulations	Nutrient profiling model available and tested for final implementation	• Report related to a situation analysis on nutrient profiling models made available by UNW and shared with WHO • Several meetings held with UNW and WHO to discuss way forward on the identified model	The model identified in the report of the NWU still needs to be adapted and tested before implementation can commence within the framework of the proposed new regulations related to health claims	Due to time as well as financial constraints within the 2010/2011 budget of the directorate, the development and implementation of the model in question have been delayed. It is envisaged that further progress will be made during 2011/2012
	Number of Codex related activities aimed at adoption of standards participated in and inclusion thereof in department's legislation	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation of the department	Participated in 11 Codex related activities and developed 3 sets of legislation based on Codex standards	One Codex event could not be attended and one set of legislation finalised and submitted to legal services for further processing in April 2011	Delays experienced regarding the filling of the vacancy of the post of the Assistant Director: Microbiology, which impacted on the performance of the directorate regarding this objective
	Final regulations on health claims published	Drafting of health claims/listing of non-essential foodstuffs regulations for publication for public comment	No progress made due to the delay regarding the implementation of the nutrient profiling model and the finalisation of the CAM regulations of Medicines Control Authority (MCA)	Not applicable	The finalisation of the nutrient profiling model and CAM regulations is a prerequisite to enable the directorate to give further attention to this objective

Overview of performance

The department planned to develop and implement a nutrient profiling model to evaluate health claims and non-essential foodstuffs for listing in regulations. During the reporting period, a situation analysis report on nutrient profiling models was produced by the University of the North West, and shared with the WHO. Delays occurred in the development and implementation of the model due to resource constraints.

Additional activities for 2010/2011 were the department's participation in 11 Codex-related activities and the developement three sets of legislation based on Codex standards. The target for 2010/2011 was to participate in 12 Codex-related activities and to develop and publish four sets of legislation.

Due to the delays in the development and implementation of a nutrient profiling model for South Africa, the proposed new regulations relating to health claims on labels of foodstuffs, as well as the listing of categories of foodstuffs with an unsatisfactory nutrient profile, were not developed.

Further progress will be made during the 2011/2012 planning cycle.

3. ANNUAL FINANCIAL STATEMENTS

ANNUAL FINANCIAL STATEMENTS FOR THE NATIONAL DEPARTMENT OF HEALTH - VOTE 15
For year ended 31 March 2011

CONTENTS

AUDIT COMMITTEE REPORT FOR THE FINANCIAL YEAR ENDED 31 MARCH 2011

NATIONAL DEPARTMENT OF HEALTH

REPORT OF THE AUDIT COMMITTEE

We are pleased to present our report in terms of the National Treasury Regulations and Guidelines, for the financial year of the National Department of Health ended 31 March 2011.

Composition of the committee

The committee is made up of the members the majority of whom are independent and financially literate. The members are:

Name of member	Designation	Date of appointment
Humphrey Buthelezi CA(SA)	Chairman, independent professional and member of the IoD	16 March 2011
Thandi Sihlaba	Risk management consultant and independent member	16 March 2011
Clement Mannya	Management consultant and independent member	16 March 2011
William Huma	Performance management expert, fellow of the IoD, advocate of the High Court of South Africa and independent member	16 March 2011
Obi Mabaso	Advocate of the High Court of South Africa and independent member	2 October 2006
Molemo Maliehe	Risk management consultant and independent member	2 October 2006
		Date of resignation
Mizeria Nyathi	Chairman until 9 March 2011, and independent director	9 March 2011
Vulani Malumbete	Legal and governance consultant and independent member	10 March 2011
Daphney Matloa	Chief financial officer, (WSETA) and independent member	11 March 2011

Attendance at meetings

The terms of reference require the committee to meet at least four times a year, as a minimum. For the year under review, the committee had two formal and three special meetings as indicated below:

Formal meetings

Name of member	Number of meetings attended
Humphrey Buthelezi CA(SA)	1/2
Thandi Sihlaba	1/2
Clement Mannya	1/2
William Huma	1/2
Obi Mabaso	2/2
Molemo Maliehe	2/2
Mizeria Nyathi	1/2
Vulani Malumbete	1/2
Daphney Matloa	1/2

Special meetings

Name of member	Number of meetings attended
Mizeria Nyathi	3/3
Obi Mabaso	2/3
Molemo Maliehe	3/3
Vulani Malumbete	2/3
Daphney Matloa	2/3

Responsibility of the Audit Committee

The Audit Committee operated in terms of the formal charter (terms of reference) which was approved by the Executive Authority. These terms of reference are in line with Section 38(1) (a) of the

Public Finance Management Act 1 of 1999 as amended by Act 29 of 1999 and the National Treasury Regulation 3.1. We further confirm that we carried out our duties in compliance with this charter though not for the full year as the committee was reconstituted on 16 March 2011.

The effectiveness of the internal control systems

The system of internal control applied by the NDoH over the financial affairs and risk management is effective but requires significant improvement to be efficient and reliable.

In line with the Public Finance Management Act (PFMA), the Internal Audit provides the Audit Committee and management with assurance that the internal controls are appropriate and effective. This is achieved by means of the risk management processes, as well as the identification of corrective actions and suggested enhancements to the controls and business processes. The committee did not review the internal audit reports for the year under review as it only assumed office on 16 March 2011. Both the interim and final management reports of the AGSA, it was noted that there were material deficiencies in the system of internal control. Accordingly, we report that the system of internal control over the financial reporting for the year under review was effective but requiring significant improvements.

Evaluation of the annual financial statements

We have:

- discussed and reviewed the audited annual financial statements together with the relevant accounting policies, to be included in the annual report, with the accounting officer and the Auditor-General South Africa
- reviewed the Auditor-General South Africa‘s management report and the related management responses thereto
- reviewed the department’s compliance with legal and regulatory provisions
- reviewed significant adjustments arising from the audit.

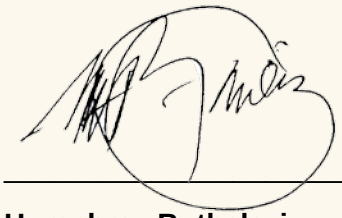
We concur and accept the Auditor-General South Africa’s qualified audit opinion on the annual financial statements for the year under review.

Internal audit function

We have assessed that the internal audit function is operating its risk based audit plan and has appropriately identified significant audit risks and related controls pertinent to the department for the following financial year.

Auditor General South Africa

We have met with the representatives of the Auditor General South Africa and confirm that they are independent of the department, have not provided any other non-audit services and there are no unresolved matters.



Humphrey Buthelezi
Chairman: Audit Committee
13 September 2011

REPORT BY THE ACCOUNTING OFFICER TO THE EXECUTIVE AUTHORITY AND PARLIAMENT OF THE REPUBLIC OF SOUTH AFRICA

FOR THE YEAR ENDED 31 MARCH 2011

Report by the Accounting Officer to the Executive Authority and Parliament of the Republic of South Africa.

1. General review of state of financial affairs

1.1 Strategic issues facing the department

(a) South Africa was faced with a quadruple burden of disease consisting of HIV & AIDS and TB; high maternal and child mortality; non-communicable diseases; and violence and injuries.

(b) The health sector developed an integrated response to these challenges, which is outlined in the Negotiated Service Delivery Agreement (NSDA) for 2010-2014. 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 presents four key outputs that the health sector must achieve namely

- Increasing life expectancy
- Decreasing maternal and child mortality rates
- Combating HIV and AIDS and Tuberculosis; and
- Strengthening health systems effectiveness.

(c) These outputs are consistent with government's outcome-based approach to improving service delivery; enhancing accountability to the public; and enhancing performance management.

(d) Health systems challenges included: sub-optimal quality of care; inadequate supply of human resource for health; inappropriate configuration of the organisational structures of health departments; lack of sound financial management; inadequate health infrastructure and inadequate health information systems.

(e) The key theme of government's work during 2010-2014 is doing things differently or business unusual. Consistent with this, health sector interventions during 2010/2011 were permeated with advocacy, social mobilisation and communication. Systems used in the health sector were also strengthened, including financial management systems; information systems; and human resource planning.

(f) Significant milestones were achieved through the strategic interventions implemented by the health sector, in partnerships with communities across the country. These are outlined in sections 1.2 and 1.3 below.

1.2 Significant events that have taken place during the year

(a) A massive HIV Counselling and Testing (HCT) campaign was launched by the President of South Africa in April 2010, which encouraged people to know their HIV status. This campaign also provided an opportunity to community members to be tested for tuberculosis (TB), and for chronic conditions such as diabetes and hypertension.

(b) By the end of 2010/2011, 11.4 million South Africans had responded to the President's call, by undergoing HIV counselling, with 9.7 million people agreeing to be tested for HIV.

(c) A massive immunisation campaign was also conducted, to protect South African children against vaccine preventable diseases. Children in the age groups 6-59 months and 60-179 months were targeted. All nine Provinces recorded a measles coverage of over 95% for the age group 6-59 months. Coverage for the slightly older age group (60-179 months) was lower, with only three of nine provinces achieving coverage of >95%.

(d) The National Consultative Health Forum (NCHF) was also convened, in line with the National Health Act of 2003. Participants from the NCHF included non-governmental organizations (NGOs); community-based organisations (CBOs); academic institutions; private health sector; traditional leaders; traditional healers; research organisations; statutory bodies; and other government departments.

(e) The overwhelmingly positive response of the people of South Africans to the HCT and immunisation campaigns, as well as the massive turn-out at the NCHF, demonstrated the effectiveness of the advocacy, social mobilisation and communication strategy.

(f) During 2010/2011, a new PHC model for the country was produced and endorsed by the National Health Council (NHC). The new PHC model places greater emphasis on both the individual and the family, and focuses on promotion and prevention, rehabilitative and referral services, rather than exclusively on curative services. It avoids fragmentation that results in multiple healthcare providers visiting families, and ensures that a single integrated team establishes relations with families in the catch-

ment area; and accentuates strong community participation as well as multi-sectoral collaboration.

(g) The department also addressed the issue of lack of accountability for meeting basic standards of good clinical care and health service management, by developing a set of uniform set of standards, which were approved by the NHC. The National Health Amendment Bill was gazetted on the 24 January 2011, to give effect to the core standards and to enforce them in the health system.

(h) A revised National Health Insurance (NHI) policy document was presented to the Inter-Ministerial Committee (IMC) on 8 February 2011. Additional technical work and revisions to the policy document were undertaken taking into account feedback from the IMC.

(i) Planning and preparatory work for the National Nursing Summit were completed during 2010/2011. The summit itself took place outside the financial year, in April 2011.

1.3 Major projects undertaken or completed during the year

(a) The department of health awarded a tender to the value of R4.2 billion over two years for the procurement of antiretroviral medicines. The usual procurement strategies were amended, which resulted in a saving of 53%. These resources will enhance access to antiretroviral treatment (ART) for more people living with HIV and AIDS, with the same resource envelope.

(b) Data from the National Health Laboratory Services (NHLS) reflects that the prevention of mother-to-child transmission of HIV (PMTCT) programme has begun yielding the desired results. Between 2008 - 2010, the volumes of PCR tests conducted increased in all nine provinces, whereas transmission rates declined significantly.

(c) The NDoH continued with the construction and rehabilitation of health facilities, to enhance patient experiences of healthcare delivery, and to improve health worker morale by providing a conducive working environment.

(d) Five tertiary hospitals designated to be improved through Public Private Partnership (PPP) were registered with the National Treasury PPP unit. These were:

- Nelson Mandela Academic in the Eastern Cape
- Chris Hani Baragwanath in Gauteng
- Dr. George Mukhari in Gauteng
- King Edward the VIII in KwaZulu-Natal
- Limpopo Academic Hospital in Limpopo.

(e) Management structures of the five flagship projects were established.

(f) Planning processes for other hospitals to be refurbished through the hospital revitalisation programme also continued during 2010/2011. These included Cecilia Makiwane hospital (EC); Madwaleni Hospital (EC); Trompsburg and Ladybrand Hospitals (FS); Free State Mental Health Hospital (FS); Dr. Pixley kaSeme (KZN); Edendale Hospital (KZN); Musina Hospital (LP); De Aar (NC); Bophelong Hospital (NW) and Valkenburg Hospital (WC).

(g) Following completion of the audit of public sector nursing colleges, a business plan for the revitalisation of nursing colleges was developed, in keeping with the 2010/2011 target.

(h) The occupation Specific Dispensation (OSD) was extended to other categories of health workers. The Public Health and Social Development Sector Bargaining Council (PHSDSBC) Resolution 2 of 2010, which makes way for the implementation of the OSD PHSDSBC Resolution for therapeutic, diagnostic and other allied health professionals, was signed on 5 November 2010. The NDoH conducted a 5% sampling in all nine provinces to ensure correct interpretation and application of the Resolution 2.

(i) A revised organisational structure of the NDoH was produced, and consultations conducted within the department. It was also submitted to the Department of Public Service and Administration (DPSA) for concurrence. The structure will be finalised during 2011.

(j) An audit of financial management practices in all nine provincial health departements was completed. The audit reflects a financial profile of each health department, including the major cost drivers. Implementation of remedial interventions also commenced, in partnership with the Technical Assistance Unit (TAU) of National Treasury. A special intervention project on the management of assets for both national and provincial departments was initiated. The national department will be a pilot site and

the project will be rolled out to three provinces, Eastern Cape; KwaZulu-Natal and Mpumalanga for technical intervention related to the asset registers and capacity building aspects, while all provinces will benefit from the review of policies and standard operating procedures for uniformity and standardization across the public sector. The project is funded by donor funds (DFID) and is expected to continue in the next financial year. The commencement of the project was unfortunately delayed.

1.4 Spending trends

Out of a total allocation for the year under review amounting to R21 661 512 billion, the department spent R20 918 579 billion which is 96.6% of the budget available. An amount of R742 933 million was under spent, resulting in a 3.4% under expenditure. The under expenditure is a slight increase compared to the previous financial year.

The economic classifications which under spent are mainly the compensation of employees (COE) which was influenced by delays in the long recruitment processes after the lifting of the moratorium late in the financial year as indicated under paragraph three of this report for capacity constraints., as well as the under expenditure in the goods and services (G&S) due to late commitments and deliveries, including challenges experienced related to the female condoms. Under expenditure is also realised under transfer payments significantly attributed to the withheld revitalization of hospitals grant for six provinces, amounting to R452 564 million. Capital expenditure was also under spent including delayed deliveries of medical and IT equipment.

Programme 1: Administration

The Administration programme conducts the overall management of the department. Activities include policy-making by the offices of the Minister, Deputy Minister and Director-General, and the provision of centralised support services, including strategic planning, legal, financial, communication, and human resource services to the department.

The programme shows an expenditure of 92.3% with an under expenditure of R21 862 million (8%) against a budget of R282 134 million.

The 8% under spending is under payment for capital assets ascribed to the delays related to finalisation of procurement procedures for the acquisition of IT equipment as well as delayed filling of critical posts after the lifting of the moratorium in October 2010. The commitments have since been made and a roll over of the funds has been requested.

Recruitment process is under way for the filling of critical posts and provision has been made in the next financial year for the funds.

Programme 2: Strategic Health Programmes

Strategic Health Programmes co-ordinates a range of strategic national health programmes by developing policies, systems, management, funding and monitoring of key programmes. Programmes include maternal, child and women's health and nutrition, administering the national HIV and AIDS/ STIs and TB programmes; and regulating the procurement of pharmaceutical supplies to ensure that essential drugs are affordable and available. Other programmes included here is medicines regulatory affairs, non-communicable diseases and communicable diseases.

The five sub-programmes are as follows:

- Maternal, Child and Women's Health
- HIV and AIDS and STIs
- Communicable Diseases
- TB Control and Management
- Non-Communicable Diseases.

The programme shows an expenditure amounting to 97.8% with an under expenditure of R160 721 million (2%) against a budget of R7 393 626 billion. The under expenditure is attributed to funds not transferred to Love Life NGO and other NGOs amounting to R44 654 million due to non compliance with the PFMA regulations. R 2 000 was not transferred to universities. Procurement processes for the female condoms posed a challenge which resulted in the under expenditure for the earmarked funds.

Programme 3: Health Planning and Monitoring

Health Planning and Monitoring supports the delivery of health services and the department as a whole. The five sub-programmes are as follows:

- Health Information Research and Evaluation
- Financial Planning and Health Economics
- Pharmaceutical Policy and Planning
- Office of Standards compliance
- Hospital Services

From a total allocation of R422 636 million, the programme has spent 92.6% of its allocated funds amounting to R391 347 million with an under expenditure of R31 289 million .

The reason for the under expenditure is attributed to the late commencement of the project for the audit of health facilities at all provinces in March 2011, due to a new approach of a comprehensive and integrated audit of all key areas at provincial level from a central point. The process is intended to be completed in March 2012 and the remaining funds for the project completion have been requested to be rolled over from Treasury. Under expenditure was also realized for delayed filling of critical posts.

Programme 4: Human Resource Management and Development

The main objective of the programme is to develop and assist provinces to implement a comprehensive long-term national human resource plan, which will ensure an equitable distribution of health human resource. The three sub-programmes are as follows:

- Human Resource Policy, Research and Planning
- Sector Labour Relations and Planning
- Human Resource Development and Management

The total allocation for the programme amounted to R1 897 551 billion. The programme shows an expenditure outcome of R1 883 283 million, which is 99.2%, with an under expenditure of R14 268 million (1%). The under expenditure is related to commitments made in March which will be paid in April for the next financial year as well as delays in the recruitment processes for critical posts.

Programme 5: Health Services

Health Service programme supports the delivery of health services, primarily in the provincial and local spheres of government. The four sub-programmes are as follows:

- District Health Services
- Environmental Health, Health Promotion and Nutrition
- Occupational Health
- Hospitals and Health Facilities Management

The programme has spent 95.8% of its R11 557 057 billion allocated funds amounting to R11 072 393 billion which resulted in an under expenditure of 4% amounting to R484 664 million. The under expenditure is mainly attributed to withheld hospital revitalisation conditional grant funds for the Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo and, Northern Cape, provinces due to delays caused by late contract/ tender awarding, termination of contracts, changes on

projects priority list and also failed to utilise projects commissioning budget as a result of uncompleted infrastructure. The budget that was surrendered to National Revenue Funds will be applied to cover committed activities that started to take off during the fourth quarter of the financial year. Since the hospital revitalisation grant should also cover planning and construction cost of the five PPP flagship projects, part of the roll over will be also requested to fund these projects.

Programme 6: International Relations, Health Trade and Health Product Regulation

This programme co-ordinates bi-lateral and multi-lateral international health relations, including donor support; and provides oversight over health trade and the development of health products.

The three sub-programmes are as follows:

- Multilateral Relations
- Food Control and Non-Medical Health Product Regulation
- Pharmaceutical and Related Product Regulation and Management

The programme has spent 72.2% of its R108 508 million allocated funds, amounting to R78 379 million with an under expenditure of R30 129 million (8%) attributed to outstanding accounts to be claimed from the Departement of International Relation and Co-operation. The projected expenditure for the programme was not realised as planned.

1.5 Virement

The following virements were affected during the financial year under review.

1.5.1 Goods and Services (R8 000 000)

The Director-General granted approval on 22 February 2011 that R6 million in the Cluster: HIV and AIDS and STIs be utilised to fund the Medical Research Council (Cluster: Health Information, Evaluation and Research) for commissioned studies on the research component of the Comprehensive HIV and AIDS Plan.

The Director-General further granted approval on 22 February 2011 that R2 million in the Cluster: HIV and AIDS and STIs be utilised to fund the Health Systems Trust (Cluster: Health Information, Evaluation and Research) to intensify support for the HIV Counselling and Testing and ART expansion campaigns within classified health facilities.

2. Services rendered by the department

2.1 Activities

The NDoH develops policies to regulate the public health sector to ensure that South Africa has a health service that meets international requirements and standards. The department also renders a laboratory service to the public through its forensic laboratories. The radiation control unit is responsible for inspections of radiation equipment ensuring that the industry complies with norms and standards.

2.2 Tariff policy

The majority of revenue collected by the NDoH is derived from applications for registration of medicines. The balance originates from laboratory tests which are being done by the forensic laboratories, which are under the control of the department. These fees are reviewed regularly and recover cost.

2.3 Free services

The department does not provide any free services.

2.4 Inventories

Reference must be made to note 5.5 in the annual financial statements for the inventory at hand at year end.

3. Capacity constraints

A moratorium which was put in place from the 2009/2010 financial year was lifted in October 2010

which leads the commencement of the recruitment process for the identified critical posts. The earmarked funds could not be fully utilised due to the long processes put in place including vetting, verification of qualifications and checks with the credit bureau before appointments are made. This resulted in the under expenditure indicated under the spending trends. The vacancy rate at year end based on funded posts was 33.2% at year end.

The Department is actively participating in the internship programme and through this it is envisaged that some of the vacancies will be filled by employing interns once they have successfully completed their programmes.

As at year end, and since the lifting of the moratorium, a total of 70 critical posts were advertised and are in the process of being filled.

4. Utilisation of donor funds

The NDoH is privileged to have partners from donor organisations. Foreign aid assistance received in cash during the year amounted to R232 466 million for various projects. These funds have been deposited in the RDP Fund and are drawn by the department to implement the projects. The expenditure amounted to R161 289 million. Donor funds are mainly sourced to areas where both the Health department and the donor agreed as an area of priority. Funds are being received from European Union for the public health sector support programme, Italy, for their support in the strengthening of the South African health system; Belgium, for TB and HIV and STI prevention; the Global Fund, for TB and AIDS and malaria prevention; CDC, for HIV and AIDS activities.
The HWSETA also donated R 1 536 million for the training of students at universities in health related fields. The full amount was expensed.

5. Trading entities and public entities

Medical Research Council

The South African Medical Research Council (MRC) was established in 1969 in terms of the South African Medical Research Council Act (1991). The objectives of the council are to promote the improvement of health and quality of life through research, development and technology transfer. Research is primarily conducted through council funded research units. Funding from the Department's vote amounts to R276 509 million in 2010/2011. The council's researchers have made significant contributions to the key priorities of the NDoH 10-Point Plan, via operational and applied research projects, by supporting programmes, or on an advisory level by serving on policy and technical teams. Examples include work on the NHI, quality and standards, the prevention of mother-to-child transmission, tuberculosis, HIV prevention, and surveillance systems. Researches burden of disease and undertakes national youth behaviour survey global youth tobacco survey and supports national demographic and health survey.

In November 2010, a new board was appointed and tasked with appointing a chief executive and assisting with the council's 2011–2015 strategic plan. The science, engineering, and technology institutes' 2010 review of the council, as well as input from its major stakeholders, will play a role in this process. The council's biggest challenge is to be able to play a pivotal role in supporting the country's national and provincial health departments in achieving their performance targets. The focus over the medium term will be on the four outcome areas of the national NDoH and alignment with the 10-Point Plan priorities.

National Health Laboratory Services

The National Health Laboratory Service (NHLS) was established in 2001 in terms of the National Health Laboratory Service Act (2000). The service supports the department by providing cost effective diagnostic laboratory services to all State clinics and hospitals. It also provides health science training and education, and research. It is recognised as the largest diagnostic pathology service in South Africa and services over 80% of the population, through a national network of approximately 265 laboratories. Its specialised divisions include the National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry and the Antivenom Unit. The service maintains strong partnerships with the NDoH and department of science and technology and education, as well as the Medical Research Council, the Council for Scientific and Industrial Research, health science faculties at universities and universities of technology across the country, provincial hospitals, clinics, local authorities and medical practitioners.

The NHLS's major source of funding will be the sale of analytical laboratory services to users such as provincial departments of health, but it continues to receive a transfer from the national department, which amounted to R124 909 million in 2010/2011 which included an amount of R47 million for the GeneXpect TB medical equipment for the improvement of the turn around time for TB tests.

Council for Medical Schemes

The Council for Medical Schemes (CMS) is the national medical schemes' regulatory authority established in terms of the Medical Schemes Act (1998). The council's vision for the medical scheme industry is that it is effectively regulated to protect the interests of members and promote fair and equitable access to private health financing. The CMS has made significant progress in delivering on its responsibility of protecting the interests of beneficiaries of medical schemes and of the public as a whole. Since 2007/2008, the council has progressed in the reshaping of the regulatory environment

to strengthen the governance of medical schemes, improve the transparency of benefits offered to members and complete the envisaged system of risk equalisation funds.

The council has further been mandated to contribute to the development of the NHI process. It also worked closely with the department in drafting the Medical Schemes Amendment Bill, which sought to introduce a risk equalisation fund, made consequential changes to the benefit designs of medical schemes, introduced provisions to strengthen governance, and laid the platform for the introduction of low income benefit options. The drafting of the Bill began on 29 June 2007 and was published in the Government Gazette on 2 June 2008. The draft Bill was put on Parliament's list but was never processed. In November 2007, the initiation of a process to review the prescribed minimum benefits with the department was approved. Amendments to the regulations are now with external lawyers for review. The council has received unqualified audit reports from the auditor general for the last five years. The council has also aligned its strategic objectives with the current health reforms. Over the medium term, the council aims to improve access to healthcare and governance of schemes, and take on projects that assist in the implementation of the NHI. Specific projects with regard to NHI have been allocated to the council. During 2010/2011 the department did not transfer funds to the council.

South African National Aids Council Trust (SANACT)

During the period under review the SANACT was dormant. SANAC itself operates as planned with its activities funded by the HIV and AIDS Cluster within the department. The total expenditure incurred for SANAC within the department amounts to R12 430 million. It is anticipated that the SANACT will be inactive for the 2010/2011 financial year.

Trading Entity

Mines and Works Compensation Fund

The Compensation Commissioner for Occupational Diseases (CCOD) is responsible for the payment of benefits to miners and ex-miners who have been certified to be suffering from lung-related diseases because of working conditions. The Mines and Works Compensation Fund derives funding from levies (Mine Account, Works Account, Research Account, and State Account) collected from controlled mines and works, as well as appropriations from Parliament. Payments to beneficiaries are made in terms of the Occupational Diseases in Mines and Works Act 78 of 1973.

The CCOD prepares and produces a separate annual financial statement and an annual report due its status as a trading entity. The expenditure incurred by the Department for the CCOD for the administrative functions amount to R2 620 million.

6. Organisations to whom transfer payments have been made

Ninety-two percent (92%) of the budget of the NDoH consists of transfer payments to third parties. These can be classified as follows –

Conditional grants - These grants transfer the major conditional grants to provinces to fund specific functions as follows –

National tertiary services grant	– R 7 398 billion
Health professions training and development Grant	– R 1 865 billion
Hospital revitalisation	– R 4 021 billion

Comprehensive HIV and AIDS plan	– R 6 012 billion
Forensic pathology services	– R 557 million

These funds flow to provincial health departments from where spending takes place on items as contained in a pre-approved business plan by both provincial and national accounting officers. More details of the transfers per province are contained in the disclosure notes and annexure of the financial statements.

There are no transfers of conditional grants by the NDoH to municipalities and the department can certify that all conditional grant funding, which was transferred, was in fact transferred into the primary bank account of the province concerned.

In terms of the Division of Revenue Act (DoRA) and the relevant framework, the performance of provinces was monitored by the department through periodic prescribed reports submitted by provinces and as well as provincial visits for verification, support and intervention purposes as well as ensuring that transferred funds are utilised for intended purposes.

Where non-compliance occurred in terms of the Act it was rectified by means of discussion and in some cases delaying transfers.

Funds were withheld for one grant viz; hospital revitalization in consultation with the affected provinces as indicated under spending trends.

Public Entities – Transfers are made to the public entities under the auspices of the NDoH and have been listed earlier in the report.

Non-Governmental organisations (NGO's) – NGO's range from national NGO's who are delivering services in the field of health and cover diverse institutions from LoveLife to Soul City to a range of smaller NGO's who are active in the field of HIV and AIDS. More details of the institutes funded can be found in ***Annexure 1 G*** of the annual financial statements. During the year under review, there were delays in transfers to some NGOs due to a process of ensuring re-alignment with the departmental priority areas and the HTC.

7. Public Private Partnerships (PPP)

A PPP agreement was concluded on 30 May 2003 and the partnership has been valid from 1 April 2003. This PPP aims to revive human vaccines manufacturing in South Africa.

In terms of the agreements entered into in 2003, the South African Government through the NDoH holds 40% shares in The Biovac Institute Pty Ltd (Biovac) whilst the Biovac Consortium holds 60%. In exchange for the 40% equity the NDoH transferred the staff and assets of the directorate, which housed the State Vaccine Institute to The Biovac Institute.

The department foresees no significant future cash flow to the PPP entity.

Part of the PPP agreement allows The Biovac Institute to source and supply all EPI vaccines of good quality at globally competitive prices to the provincial health departments.

Both The Biovac Consortium and the DoH were requested to dilute their equity in order to allow Cape Biotech (part of Department of Science and Technology) to take up a 12,5% equity stake. Cape Biotech has invested in excess of R35 million into The Biovac Institute. This dilution has been approved by Treasury and implemented in 2010.

The transfers into the PPP was estimated to have a value of R13.5 million and a valuation done on the December 2010 annual financial statement on the net assets value method placed a value of R26.1 million on the NDoH stake in the PPP.

In 2009 a review of the PPP was initiated by DoH and Treasury. The review process was concluded

in 2010 and an extension of the supply agreement was given to the PPP for further period to December 2016 in order to allow the PPP to meet its obligations/undertakings.

8. Corporate governance arrangements

The department has an active risk management unit which is currently in the Internal Audit Directorate for assistance with the establishment and sustainability. Risk assessment was conducted during the year under review and a departmental risk profile has been developed. The risk assessment is conducted annually and the risk register is updated accordingly.

The department has a risk policy which includes a fraud Pprevention plan. Fraud awareness campaigns are conducted through a series of workshops with units in the department to institutionalise risk management and to instil a fraud prevention culture.

The department has a fully functional internal audit unit which co-ordinates its efforts with other assurance providers. The unit performs audits in terms of its approved audit plan and reports functionally to the Audit Committee and administratively to the accounting officer.

An internal review is underway to ensure that the unit is capacitate appropriately.

The Audit Committee could not operate in accordance with its plan during the year under review due to resignations of three of its members in February 2011. A new committee was appointed to continue the Audit Committee functions in March 2011.

9. Discontinued activities / activities to be discontinued

No activities were discontinued during the year under review.

10. New / proposed activities

The department is undergoing a restructuring process to ensure alignment with the priorities and the NSDA. A new budget structure will be operational in the next financial year.

11. Asset management

- **Asset management reforms**

The department has progressed substantially in completing its asset management implementation plan. A physical stock take of all assets was conducted (twice for those buildings that were relocated to Civitas Building) during the year under review and an asset register is available for audit purposes.

12. Events after the reporting date

None.

13. Performance information

To enhance the quality of performance information, and create uniformity in the implementation of the District Health Information System (DHIS), which is the routine information system of the health sector, the NDoH produced a national policy and standard operating procedures (SOPs) for the DHIS. This was processed through the National Health Information Systems Committee (NHISSA). During 2011/2012, the DHIS policy will be tabled before the Technical Advisory Committee of the

NHC and implemented across the health sector.

Two data clean up workshops were conducted in April and May 2011, with senior officials from provincial departments responsible for health information systems. The objectives of these workshops were to improve alignment between DHIS data at the disposal of the NDoH and data available at Provincial DoH level. It is anticipation that consistent data will be reported in the 2010/2011 Annual Reports of the National and the nine provincial departments.

The department also produced an updated *Framework for the development, quarterly monitoring of the Annual Performance Plans and the Operational Plans of the National Department of Health (DoH),* to replace an earlier framework developed in 2007, and to address the policy gaps identified by the Auditor-General of South Africa (AGSA). Following their review of systems for collection and collation of performance information conducted during 2010/2011, the AGSA produced a *Dashboard Report on the Drivers of Internal Control.* The AGSA reported that the NDoH was making progress towards the provision of leadership required to enhance the reliability of reported performance information.

The identified progress was specific to three objectives namely:

- Providing effective leadership based on a culture of honesty, ethical business practices and good governance, protecting and enhancing the best interests of the entity.
- Exercising oversight responsibility regarding financial and performance reporting and compliance and related internal controls.
- Implementing effective HR management to ensure that adequate and sufficiently skilled resources are in place and that performance is monitored.

The AGSA also identified challenges in several areas including:

- Lack of established and communicated policies and procedures to enable and support understanding and execution of internal control objectives, processes, and responsibilities.
- Lack of proper record keeping in a timely manner to ensure that complete, relevant and accurate information is accessible and available to support performance reporting.
- Lack of an implementation plan to address internal control deficiencies.
- Lack of an IT governance framework that supports and enables the business, delivers value and improves performance.
- Lack of regular, accurate and complete financial and performance reports that are supported and evidenced by reliable information.
- Lack of formal controls over IT systems to ensure the reliability of the systems and the availability, accuracy and protection of information.

The updated *Framework for the development, quarterly monitoring of the Annual Performance Plans and the Operational Plans of the National Department of Health (DoH)* is a comprehensive approach

to address the issues highlighted in above.

Monitoring and evaluation of progress with the implementation of the health sector's NSDA 2010-2014, has been constrained by the lack of availability of good quality and reliable data to track progress towards improving life expectancy has been a key impediment. To address this, in October 2010 the department established a Health Data Advisory and Co-ordination Committee, which will improve the quality and integrity of data on health indicators. This committee consists of researchers from diverse academic and research institutions, statisticians and demographers. The committee has three sub-committees focusing on improving data quality for: (i) Life expectancy; child mortality and maternal mortality; (ii) HIV and AIDS and TB, and (iii) health systems.

During 2010/2011, the Department also continued to implement the quarterly reporting system (QRS) introduced in 2003/2004 for monitoring the implementation of the annual performance plans (APPs) of the national and provincial departments. This system also serves to identify areas where support is required and to provide timeously by national and provincial departments of health and thus provide support to NDoH clusters and provincial departments of health where this is required.

For the financial year 2010/2011, all nine provinces (100%) submitted all four quarterly progress reports on the implementation of their APPs, as required. The submission rate of clusters at the National NDoH hovered close to 100% during 2010/2011. Data completeness and quality have also improved significantly over the years, although there are still a few challenges.

During 2010/2011, the NDoH continued to analyse the data in the quarterly progress reports submitted, and compiled summary reports at the end of each quarter, reflecting both areas of good progress with the implementation of both national and provincial plans, as well as areas needing intervention.

The summary reports of progress with the implementation of the APPs of the national and provincial departments for 2010/2011-2012/2013 during all four quarters of 2010/2011, are available from the NDoH.

14. SCOPA resolutions

There was no appearance for the 2009/10 financial year at the SCOPA. Prior year resolutions have been dealt with.

15. Prior modifications to audit reports

Nature of qualification: Qualified	Financial year in which it first arose	Progress made in clearing the matter
Departmental revenue. Related to revenue from the Medical Control Council (MCC)	2008/2009	Audit findings and recommendations addressed
Goods and services related to travel and subsistence	2008/2009	Audit findings and recommendations addressed

16. Exemptions and deviations received from the National Treasury

None.

17. Other

The investigation regarding the fraudulent transfer of an amount of R5.2 million in August 2009 is still underway. A report has been received from the National Intelligence Authority. The matter is still being investigated by both the South African Police Services (SAPS) and the National Treasury.

18. Acknowledgements

I wish to express my appreciation to the Minister of Health as well as all members of staff for their hard work, loyalty and commitment in pursuing the objectives of the NDoH.

19. Approval

The Annual Financial Statements set out on pages 148 to 231 have been approved by the Accounting Officer.

_____

Ms MP Matsoso
Director-General:Health
Date: 31 May 2011

REPORT OF THE AUDITOR-GENERAL TO PARLIAMENT ON VOTE NO. 15: NATIONAL DEPARTMENT OF HEALTH FOR THE YEAR ENDED 31 MARCH 2011

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the accompanying financial statements of the National Department of Health, which comprise the appropriation statement, the statement of financial position as at 31 March 2011, the statement of financial performance, statement of changes in net assets and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory information, as set out on pages 148 to 214.

Accounting officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation of these financial statements in accordance with the *Departmental Financial Reporting Framework* prescribed by the National Treasury, as set out in accounting policy note 1.1 and in the manner required by the Public Finance Management Act of South Africa (PFMA), and for such internal control as management determines necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-General's responsibility

3. As required by section 188 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996) and section 4 of the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), my responsibility is to express an opinion on these financial statements based on my audit.

4. I conducted my audit in accordance with International Standards on Auditing and *General Notice 1111 of 2010* issued in *Government Gazette 33872 of 15 December 2010*. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance that the financial statements are free from material misstatement.

5. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

6. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my qualified audit opinion.

Basis for qualified opinion

Movable tangible capital assets

7. Movable tangible capital assets are disclosed in note 29 to the financial statements at an amount of R130 111 000 and minor assets are disclosed in note 29.4 to the financial statements at an amount of R34 402 000. The asset register used to account for assets was not properly maintained during the year under review. A process was undertaken during July 2011 to bar-code all assets and confirm the physical verification thereof. Due to the significance of inadequate reconciliations between the physical asset count and the asset register, I was unable to get adequate audit assurance relating to the valuation and allocation of assets as disclosed in the disclosure notes. There were no satisfactory alternative procedures that could be performed.

Qualified Opinion

8. In my opinion, except for the effect of the matter described in the Basis for qualified opinion paragraph, the financial statements present fairly, in all material respects, the financial position of the National Department of Health as at 31 March 2011 and its financial performance and cash flows for the year then ended, in accordance with the *Departmental Financial Reporting Framework* prescribed by the National Treasury and the requirements of the PFMA.

Emphasis of matters

9. I draw attention to the matters below. My opinion is not modified in respect of these matters.

Restatement of comparative figures

10. As disclosed in note 21 to the financial statements, the comparative figures for operating lease expenditure for buildings and other fixed structures for the year ended 31 March 2010 have been restated with an amount of R146 683 000 as a result of no lease commitment provision made in the previous year. This was corrected in the 2010-11 financial year in the financial statements of the National Department of Health.

Irregular expenditure

11. As disclosed in note 23 to the financial statements, irregular expenditure to the amount of R43 274 000 (2010: R13 639 000) was incurred, as proper supply chain management processes were not followed.

Additional matters

12. I draw attention to the matters below. My opinion is not modified in respect of these matters.

Unaudited supplementary schedules

13. The supplementary information set out in annexures 1A to 5 does not form part of the financial statements and is presented as additional information. I have not audited these annexures and, accordingly, I do not express an opinion thereon.

Financial reporting framework

14. The financial reporting framework prescribed by the National Treasury and applied by the department is a compliance framework. Thus my opinion would have reflected that the financial statements had been properly prepared instead of fairly presented as required by section 20(2)(a) of the PAA, which requires me to express an opinion of the fair presentation of the financial statements of the department.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

15. In accordance with the PAA and in terms of *General notice 1111 of 2010*, issued in *Government Gazette 33872 of 15 December 2010,* I include below my findings on the annual performance report as set out on pages 27 to 114 and material non-compliance with laws and regulations applicable to the National Department of Health.

Predetermined objectives

Reliability of information

16. The reported performance information was deficient in respect of the following criteria:

- **Validity:** The reported performance was not supported by sufficient appropriate audit evidence.
- **Accuracy:** The amounts, numbers and other data relating to reported actual performance have not been recorded and reported appropriately.
- **Completeness:** All actual results and events that should have been recorded have not been included in the reported performance information.

17. With respect to the reliability of reported information, the following material programmes were selected for audit purposes, and the reliability of the reported information was tested on a sam-

ple basis at the National Department and at 20 health facilities:

- Programme 2 – Strategic Health Programmes
- Programme 5 – Health Services

18. The following audit findings relate to the above:

The validity and accuracy of reported performance against indicators could not be confirmed as inadequate supporting source information was provided

19. For 22 of the selected 27 indicators of programme 2, the validity and accuracy of the reported indicators could not be established as sufficient appropriate audit evidence could not be provided.

20. For nine of the selected 22 indicators of programme 5, the validity and accuracy of the reported indicators could not be established as sufficient appropriate audit evidence could not be provided.

Reported performance against targets is not complete

21. In the case of 35 % of the 20 health facilities selected for audit purposes, health data as contained in the patient files was not recorded in the applicable register and on the monthly input form. Reported actual performance against pre-determined objectives, as contained in the annual report, was therefore not complete.

Compliance with laws and regulations

Service delivery reporting

22. The department did not have and maintain an effective, efficient and transparent system of internal control regarding performance management, which described and represented how the department's processes of performance monitoring, measurement, review and reporting were conducted, organised and managed, as required by section 38(1**)**(a)(i) and (b) of the PFMA. A process commenced after the financial year-end to develop, approve and implement a system policy and procedure framework.

Annual financial statements

23. The accounting officer submitted financial statements for auditing that were not prepared in all material aspects in accordance with the *Departmental Financial Reporting Framework* prescribed by the National Treasury (and supported by full and proper records) as required by section 40(1)((a) and) (b) of the PFMA. Certain material misstatements identified by the AGSA with regard to disclosure notes in respect of contingent liabilities, commitments and lease commitments were subsequently corrected.

Audit Committee

24. The audit committee did not function as per the requirements of Treasury Regulation 3.1 in that it did not review the activities of the internal audit function, including its internal audit reports, the

reports of significant investigations and the responses of management to specific recommendations. Three members of audit committee resigned in February 2011. A new audit committee was constituted in March 2011.

Procurement and contract management

25. In certain instances, goods and services with a transaction value of between R10 000 and R500 000 were procured without inviting at least three written price quotations from prospective suppliers as per the requirements of TR 16A6.1 and National Treasury Practice Note 8 of 2007-08.

26. In certain instances, goods and services with a transaction value of over R500 000 were not procured by means of a competitive bidding process as per the requirements of TR 16A6.1 and TR 16A6.4 and National Treasury Practice Notes 6 and 8 of 2007-08.

27. Awards were made to suppliers who did not declare their employment by the state as per the requirements of Practice Note 7 of 2009-10.

28. Certain employees performed remunerative work outside their employment in the department without written permission from the relevant authority as per the requirements of section 30 of the Public Service Act.

29. The accounting officer did not always take effective and appropriate steps to prevent and detect irregular expenditure as per the requirements of section 38(1)(c)(ii) of the PFMA and TR 9.1.1.

Human resource management

30. The department is currently in the process of reviewing and implementing a revised organisational structure. The human resource plan was not yet approved as required by Public Service Regulations.

Asset management

31. The accounting officer did not implement adequate control systems for the safeguarding and maintenance of assets to prevent theft, losses, wastage and misuse, as required by Treasury Regulation 10.1.

Conditional grants

32. The transferring national officer did not adequately monitor expenditure and non-financial performance information on programmes funded by the allocation, as per the requirements of section 9(1)(b)(i) of the Division of Revenue Act (DoRA).

INTERNAL CONTROL

33. In accordance with the PAA and in terms of *General notice 1111 of 2010*, issued in *Government Gazette 33872 of 15 December 2010,* I considered internal control relevant to my audit, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters reported below are limited to the significant deficiencies that resulted in the basis for qualified opinion, the findings on the annual performance report and the findings on compliance with laws and regulations included in this report.

- Leadership
    - The accounting officer commenced late in the financial year with a process to ensure that an appropriately documented and approved policy and procedure framework would be developed and implemented for predetermined objectives.

- Financial and performance management
    - Management did not adequately review the disclosure notes to the financial statements provided for audit, resulting in material misstatements therein.
    - Numerous misstatements were identified with regard to the validity, accuracy and completeness of performance information as a result of health information being collated from different sources, from different locations and an inadequate review process during the finalisation of the performance information.
    - Inadequate controls have been implemented to review the accuracy of the asset register. Monthly test counts have not been performed to ensure that assets have been properly accounted for.

INVESTIGATIONS

34. Investigations in progress:

- The department is investigating allegations of financial misconduct by an official who travelled internationally without ministerial approval.
- The department is also investigating allegations of fraud in the supply chain management environment as follows:
    - Allegations of fraudulent transactions amounting to R845 196 involving the department's travel agency
    - Allegations of fraud in the procurement of health promotions materials to the amount of R82 000
- The National Treasury was requested on 9 July 2010 by the NDoH to perform a forensic audit on fraudulent payments that were made on the Basic Accounting System during the 2009-10 financial year
- An investigation into tenders which were approved without sufficient funding being available in prior financial periods, is in progress.

OTHER REPORTS

Performance audits

35. A performance audit was conducted during the year under review on the department's use of consultants. The draft management report was issued on 21 April 2011. The audit is currently in progress.

36. A follow up audit was performed on the NDoH Forensic Chemistry Laboratories. The management report was issued on 5 November 2010. The audit has been finalised and management is addressing the findings raised.

Donor Funding

37. An audit was performed on the donor funds received by the department in respect of the Global Funds Grant: Strengthening National and Provincial Capacity for Prevention, Treatment, Care and Support Related to HIV and Tuberculosis for the year ended 31 March 2010. An unqualified audit report was issued on 10 December 2010.

38. An audit was performed on the donor funds received by the department in respect of the Global Funds Grant: Expanding Services and Strengthening Systems for the Implementation of the Comprehensive Plan for HIV and AIDS in South Africa for the year ended 31 March 2010. An unqualified audit report was issued on 10 December 2010.

Auditor - General

Pretoria

14 September 2011

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

Appropriation per programme									
	2010/11							2009/10	
APPROPRIATION STATEMENT	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1. ADMINISTRATION									
Current payment	263 977	(187)	-	263 790	254 535	9 255	96,5%	266 176	265 594
Transfers and subsidies	370	187	-	557	551	6	98,9%	364	362
Payment for capital assets	17 787	-	-	17 787	5 179	12 608	29,1%	8 121	3 959
Payment for financial assets	-	-	-	-	7	(7)		-	8
	282 134	**-**	**-**	**282 134**	**260 272**	**21 862**		**274 661**	**269 923**
2. STRATEGIC HEALTH PROGRAMMES									
Current payment	508 047	(50 210)	(8 000)	449 837	345 722	104 115	76,9%	557 937	542 235
Transfers and subsidies	6 877 256	50 210	-	6 927 466	6 881 027	46 439	99,3%	5 209 749	5 206 430
Payment for capital assets	16 323	-	-	16 323	5 895	10 428	36,1%	8 779	3 527
Payment for financial assets	-	-	-	-	261	(261)		-	7
	7 401 626	**-**	**(8 000)**	**7 393 626**	**7 232 905**	**160 721**		**5 776 465**	**5 752 199**
3. HEALTH PLANNING AND MONITORING									
Current payment	130 527	(4 626)	-	125 901	100 665	25 236	80,0%	117 645	111 727
Transfers and subsidies	277 839	4 626	8 000	290 465	286 056	4 409	98,5%	288 355	288 352
Payment for capital assets	6 270	-	-	6 270	4 548	1 722	72,5%	8 201	3 185
Payment for financial assets	-	-	-	-	78	(78)		-	-
	414 636	**-**	**8 000**	**422 636**	**391 347**	**31 289**		**414 201**	**403 264**

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

Appropriation per programme									
	2010/11							2009/10	
APPROPRIATION STATEMENT	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4. HUMAN RESOURCES MANAGEMENT AND DEVELOPMENT									
Current payment	31 637	-	-	31 637	17 740	13 897	56,1%	40 730	33 904
Transfers and subsidies	1 865 387	-	-	1 865 387	1 865 387	-	100.00%	1 759 898	1 759 897
Payment for capital assets	527	-	-	527	119	408	22,6%	710	189
Payment for financial assets	-	-	-	-	37	(37)		-	-
	1 897 551	**-**	**-**	**1 897 551**	**1 883 283**	**14 268**		**1 801 338**	**1 793 990**
5. HEALTH SERVICES									
Current payment	131 403	(31)	-	131 372	101 508	29 864	77,3%	80 988	61 522
Transfers and subsidies	11 422 419	31	-	11 422 450	10 969 103	453 347	96,0%	9 989 700	9 608 131
Payment for capital assets	3 235	-	-	3 235	1 742	1 493	53,8 %	3 059	1 693
Payment for financial assets	-	-	-	-	40	(40)		-	13
	11 557 057	**-**	**-**	**11 557 057**	**11 072 393**	**484 664**		**10 073 747**	**9 671 359**
6. INTERNATIONAL RELATIONS, HEALTH TRADE AND HEALTH PRODUCT REGULATION									
Current payment	107 732	(92)	-	107 640	77 838	29 802	72,3%	81 907	74 712
Transfers and subsidies	-	92	-	92	99	(7)	107,6 %	269	268
Payment for capital assets	776	-	-	776	299	477	38,5%	871	493
Payment for financial assets	-	-	-	-	143	(143)		-	2
	108 508	**-**	**-**	**108 508**	**78 379**	**30 129**		**83 047**	**75 475**
TOTAL	**21 661 512**	**-**	**-**	**21 661 512**	**20 918 579**	**742 933**	**96,6%**	**18 423 459**	**17 966 210**

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

	2010/11			2009/10	
	Final Appropriation	**Actual Expenditure**		**Final Appropriation**	**Actual Expenditure**
TOTAL (brought forward)	21 661 512	20 918 579		**18 423 459**	17 966 210
Reconciliation with statement of financial performance					
ADD					
Departmental receipts	27 248			45 190	
Aid assistance	234 002			375 957	
Actual amounts per statement of financial performance (total revenue)	**21 922 762**			18 844 606	
ADD					
Aid assistance		163 217			323 249
Actual amounts per statement of financial performance (total expenditure)		21 081 796			18 289 459

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

Appropriation per economic classification									
	2010/11							2009/10	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Compensation of employees	384 404	-	-	384 404	353 654	30 750	92,0%	333 682	333 023
Goods and services	788 919	(55 146)	(8 000)	725 773	544 355	181 418	75,0%	811 701	756 671
Transfers and subsidies									
Provinces and municipalities	19 892 773	-	-	19 892 773	19 440 209	452 564	97,7%	16 702 499	16 321 348
Departmental agencies and accounts	355 616	51 800	6 000	413 416	409 008	4 408	98,9%	335 850	335 850
Universities and technikons	1 060	2 940	-	4 000	2 000	2 000	50,0%	1 000	500
Public corporations and private enterprises	-	-	-	-	-	-		38	37
Non-profit institutions	193 822	-	2 000	195 822	150 386	45 436	76,8%	206 015	202 781
Households	-	406	-	406	619	(213)	152,5%	933	923
Gifts and Donations	-	-	-	-	-	-		2 000	2 001
Payments for capital assets									
Machinery and equipment	44 918	-	-	44 918	17 576	27 342	39,1%	28 594	11 730
Software and other intangible assets	-	-	-	-	206	(206)		1 147	1 316
Payments for financial assets	-	-	-	-	566	(566)		-	30
Total	**21 661 512**	**-**	**-**	**21 661 512**	**20 918 579**	**742 933**	**96,6%**	**18 423 459**	**17 966 210**

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

DETAIL PER PROGRAMME 1 - ADMINISTRATION

Detail per sub-programme	2010/11 Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	2009/10 Final Appropriation	2009/10 Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1.1 MINISTER									
Current payment	1 816	-	-	1 816	1 811	5	99,7%	1 059	1 056
1.2 DEPUTY MINISTER									
Current payment	1 496	-	-	1 496	698	798	46,7%	847	842
1.3 MANAGEMENT									
Current payment	28 633	(2 584)	-	26 049	23 387	2 662	89,8%	21 115	21 086
Payment for capital assets	315	-	-	315	150	165	47,6%	427	167
Payment for financial assets	-	-	-	-	1	(1)		-	1
1.4 CORPORATE SERVICES									
Current payment	180 471	(1 287)	-	179 184	173 394	5 790	96,8%	196 689	196 188
Transfers and subsidies	370	187	-	557	551	6	98,9%	364	362
Payment for capital assets	17 472	-	-	17 472	5 029	12 443	28,8%	7 694	3 792
Payment for financial assets	-	-	-	-	6	(6)		-	7
1.5 OFFICE ACCOMMODATION									
Current payment	51 561	3 684	-	55 245	55 245	-	100,0%	46 466	46 422
Total	**282 134**	**-**	**-**	**282 134**	**260 272**	**21 862**	**92,3%**	**274 661**	**269 923**

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

DETAIL PER PROGRAMME 1 - ADMINISTRATION

	2010/11							2009/10	
Programme 1 per Economic classification	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appro-priation	Actual expendi-ture
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Compensation of employees	114 409	-	-	114 409	105 880	8 529	92,5%	100 493	100 473
Goods and services	149 568	(187)	-	149 381	148 655	726	99,5%	165 683	165 121
Transfers and subsidies to:									
Departmental agencies and accounts	370	-	-	370	370	-	100%	300	300
Public corporations and private enterprises	-	-	-	-	-	-		38	37
Households	-	187	-	187	181	6	96,8%	26	25
Payment for capital assets									
Machinery and equipment	17 787	-	-	17 787	5 076	12 711	28,5%	8 059	3 830
Software and other intangible assets	-	-	-	-	103	(103)		62	129
Payment for financial assets	-	-	-	-	7	(7)		-	8
Total	**282 134**	**-**	**-**	**282 134**	**260 272**	**21 862**	**92,3%**	**274 661**	**269 923**

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

DETAIL PER PROGRAMME 2– STRATEGIC HEALTH PROGRAMMES

	2010/11							2009/10	
Detail per sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
2.1 MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION									
Current payment	56 315	(21)	-	56 294	51 148	5 146	90,9%	54 576	54 562
Transfers and subsidies	1 149	21	-	1 170	21	1 149	1,8%	1 084	636
Payment for capital assets	443	-	-	443	67	376	15,1%	421	230
2.2 HIV AND AIDS AND STI's									
Current payment	349 709	(47 972)	(8 000)	293 737	219 962	73 775	74,9%	286 812	280 540
Transfers and subsidies	6 236 191	2 972	-	6 239 163	6 195 107	44 056	99,3%	4 573 183	4 570 450
Payment for capital assets	3 400	-	-	3 400	682	2 718	20,1%	1 208	658
Payment for financial assets	-	-	-	-	187	(187)		-	6
2.3 COMMUNICABLE DISEASES									
Current payment	16 571	-	-	16 571	13 779	2 792	83,2%	158 568	153 981
Transfers and subsidies	40 663	-	-	40 663	40 663	-	100,0%	50 000	50 000
Payment for capital assets	412	(11)	-	401	205	196	51,1%	390	190

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

DETAIL PER PROGRAMME 2– STRATEGIC HEALTH PROGRAMMES

	2010/11							2009/10	
Detail per sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Payment for financial assets								-	1
2.4 NON-COMMUNICABLE DISEASES									
Current payment	58 074	(17)	-	58 057	47 831	10 226	82,4%	44 144	42 533
Transfers and subsidies	595 368	47 217	-	642 585	642 584	1	100.0%	579 817	579 679
Payment for capital assets	11 910	-	-	11 910	4 773	7 137	40,1%	6 611	2 355
Payment for financial assets	-	-	-	-	74	(74)		-	-
2.5 TB CONTROL AND MANAGEMENT									
Current payment	27 378	(2 200)	-	25 178	13 002	12 176	51,6%	13 837	10 619
Transfers and subsidies	3 885	-	-	3 885	2 652	1 233	68,3%	5 665	5 665
Payment for capital assets	158	11	-	169	168	1	99,4%	149	94
Total	**7 401 626**	**-**	**(8 000)**	**7 393 626**	**7 232 905**	**160 721**	**97,8%**	**5 776 465**	**5 752 199**

NATIONAL DEPARTMENT OF HEALTH
VOTE 15

APPROPRIATION STATEMENT
for the year ended 31 March 2011

DETAIL PER PROGRAMME 2– STRATEGIC HEALTH PROGRAMMES

	2010/11							2009/10	
Programme 2 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	90 583	-	-	90 583	86 801	3 782	95,8%	79 262	78 721
Goods and services	417 464	(50 210)	(8 000)	359 254	258 921	100 333	72,1%	478 675	463 514
Transfers and subsidies to:									
Provinces and municipalities	6 608 719	-	-	6 608 719	6 608 719	-	100,0%	4 928 055	4 927 968
Departmental agencies and accounts	77 709	47 200	-	124 909	124 909	-	100,0%	76 475	76 475
Universities and technikons	1 060	2 940	-	4 000	2 000	2 000	50,0%	1 000	500
Non-profit institutions	189 768	-	-	189 768	145 114	44 654	76,5%	202 180	199 449
Households	-	70	-	70	285	(215)	407,1%	39	37
Gifts and donations	-	-	-	-	-	-		2 000	2 001
Payment for capital assets									
Machinery and equipment	16 323	-	-	16 323	5 895	10 428	36,1%	8 769	3 239
Software and other intangible assets	-	-	-	-	-	-		10	288
Payment for financial assets	-	-	-	-	261	(261)		-	7
Total	**7 401 626**	**-**	**(8 000)**	**7 393 626**	**7 232 905**	**160 721**	**97,8%**	**5 776 465**	**5 752 199**

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DETAIL PER PROGRAMME 3 – HEALTH PLANNING AND MONITORING

	2010/11							2009/10	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
3.1 HEALTH INFORMATION RESEARCH AND EVALUATION									
Current payment	28 577	(4 616)	-	23 961	21 192	2 769	88,4%	36 561	36 850
Transfers and subsidies	273 846	4 616	8 000	286 462	286 046	416	99,9%	254 339	254 338
Payment for capital assets	1 621	(110)	-	1 511	423	1 088	28,0%	3 654	2 217
3.2 FINANCIAL PLANNING AND HEALTH ECONOMICS									
Current payment	36 241	-	-	36 241	25 683	10 558	70,9%	26 474	24 938
Transfers and subsidies	3 993	-	-	3 993	-	3 993	0%	33 865	33 865
Payment for capital assets	3 542	110	-	3 652	3 651	1	100,0%	3 642	388
3.3 PHARMACEUTICAL POLICY AND PLANNING									
Current payment	15 508	-	-	15 508	12 864	2 644	83,0%	15 097	15 085
Payment for capital assets	318	-	-	318	118	200	37,1%	160	113
Payment for financial assets	-	-	-	-	77	(77)		-	-
3.4 OFFICE OF STANDARDS COMPLIANCE									
Current payment	50 201	(10)	-	50 191	40 926	9 265	81,5%	39 513	34 854
Transfers and subsidies	-	10	-	10	10	-	100,0%	151	149
Payment for capital assets	789	-	-	789	356	433	45,1%	745	467
Payment for financial assets	-	-	-	-	1	(1)		-	-
Total	**414 636**	**-**	**8 000**	**422 636**	**391 347**	**31 289**	**92,6%**	**414 201**	**403 264**

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DETAIL PER PROGRAMME 3 – HEALTH PLANNING AND MONITORING

	2010/11							2009/10	
Programme 3 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appro-priation**	**Actual Expenditure**	**Variance**	**Expendi-ture as % of final ap-propriation**	**Final Appropria-tion**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employ-ees	69 647	-	-	69 647	60 259	9 388	86,5%	56 681	56 654
Goods and services	60 880	(4 626)	-	56 254	40 407	15 847	71,8%	60 964	55 073
Transfers and subsidies to:									
Provinces and municipali-ties	-	-	-	-	-	-		30 000	30 000
Departmental agencies and accounts	274 917	4 600	6 000	285 517	281 109	4 408	98,5%	255 396	255 396
Non-profit institutions	2 922	-	2 000	4 922	4 922	-	100,0%	2 757	2 757
Households	-	26	-	26	24	2	92,3%	202	199
Payment for capital as-sets									
Machinery and equipment	6 270	-	-	6 270	4 507	1 763	71,9%	7 126	2 286
Software and other intangi-ble assets	-	-	-	-	41	(41)		1 075	899
Payment for financial assets	-	-	-	-	78	(78)		-	-
Total	**414 636**	**-**	**8 000**	**422 636**	**391 347**	**31 289**	**92,6%**	**414 201**	**403 264**

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DETAIL PER PROGRAMME 4 – HUMAN RESOURCES MANAGEMENT AND DEVELOPMENT

	2010/11							2009/10	
Detail per sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4.1 HUMAN RESOURCES POLICY, RESEARCH AND PLANNING									
Current payment	8 787	-	-	8 787	6 982	1 805	79,5%	22 502	17 140
Payment for capital assets	69	-	-	69	23	46	33,3%	210	74
4.2 SECTOR LABOUR RELATIONS AND PLANNING									
Current payment	3 682	-	-	3 682	2 715	967	73,7%	3 464	3 391
Payment for capital assets	351	-	-	351	39	312	11,1%	331	96
4.3 HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT									
Current payment	19 168	-	-	19 168	8 043	11 125	42,0%	14 764	13 373
Transfers and subsidies	1 865 387	-	-	1 865 387	1 865 387	-	100,0%	1 759 898	1 759 897
Payment for capital assets	107	-	-	107	57	50	53,3%	169	19
Payment for financial assets	-	-	-	-	37	(37)		-	-
Total	**1 897 551**	**-**	**-**	**1 897 551**	**1 883 283**	**14 268**	**99,2%**	**1 801 338**	**1 793 990**

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DETAIL PER PROGRAMME 4 – HUMAN RESOURCE MANAGEMENT AND DEVELOPMENT

	2010/11							2009/10	
Programme 4 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	17 711	-	-	17 711	13 685	4 026	77,3%	16 096	16 058
Goods and services	13 926	-	-	13 926	4 055	9 871	29,1%	24 634	17 846
Transfers and subsidies to:									
Provinces and municipalities	1 865 387	-	-	1 865 387	1 865 387	-	100,0%	1 759 799	1 759 799
Households	-	-	-	-	-	-		99	98
Payment for capital assets									
Machinery and equipment	527	-	-	527	119	408	22,6%	710	189
Payment for financial assets	-	-	-	-	37	(37)		-	-
Total	**1 897 551**	**-**	**-**	**1 897 551**	**1 883 283**	**14 268**	**99,2%**	**1 801 338**	**1 793 990**

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DETAIL PER PROGRAMME 5 – HEALTH SERVICES

Detail per sub-programme	2010/11							2009/10	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
5.1 DISTRICT HEALTH SERVICES									
Current payment	46 043	(31)	-	46 012	28 809	17 203	62,6%	27 389	11 469
Transfers and subsidies	95	31	-	126	30	96	23,8%	96	-
Payment for capital assets	280	-	-	280	28	252	10,0%	266	126
Payment for financial assets	-	-	-	-	-	-		-	12
5.2 ENVIRONMENTAL HEALTH PROMOTION AND NUTRITION									
Current payment	18 939	-	-	18 939	9 861	9 078	52,1%	10 777	10 685
Transfers and subsidies	1 037	-	-	1 037	350	687	33,8%	982	575
Payment for capital assets	209	-	-	209	21	188	10,0%	203	27
5.3 OCCUPATIONAL HEALTH									
Current payment	27 186	-	-	27 186	26 471	715	97,4%	24 502	24 474
Transfers and subsidies	2 620	-	-	2 620	2 620	-	100,0%	3 977	3 975
Payment for capital assets	2 045	-	-	2 045	1 475	570	72,1%	1 294	264
Payment for financial assets	-	-	-	-	1	(1)		-	-
5.4 HOSPITALS AND HEALTH FACILITIES MANAGEMENT									
Current payment	39 235	-	-	39 235	36 367	2 868	92,7%	18 320	14 894
Transfers and subsidies	11 418 667	-	-	11 418 667	10 966 103	452 564	96,0%	9 984 645	9 603 581
Payment for capital assets	701	-	-	701	218	483	31,1%	1 296	1 276
Payment for financial assets	-	-	-	-	39	(39)		-	1
Total	**11 557 057**	**-**	**-**	**11 557 057**	**11 072 393**	**484 664**	**95,8%**	**10 073 747**	**9 671 359**

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DETAIL PER PROGRAMME 5 – HEALTH SERVICES

	2010/11							2009/10	
Programme 5 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	45 800	-	-	45 800	43 571	2 229	95,1%	39 930	39 909
Goods and services	85 603	(31)	-	85 572	57 937	27 635	67,7%	41 058	21 613
Transfers and subsidies to:									
Provinces and municipalities	11 418 667	-	-	11 418 667	10 966 103	452 564	96,0%	9 984 645	9 603 581
Departmental agencies and accounts	2 620	-	-	2 620	2 620	-	100,0%	3 679	3 679
Non-profit institutions	1 132	-	-	1 132	350	782	30,9%	1 078	575
Households	-	31	-	31	30	1	96,8%	298	296
Payment for capital assets									
Machinery and equipment	3 235	-	-	3 235	1 680	1 555	51,9%	3 059	1 693
Software and other intangible assets	-	-	-	-	62	(62)		-	-
Payment for financial assets	-	-	-	-	40	(40)		-	13
Total	**11 557 057**	**-**	**-**	**11 557 057**	**11 072 393**	**484 664**	**95,8%**	**10 073 747**	**9 671 359**

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for the year ended 31 March 2011

DETAIL PER PROGRAMME 6 – INTERNATIONAL RELATIONS, HEALTH TRADE AND HEALTH PRODUCT REGULATION

	2010/11							2009/10	
Detail per sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appro-priation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
6.1 MULTILATERAL RELATIONS									
Current payment	50 150	-	-	50 150	35 917	14 233	71,6%	37 293	34 885
Transfers and subsidies	-	-	-	-	-	-		1	1
Payment for capital assets	586	(75)	-	511	16	495	3,1%	241	75
6.2 FOOD CONTROL AND NON-MEDICAL HEALTH PRODUCT REGULATION									
Current payment	6 132	-	-	6 132	5 681	451	92,6%	5 413	5 389
Transfers and subsidies	-	-	-	-	8	(8)		-	-
Payment for capital assets	42	-	-	42	61	(19)	145,2%	280	54
6.3 PHARMACEUTICAL AND RELATED PRODUCT REGULA-TION									
Current payment	51 450	(92)	-	51 358	36 240	15 118	70,6%	39 201	34 438
Transfers and subsidies	-	92	-	92	91	1	98,9%	268	267
Payment for capital assets	148	75	-	223	222	1	99,6%	350	364
Payment for financial assets	-	-	-		143	(143)		-	2
Total	**108 508**	**-**	**-**	**108 508**	**78 379**	**30 129**	**72,2%**	**83 047**	**75 475**

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for the year ended 31 March 2011

DETAIL PER PROGRAMME 6 – INTERNATIONAL RELATIONS, HEALTH TRADE AND HEALTH PRODUCT REGULATION

	2010/11							2009/10	
Programme 6 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	46 254	-	-	46 254	43 458	2 796	94,0%	41 220	41 208
Goods and services	61 478	(92)	-	61 386	34 380	27 006	56,0%	40 687	33 504
Transfers and subsidies to:									
Households	-	92	-	92	99	(7)	107,6%	269	268
Payment for capital assets									
Machinery and equipment	776	-	-	776	299	477	38,5%	871	493
Payment for financial assets	-	-	-	-	143	(143)		-	2
Total	**108 508**	**-**	**-**	**108 508**	**78 379**	**30 129**	**72,2%**	**83 047**	**75 475**

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NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2011

1. **Detail of transfers and subsidies as per Appropriation Act (after virement):**
   Detail of these transactions can be viewed in the note on transfers and subsidies, disclosure notes and annexure 1 (A-H) to the annual financial statements.

2. **Detail of specifically and exclusively appropriated amounts voted (after virement):**
   Detail of these transactions can be viewed in note 1 (annual appropriation) to the annual financial statements.

3. **Detail on financial transactions in assets and liabilities**
   Detail of these transactions per programme can be viewed in the note on financial transactions in assets and liabilities to the annual financial statements.

4. **Explanations of material variances from amounts voted (after virement):**

4.1 Per Programme

	Final Appropriation	Actual Expenditure	Variance R'000	Variance as a % of Final Appropriation
	R'000	R'000	R'000	%
Administration	282 134	260 272	21 862	92%
The underspending can mainly be attributed to slow procurement of capital assets, specifically servers and the fact that the moratorium on the filling of posts were only lifted late in the financial year resulting in all positions not being filled before year end.				
Strategic Health Programmes	7 393 626	7 232 905	160 721	98%
The underspending can mainly be attributed to the fact that the moratorium on the filling of posts was only lifted late in the financial year resulting in all positions not being filled before year end, this also caused an underspending in goods and services. The department furthermore experienced a delay in the procurement of female condoms due to supplier challenges.				
Health Planning and Monitoring	422 636	391 347	31 289	93%
The underspending can mainly be attributed to the fact that the moratorium on the filling of posts were only lifted late in the financial year resulting in all positions not being filled before year end, this also caused an underspending in goods and services. The establishment of the Office of Standards of Compliance could also not be finalised before year end.				
Human Resource Management and Development	1 897 551	1 883 283	14 268	99%
The underspending can mainly be attributed to the fact that the moratorium on the filling of posts were only lifted late in the financial year resulting in all positions not being filled before year end, this also caused an underspending in goods and Services.				
Health Services	11 557 057	11 072 393	484 664	96%
The underspending can mainly be attributed to the fact that the moratorium on the filling of posts were only lifted late in the financial year resulting in all positions not being filled before year end, this also caused an underspending in Goods and services. The Department furthermore withheld funds on the hospital revitalization conditional grant.				
International Relations, Health Trade and Health Product Regulations	108 508	78 379	30 129	72%

The underspending can mainly be attributed to the fact that the moratorium on the filling of posts were only lifted late in the financial year resulting in all positions not being filled before year end, this also caused an underspending in goods and services. The Department furthermore set aside funds for the nursing summit that will only flow in the 2011/2012 financial year.

4.2 Per Economic classification	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
	R'000	R'000	R'000	%
Current payments:				
Compensation of employees	384 404	353 654	30 750	92%
Goods and services	725 773	544 355	181 418	75%
Transfers and subsidies:				
Provinces and municipalities	19 892 773	19 440 209	452 564	98%
Departmental agencies and accounts	413 416	409 008	4 408	99%
Universities and technikons	4 000	2 000	2 000	50%
Non-profit institutions	195 822	150 386	45 436	77%
Households	406	619	(213)	152%
Payments for capital assets:				
Machinery and equipment	44 918	17 576	27 342	39%
Software and other intangible assets	-	206	(206)	
Payment for financial assets	-	566	(566)	

Compensation of employees – moratorium on the filling of posts only lifted late in the financial year, resulting in all vacancies not being filled before year-end.
Goods and services – The high vacancy rate resulted in slow spending on the operational budget, furthermore the procurement challenges on female condoms and the overrun to the new financial year on the nursing summit contributed to the underspending.
Transfers and subsidies – Provinces – portion of the hospital revitalisation condition grant was withheld. Universities - payment to Wits University could not be processed due to outstanding banking details.
Machinery and equipment – Procurement process of servers and the highly specialized laboratory equipment were delayed due to the move to Citivas Building.

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STATEMENT OF FINANCIAL PERFORMANCE
for the year ended 31 March 2011

PERFORMANCE	*Note*	2010/11 R'000	2009/10 R'000
REVENUE			
Annual appropriation	*1*	21 661 512	18 423 459
Departmental revenue	*2*	27 248	45 190
Aid assistance	*3*	234 002	375 957
TOTAL REVENUE		**21 922 762**	**18 844 606**
EXPENDITURE			
Current expenditure			
Compensation of employees	*4*	353 654	333 023
Goods and services	*5*	544 355	756 671
Aid assistance	*3*	163 079	322 911
Total current expenditure		**1 061 088**	**1 412 605**
Transfers and subsidies			
Transfers and subsidies	*7*	20 002 222	16 863 440
Total transfers and subsidies		**20 002 222**	**16 863 440**
Expenditure for capital assets			
Tangible capital assets	*8*	17 714	12 068
Software and other intangible assets	*8*	206	1 316
Total expenditure for capital assets		**17 920**	**13 384**
Payment for financial assets	*6*	566	30
TOTAL EXPENDITURE		**21 081 796**	**18 289 459**
SURPLUS/(DEFICIT) FOR THE YEAR		**840 966**	**555 147**
Reconciliation of Net Surplus/(Deficit) for the year			
Voted funds		742 933	457 249
Annual appropriation		290 369	76 098
Conditional grants		452 564	381 151
Departmental revenue	*13*	27 248	45 190
Aid assistance	*3*	70 785	52 708
SURPLUS/(DEFICIT) FOR THE YEAR		**840 966**	**555 147**

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STATEMENT OF FINANCIAL POSITION
for the year ended 31 March 2011

POSITION	***Note***	**2010/11**	**2009/10**
		R'000	**R'000**
ASSETS			
Current assets		**159 501**	**298 553**
Cash and cash equivalents	*9*	130 711	261 398
Prepayments and advances	*10*	11 481	3 836
Receivables	*11*	17 309	33 319
TOTAL ASSETS		**159 501**	**298 553**
LIABILITIES			
Current liabilities		**158 304**	**297 631**
Voted funds to be surrendered to the Revenue Fund	*12*	67 933	157 249
Departmental revenue to be surrendered to the Revenue Fund	*13*	156	34 387
Payables	*14*	17 767	33 997
Aid assistance repayable	*3*	69 351	70 335
Aid assistance unutilised	*3*	3 097	1 663
Non-current liabilities			
Payables	*15*	-	-
TOTAL LIABILITIES		**158 304**	**297 631**
NET ASSETS		**1 197**	**922**
Represented by:			
Recoverable revenue		1 197	922
TOTAL		**1 197**	**922**

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STATEMENT OF CHANGES IN NET ASSETS
as at 31 March 2011

NET ASSETS	*Note*	2010/11 R'000	2009/10 R'000
Recoverable revenue			
Opening balance		922	840
Transfers:		**275**	**82**
Debts recovered (included in departmental receipts)		(757)	(331)
Debts raised		1 032	413
Closing balance		**1 197**	**922**
TOTAL		**1 197**	**922**

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CASH FLOW STATEMENT
as at 31 March 2011

CASH FLOW	*Note*	2010/11 R'000	2009/10 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts		**21 247 762**	**18 544 606**
Annual appropriated funds received	*1.1*	20 986 512	18 123 459
Departmental revenue received	*2*	27 248	45 190
Aid assistance received	*3*	234 002	375 957
Net (increase)/decrease in working capital		(7 865)	(70)
Surrendered to Revenue Fund		(218 728)	(387 792)
Surrendered to RDP Fund/Donor		(70 335)	(72 589)
Current payments		(1 061 088)	(1 412 605)
Payment for financial assets		(566)	(30)
Transfers and subsidies paid		(20 002 222)	(16 863 440)
Net cash flow available from operating activities	*15*	**(113 042)**	**(191 920)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for capital assets	*8*	(17 920)	(13 384)
Net cash flows from investing activities		**(17 920)**	**(13 384)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Increase/(decrease) in net assets		275	82
Increase/(decrease) in non-current payables		-	(42)
Net cash flows from financing activities		**275**	**40**
Net increase/(decrease) in cash and cash equivalents		(130 687)	(205 264)
Cash and cash equivalents at beginning of period		261 398	466 662
Cash and cash equivalents at end of period	*16*	**130 711**	**261 398**

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ACCOUNTING POLICIES
for the year ended 31 March 2011

The financial statements have been prepared in accordance with the following policies, which have been applied consistently in all material aspects, unless otherwise indicated. However, where appropriate and meaningful, additional information has been disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999), and the Treasury Regulations issued in terms of the Act and the Division of Revenue Act, Act 1 of 2010.

1. Presentation of the financial statements

1.1 Basis of preparation

The financial statements have been prepared on a modified cash basis of accounting, except where stated otherwise. The modified cash basis constitutes the cash basis of accounting supplemented with additional disclosure items. Under the cash basis of accounting transactions and other events are recognised when cash is received or paid.

1.1 Presentation currency

All amounts have been presented in the currency of the South African Rand (R) which is also the functional currency of the department.

1.2 Rounding

Unless otherwise stated all financial figures have been rounded to the nearest one thousand Rand (R'000).

1.3 Comparative figures

Prior period comparative information has been presented in the current year's financial statements. Where necessary figures included in the prior period financial statements have been reclassified to ensure that the format in which the information is presented is consistent with the format of the current year's financial statements.

1.4 Comparative figures - appropriation statement

A comparison between actual amounts and final appropriation per major classification of expenditure is included in the appropriation statement.

2. Revenue

2.1 Appropriated funds

Appropriated funds comprises of departmental allocations as well as direct charges against revenue fund (i.e. statutory appropriation).

Appropriated funds are recognised in the financial records on the date the appropriation becomes effective. Adjustments made in terms of the adjustments budget process are recognised in the financial records on the date the adjustments become effective.

Unexpended appropriated funds are surrendered to the National Revenue Fund. Any amounts owing to the National Revenue Fund at the end of the financial year are recognised as payable in the statement of financial position.

Any amount due from the National Revenue Fund at the end of the financial year is recognised as a receivable in the statement of financial position.

2.2 Departmental revenue

All departmental revenue is recognised in the statement of financial performance when received and is subsequently paid into the National Revenue Fund, unless stated otherwise.

Any amount owing to the National Revenue Fund is recognised as a payable in the statement of financial position.

No accrual is made for amounts receivable from the last receipt date to the end of the reporting period.

These amounts are however disclosed in the disclosure note to the annual financial statements.

2.3 Direct Exchequer receipts

All direct exchequer receipts are recognised in the statement of financial performance when the cash is received and is subsequently paid into the National/Provincial Revenue Fund, unless stated otherwise.

Any amount owing to the National Revenue Funds at the end of the financial year is recognised as a payable in the statement of financial position.

2.4 Direct exchequer payments

All direct exchequer payments are recognised in the statement of financial performance when final authorisation for payment is effected on the system (by no later than 31 March of each year).

2.5 Aid assistance

Aids assistance is recognised as revenue when received.

All in-kind aid assistance is disclosed at fair value on the date of receipt in the annexures to the annual financial statements.

The cash payments made during the year relating to aid assistance projects are recognised as expenditure in the statement of financial performance when final authorisation for payments is effected on the system (by no later than 31 March of each year).

The value of the assistance expensed prior to the receipt of funds is recognised as a receivable in the statement of financial position.

Inappropriately expensed amounts using aid assistance and any unutilised amounts are recognised as payables in the statement of financial position.

3. Expenditure

3.1 Compensation of employees

3.1.1 Salaries and wages

Salaries and wages are expensed in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

Other employee benefits that give rise to a present legal or constructive obligation are disclosed in the disclosure notes to the financial statements at its face value and are not recognised in the statement of financial performance or position.

Employee costs are capitalised to the cost of a capital project when an employee spends more than 50% of his/her time on the project. These payments form part of expenditure for capital assets in the statement of financial performance.

3.1.2 Social contributions

Employer contributions to post employment benefit plans in respect of current employees are expensed in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

No provision is made for retirement benefits in the financial statements of the department. Any potential liabilities are disclosed in the financial statements of the National Revenue Fund and not in the financial statements of the employer department.

Employer contributions made by the department for certain of its ex-employees (such as medical benefits) are classified as transfers to households in the statement of financial performance.

3.2 Goods and services

Payments made during the year for goods and/or services are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system

(by no later than 31 March of each year).

The expense is classified as capital if the goods and/or services were acquired for a capital project or if the total purchase price exceeds the capitalisation threshold (currently R5, 000). All other expenditures are classified as current.

Rental paid for the use of buildings or other fixed structures is classified as *goods and services* and not as *rent on land.*

3.3 Interest and rent on land

Interest and rental payments are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year). This item excludes rental for the use of buildings or other fixed structures. If it is not possible to distinguish between payment for the use of land and the fixed structures on it, the whole amount should be recorded under goods and services.

3.4 Payments for financial assets

Debts are written off when identified as irrecoverable. Debts written-off are limited to the amount of savings and/or underspending of appropriated funds. The write off occurs at year-end or when funds are available. No provision is made for irrecoverable amounts but an estimate is included in the disclosure notes to the financial statements amounts.

All other losses are recognised when authorisation has been granted for the recognition thereof.

3.5 Transfers and subsidies

Transfers and subsidies are recognised as an expense when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

3.6 Unauthorised expenditure

When confirmed unauthorised expenditure is recognised as an asset in the statement of financial position until such time as the expenditure is either approved by the relevant authority, recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

Unauthorised expenditure approved with funding is derecognised from the statement of financial position when the unauthorised expenditure is approved and the related funds are received.

Where the amount is approved without funding it is recognised as expenditure in the statement of financial performance on the date of approval.

3.7 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is recognised as expenditure in the statement of financial performance according to the nature of the payment and not as a separate line item on the face of the statement. If the expenditure is recoverable it is treated as an asset until it is recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

3.8 Irregular expenditure

Irregular expenditure is recognised as expenditure in the statement of financial performance. If the expenditure is not condoned by the relevant authority it is treated as an asset until it is recovered or written off as irrecoverable.

4. Assets

4.1 Cash and cash equivalents

Cash and cash equivalents are carried in the statement of financial position at cost.

Bank overdrafts are shown separately on the face of the statement of financial position.

For the purposes of the cash flow statement, cash and cash equivalents comprise cash on hand, deposits held, other short-term highly liquid investments and bank overdrafts.

4.2 Other financial assets

Other financial assets are carried in the statement of financial position at cost.

4.3 Prepayments and advances

Amounts prepaid or advanced are recognised in the statement of financial position when the payments are made and are derecognised as and when the goods/services are received or the funds are utilised.

Prepayments and advances outstanding at the end of the year are carried in the statement of financial position at cost.

4.4 Receivables

Receivables included in the statement of financial position arise from cash payments made that are recoverable from another party (including departmental employees) and are derecognised upon recovery or write-off.

Receivables outstanding at year-end are carried in the statement of financial position at cost plus any accrued interest. Amounts that are potentials irrecoverable are included in the disclosure notes.

4.5 Inventory

Inventories that qualify for recognition must be initially reflected at cost. Where inventories are acquired at no cost, or for nominal consideration, their cost shall be their fair value at the date of acquisition.

All inventory items at year-end are reflected using the weighted average cost or FIFO cost formula.

4.6 Capital assets

4.6.1 Movable assets

Initial recognition
A capital asset is recorded in the asset register on receipt of the item at cost. Cost of an asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the movable capital asset is stated at fair value. Where fair value cannot be determined, the capital asset is included in the asset register at R1.

All assets acquired prior to 1 April 2002 are included in the register R1.

Subsequent recognition

Subsequent expenditure of a capital nature is recorded in the statement of financial performance as "expenditure for capital assets" and is capitalised in the asset register of the department on completion of the project.

Repairs and maintenance is expensed as current "goods and services" in the statement of financial performance.

4.6.2 Immovable assets

Initial recognition

A capital asset is recorded on receipt of the item at cost. Cost of an asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the immovable capital asset is stated at R1 unless the fair value for the asset has been reliably estimated.

Subsequent recognition

Work-in-progress of a capital nature is recorded in the statement of financial performance as "expenditure for capital assets". On completion, the total cost of the project is included in the asset register of the department that is accountable for the asset.

Repairs and maintenance is expensed as current "goods and services" in the statement of financial performance.

5. Liabilities

5.1 Payables

Recognised payables mainly comprise of amounts owing to other governmental entities. These payables are carried at cost in the statement of financial position.

5.2 Contingent liabilities

Contingent liabilities are included in the disclosure notes to the financial statements when it is possible that economic benefits will flow from the department, or when an outflow of economic benefits or service potential is probable but cannot be measured reliably.

5.3 Contingent assets

Contingent assets are included in the disclosure notes to the financial statements when it is probable that an inflow of economic benefits will flow to the entity.

5.4 Commitments

Commitments are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

5.5 Accruals

Accruals are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

5.6 Employee benefits

Short-term employee benefits that give rise to a present legal or constructive obligation are disclosed in the disclosure notes to the financial statements. These amounts are not recognised in the state-

ment of financial performance or the statement of financial position.

5.7 Lease commitments

Finance lease

Finance leases are not recognised as assets and liabilities in the statement of financial position. Finance lease payments are recognised as an expense in the statement of financial performance and are apportioned between the capital and interest portions. The finance lease liability is disclosed in the disclosure notes to the financial statements.

Operating lease
Operating lease payments are recognised as an expense in the statement of financial performance. The operating lease commitments are disclosed in the discloser notes to the financial statement.

5.8 Impairment and other provisions

The department tests for impairment where there is an indication that a receivable, loan or investment may be impaired. An assessment of whether there is an indication of possible impairment is done at each reporting date. An estimate is made for doubtful loans and receivables based on a review of all outstanding amounts at year-end. Impairments on investments are calculated as being the difference between the carrying amount and the present value of the expected future cash flows / service potential flowing from the instrument.

Provisions are disclosed when there is a present legal or constructive obligation to forfeit economic benefits as a result of events in the past and it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation and a reliable estimate of the obligation can be made.

6. Receivables for departmental revenue

Receivables for departmental revenue are disclosed in the disclosure notes to the annual financial statements.

7. Net Assets

7.1 Capitalisation reserve

The capitalisation reserve comprises of financial assets and/or liabilities originating in a prior reporting period but which are recognised in the statement of financial position for the first time in the current

reporting period. Amounts are recognised in the capitalisation reserves when identified in the current period and are transferred to the National Revenue Fund when the underlining asset is disposed and the related funds are received.

7.2 Recoverable revenue

Amounts are recognised as recoverable revenue when a payment made in a previous financial year becomes recoverable from a debtor in the current financial year. Amounts are either transferred to the National Revenue Fund when recovered or are transferred to the statement of financial performance when written-off.

8. Related party transactions

Specific information with regards to related party transactions is included in the disclosure notes.

9. Key management personnel

Compensation paid to key management personnel including their family members where relevant, is included in the disclosure notes.

10. Public private partnerships

A description of the PPP arrangement, the contract fees and current and capital expenditure relating to the PPP arrangement is included in the disclosure notes.

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2011

1. Annual Appropriation

1.1 Annual Appropriation

Included are funds appropriated in terms of the Appropriation Act (and the Adjustments Appropriation Act) for National Departments (Voted funds) and provincial departments:

	Final Appropriation R'000	Actual Funds Received R'000	Funds not requested/ not received R'000	Appropriation received 2009/10 R'000
Administration	282 134	282 134	-	274 661
Strategic Health Programmes	7 393 626	7 171 190	222 436	5 478 816
Health Planning and Monitoring	422 636	422 636	-	414 201
Human Resources Management and Development	1 897 551	1 897 551	-	1 801 338
Health Services	11 557 057	11 104 493	452 564	10 073 747
International Relations, Health Trade and Health Product Regulation	108 508	108 508	-	80 696
Total	**21 661 512**	**20 986 512**	**675 000**	**18 123 459**

Programme 2: Funds were not requested for the payment of NGO's, as some of the NGO's did not adhere to the conditions set to receive funding.
Programme 5: The provincial departments of health did not spend as anticipated on the hospital revitalization conditional grand, therefore six provinces final installments and one province second last installment were withheld.

2. Departmental revenue

	Note	2010/11 R'000	2009/10 R'000
Sales of goods and services other than capital assets	2.1	25 966	38 412
Interest, dividends and rent on land	2.2	355	1 012
Financial transactions in assets and liabilities	2.3	927	5 766
Total revenue collected		**27 248**	**45 190**
Departmental revenue collected		**27 248**	**45 190**

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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2.1 Sales of goods and services other than capital assets

	Note 2	2010/11 R'000	2009/10 R'000
Sales of goods and services produced by the department		25 907	38 355
Sales by market establishment		89	69
Administrative fees		25 649	38 140
Other sales		169	146
Sales of scrap, waste and other used current goods		59	57
Total		**25 966**	**38 412**

2.2 Interest, dividends and rent on land

	Note 2	2010/11 R'000	2009/10 R'000
Interest		355	1 012
Total		**355**	**1 012**

2.3 Transactions in financial assets and liabilities

	Note 2	2010/11 R'000	2009/10 R'000
Stale cheques written back		14	16
Other Receipts including Recoverable Revenue		913	5 750
Total		**927**	**5 766**

3. Aid assistance

3.1 Aid assistance received in cash from RD

	Note	2010/11 R'000	2009/10 R'000
Foreign			
Opening Balance		71 606	91 879
Revenue		232 466	374 294
Expenditure		(161 289)	(321 978)
Current		(161 151)	(321 640)
Capital		(138)	(338)
Surrendered to the RDP		(70 335)	(72 589)
Closing Balance		**72 448**	**71 606**

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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3.2 Aid assistance received in cash from other sources

	2010/11 R'000	2009/10 R'000
Local		
Opening Balance	392	-
Revenue	1 536	1 663
Expenditure	(1 928)	(1 271)
Current	(1 928)	(1 271)
Closing Balance	**-**	**392**

3.3 Total assistance

	2010/11 R'000	2009/10 R'000
Opening Balance	71 998	91 879
Revenue	234 002	375 957
Expenditure	(163 217)	(323 249)
Current	(163 079)	(322 911)
Capital	(138)	(338)
Surrendered / Transferred to retained funds	(70 335)	(72 589)
Closing Balance	**72 448**	**71 998**

Analysis of balance	*Note*	2010/11 R'000	2009/10 R'000
Aid assistance unutilised		3 097	1 663
RDP		3 097	1 271
Other sources		-	392
Aid assistance repayable		69 351	70 335
RDP		69 351	70 335
Closing balance		**72 448**	**71 998**

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4. Compensation of employees

4.1 Salaries and Wages

	Note	2010/11	2009/10
		R'000	R'000
Basic salary		236 719	225 733
Performance award		4 734	4 886
Service Based		365	173
Compensative/circumstantial		3 381	4 237
Periodic payments		13	312
Other non-pensionable allowances		65 126	55 997
Total		**310 338**	**291 338**

4.2 Social contributions

	Note	2010/11	2009/10
		R'000	R'000
Employer contributions			
Pension		29 355	28 898
Medical		13 924	12 747
Bargaining council		37	40
Total		**43 316**	**41 685**
Total compensation of employees		**353 654**	**333 023**
Average number of employees		1 277	1 289

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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5. Goods and services

	Note	2010/11 R'000	2009/10 R'000
Administrative fees		156	239
Advertising		49 181	95 149
Assets less then R5 000	5.1	1 662	2 177
Bursaries (employees)		956	949
Catering		3 743	2 527
Communication		17 344	15 952
Computer services	5.2	12 691	31 279
Consultants, contractors and agency/outsourced services	5.3	99 861	69 180
Entertainment		245	211
Audit cost – external	5.4	16 100	31 648
Inventory	5.5	174 418	351 611
Owned and leasehold property expenditure	5.6	51 751	49 667
Transport provided as part of the departmental activities		-	145
Travel and subsistence	5.7	74 029	69 740
Venues and facilities		10 387	10 770
Training and staff development		4 757	8 250
Other operating expenditure	5.8	27 074	17 177
Total		**544 355**	**756 671**

5.1 Assets less than R5 000

	Note 5	2010/11 R'000	2009/10 R'000
Tangible assets		1 662	2 177
Machinery and equipment		1 662	2 177
Total		**1 662**	**2 177**

5.2 Computer services

	Note 5	2010/11 R'000	2009/10 R'000
SITA computer services		3 162	18 741
External computer service providers		9 529	12 538
Total		**12 691**	**31 279**

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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5.3 Consultants, contractors and agency/outsourced services

	Note 5	2010/11 R'000	2009/10 R'000
Business and advisory services		69 188	39 146
Legal costs		650	1 741
Contractors		18 812	15 698
Agency and support/outsourced services		11 211	12 595
Total		**99 861**	**69 180**

5.4 Audit cost – External

	Note 5	2010/11 R'000	2009/10 R'000
Regularity audits		15 299	8 012
Performance audits		801	3 616
Other audits		-	20 020
Total		**16 100**	**31 648**

5.5 Inventory

	Note 5	2010/11 R'000	2009/10 R'000
Fuel, oil and gas		255	323
Other consumable materials		6 069	4 701
Stationery and printing		18 616	21 045
Medical supplies		119 476	325 542
Medicine		30 002	-
Total		**174 418**	**351 611**

5.6 Property payments

	Note 5	2010/11 R'000	2009/10 R'000
Municipal services		6 527	-
Property management fees		326	-
Property maintenance and repairs		6 629	-
Other		38 269	49 667
Total		**51 751**	**49 667**

5.7 Travel and subsistence

	Note 5	2010/11 R'000	2009/10 R'000
Local		58 068	54 603
Foreign		15 961	15 137
Total		**74 029**	**69 740**

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5.8 Other operating expenditure

	Note 5	2010/11 R'000	2009/10 R'000
Professional bodies, membership and subscription fees		17 575	11 481
Resettlement costs		1 471	3 282
Other		8 028	2 414
Total		**27 074**	**17 177**

6. Payments for financial assets

	Note	2010/11 R'000	2009/10 R'000
Debts written off	6.1	566	30
Total		**566**	**30**

6.1 Debts written off

	Note 6	2010/11 R'000	2009/10 R'000
Nature of debts written off			
Salary debt		46	2
Tax debt		2	14
Dishonoured cheques		206	-
Forensic Chemistry Analysis		73	-
Annexure 9 Medication		10	-
Travel and subsistence		2	-
State guarantee		36	-
Debts written off relating to fruitless and wasteful expenditure		191	12
Bursary		-	2
Total		**566**	**30**

6.2 Assets written off

	Note	2010/11 R'000	2009/10 R'000
Nature of write off			
Equipment < R5 000		-	6
Inventory		-	72
Machinery and equipment		23	74
Total		**23**	**152**

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7. Transfers and subsidies

	Note	2010/11 R'000	2009/10 R'000
Provinces and municipalities	31	19 440 209	16 321 348
Departmental agencies and accounts	Annex 1C	409 008	335 850
Universities and technikons	Annex 1D	2 000	500
Public corporations and private enterprises	Annex 1E	-	37
Non-profit institutions	Annex 1G	150 385	202 781
Households	Annex 1H	396	923
Gifts, donations and sponsorships made	Annex 1K	224	2 001
Total		**20 002 222**	**16 863 440**

8. Expenditure for capital assets

	Note	2010/11 R'000	2009/10 R'000
Tangible assets		17 714	12 068
Machinery and equipment	29	17 714	12 068
Software and other intangible assets		**206**	**1 316**
Computer software	30	206	1 316
Total		**17 920**	**13 384**

8.1 Analysis of funds utilised to acquire capital assets – 2010/11

	Voted funds R'000	Aid assistance R'000	Total R'000
Tangible assets	**17 576**	**138**	**17 714**
Machinery and equipment	17 576	138	17 714
Software and other intangible assets	**206**	**-**	**206**
Computer software	206	-	206
Total	**17 782**	**138**	**17 920**

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Analysis of funds utilised to acquire capital assets – 2009/10

	Voted funds	Aid assistance	Total
	R'000	R'000	R'000
Tangible assets	**11 730**	**338**	**12 068**
Machinery and equipment	11 730	338	12 068
Software and other intangible assets	**1 316**	**-**	**1 316**
Computer software	1 316	-	1 316
Total	**13 046**	**338**	**13 384**

9. Cash and cash equivalents

	Note	2010/11	2009/10
		R'000	R'000
Consolidated Paymaster General Account		130 686	261 373
Cash on hand		25	25
Total		**130 711**	**261 398**

10. Prepayments and advances

	Note	2010/11	2009/10
		R'000	R'000
Travel and subsistence		659	431
Advances paid to other entities		10 822	3 405
Total		**11 481**	**3 836**

11. Receivables

		2010/11				2009/10
		R'000	R'000	R'000	R'000	R'000
	Note	Less than one year	One to three years	Older than three years	Total	Total
Claims recoverable	11.1 Annex 4	4 719	964	3 689	9 372	25 894
Recoverable expenditure	11.2	917	4 660	-	5 577	5 408
Staff debt	11.3	413	297	99	809	1 204
Other debtors	11.4	583	551	417	1 551	813
Total		**6 632**	**6 472**	**4 205**	**17 309**	**33 319**

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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11.1 Claims recoverable

	Note 11	2010/11 R'000	2009/10 R'000
National departments		1 176	20 632
Provincial departments		8 196	5 262
Total		**9 372**	**25 894**

11.2 Recoverable expenditure (disallowance accounts)

	Note 11	2010/11 R'000	2009/10 R'000
Dishonoured cheques		-	310
Salary debt		4	3
Damages and losses		5 573	5 095
Total		**5 577**	**5 408**

11.3 Staff debt

	Note 11	2010/11 R'000	2009/10 R'000
Bursary debt		515	389
Salary overpayments		157	510
State guarantees		-	34
Tax debt		1	191
Loss / damage to state property		73	80
Other		63	-
Total		**809**	**1 204**

11.4 Other debtors

	Note 11	2010/11 R'000	2009/10 R'000
Schedule 9 medication		58	58
Laboratory tests		1	60
Other debtors		70	76
Ex-employees		1 422	619
Total		**1 551**	**813**

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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12. Voted funds to be surrendered to the Revenue Fund

	Note	2010/11 R'000	2009/10 R'000
Opening balance		157 249	376 699
Transfer from statement of financial performance		742 933	457 249
Voted funds not requested/not received	1.1	(675 000)	(300 000)
Paid during the year		(157 249)	(376 699)
Closing balance		**67 933**	**157 249**

13. Departmental revenue and NRF Receipts to be surrendered to the Revenue Fund

	Note	2010/11 R'000	2009/10 R'000
Opening balance		34 387	290
Transfer from statement of financial performance		27 248	45 190
Paid during the year		(61 479)	(11 093)
Closing balance		**156**	**34 387**

14. Payables – current

	Note	2010/11 Total R'000	2009/10 Total R'000
Advances received	14.1	17 538	33 326
Clearing accounts	14.2	229	224
Other payables	14.3	-	447
Total		**17 767**	**33 997**

14.1 Advances received

	Note 14	2010/11 R'000	2009/10 R'000
Advances for Havana Students: Mpumalanga Province		1 018	1 712
Advances for Havana Students: KwaZulu/Natal Province		2 319	3 944
Advances for Havana Students: Limpopo Province		6 737	14 539
Advances to Cuba for Havana Students: Eastern Cape Province		1 558	3 192
Advances to Cuba for Havana Students: Northern Cape Province		2 636	3 410
Advances to Cuba for Havana Students: North West Province		3 270	4 471
Advances to National Departments		-	2 058
Total		**17 538**	**33 326**

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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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14.2 Clearing accounts

	Note 14	2010/11 R'000	2009/10 R'000
Income Tax		224	211
Pension Fund		3	13
Bargaining Council		1	-
Garnishee Orders		1	-
Total		**229**	**224**

14.3 Other payables

	Note 14	2010/11 R'000	2009/10 R'000
Communicative Responsive Programme		-	410
GE – Healthcare		-	37
Total		**-**	**447**

15. Net cash flow available from operating activities

	Note	2010/11 R'000	2009/10 R'000
Net surplus/(deficit) as per Statement of Financial Performance		840 966	555 147
Add back non cash/cash movements not deemed operating activities		(954 008)	(747 067)
(Increase)/decrease in receivables – current		16 010	(14 532)
(Increase)/decrease in prepayments and advances		(7 645)	4 053
Increase/(decrease) in payables – current		(16 230)	10 409
Expenditure on capital assets		17 920	13 384
Surrenders to Revenue Fund		(218 728)	(387 792)
Surrenders to RDP Fund/Donor		(70 335)	(72 589)
Voted funds not requested/not received		(675 000)	(300 000)
Net cash flow generated by operating activities		**(113 042)**	**(191 920)**

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16. Reconciliation of cash and cash equivalents for cash flow purposes

	Note	2010/11	2009/10
		R'000	R'000
Consolidated Paymaster General account		130 686	261 373
Cash on hand		25	25
Total		**130 711**	**261 398**

These amounts are not recognised in the annual financial statements and are disclosed to enhance the usefulness of the annual financial statements.

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17. Contingent liabilities and contingent assets

17.1 Contingent liabilities

		Note	2010/11 R'000	2009/10 R'000
Liable to	**Nature**			
Motor vehicle guarantees	Employees	*Annex 3A*	283	190
Housing loan guarantees	Employees	*Annex 3A*	635	746
Claims against the department		*Annex 3B*	199	-
Other departments		*Annex 5*	37 524	-
Total			**38 641**	**936**

18. Commitments

	Note	2010/11 R'000	2009/10 R'000
Current expenditure		**190 558**	**267 665**
Approved and contracted		187 874	266 847
Approved but not yet contracted		2 684	818
Capital expenditure (including transfers)		**1 167**	**8 410**
Approved and contracted		1 038	8 410
Approved but not yet contracted		129	-
Total Commitments		**191 725**	**276 075**

Cellular phones: Contracts are for periods of 24 months.
Tenders: Depending on the period agreed upon in the service level agreement of each tender.

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19. Accruals

			2010/11 R'000	2009/10 R'000
Listed by economic classification				
	30 Days	**30+ Days**	**Total**	**Total**
Goods and services	1 769	58 585	60 354	65 087
Capital assets	319	208	527	237
Total	**2 088**	**58 793**	**60 881**	**65 324**

	Note	2010/11 R'000	2009/10 R'000
Listed by programme level			
Programme 1: Administration		10 898	9 333
Programme 2: Strategic Health Programmes		6 559	47 788
Programme 3: Health Planning and Monitoring		41 878	4 561
Programme 4: Human Resource Management and Development		918	257
Programme 5: Health Services		349	2 787
Programme 6: International Relations, Health Trade and Health Product Regulation		279	598
Total		**60 881**	**65 324**

	Note	2010/11 R'000	2009/10 R'000
Confirmed balances with other departments	*Annex 5*	17 538	33 326
Confirmed balances with other government entities	*Annex 5*	-	447
Total		**17 538**	**33 773**

20. Employee benefits

	Note	2010/11 R'000	2009/10 R'000
Leave entitlement		12 836	11 571
Service bonus (Thirteenth cheque)		9 430	9 226
Performance bonus		59	-
Capped leave commitments		16 043	15 579
Total		**38 368**	**36 376**

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In the leave entitlement an amount of R 724 685.25 for negative leave credits is included. An amount of R 118 072.64 regarding negative capped leave credits are included in capped leave commitments.

21. Lease commitments

21.1 Operating leases expenditure

2010/11	Buildings and other fixed structures R'000	Machinery and equipment R'000	Total R'000
Not later than 1 year	26 166	926	27 092
Later than 1 year and not later than 5 years	133 341	278	133 619
Later than five years	-	-	-
Total lease commitments	**159 507**	**1 204**	**160 711**

2009/10	Buildings and other fixed structures R'000	Machinery and equipment R'000	Total R'000
Not later than 1 year	23 789	1 016	24 805
Later than 1 year and not later than 5 years	121 708	143	121 851
Later than five years		27	27
Total lease commitments	**145 497**	**1 186**	**146 683**

Note: Lease commitments regarding buildings were not disclosed previous years.

22. Receivables for departmental revenue

	Note	2010/11 R'000	2009/10 R'000
Sales of goods and services other than capital assets		4	8
Total		**4**	**8**

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23. Irregular expenditure

23.1 Reconciliation of irregular expenditure

	Note	2010/11 R'000	2009/10 R'000
Opening balance		13 639	7 854
Add: Irregular expenditure – relating to prior year		201	903
Add: Irregular expenditure – relating to current year		33 227	4 916
Less: Amounts condoned		(3 744)	(31)
Less: Amounts not recoverable (not condoned)		(49)	-
Less: Amounts not recoverable (not condoned)		-	(3)
Irregular expenditure awaiting condonation		**43 274**	**13 639**
Analysis of awaiting condonation per age classification			
Current year		31 520	4 916
Prior years		11 754	8 723
Total		**43 274**	**13 639**

23.2 Details of irregular expenditure – current year

Incident	Disciplinary steps taken/criminal proceedings	2010/11 R'000
Appointment of preferred consultant	Under investigation	921
Appointment of preferred supplier to manage World AIDS Day	Under investigation	1 706
Presidential launch of HIV Counselling & testing campaign	Under investigation	753
Procurement of non-profit volunteers for 2010 FIFA World Cup	Under investigation	1 963
SA Clinical Trials Register – WITS Health Consortium	Under investigation	855
2010 World TB Day commemoration – Ethekwini, KZN	Under investigation	1 990
Travel Agents	Under investigation	23 358
Payments not made according to procedures – Magauta	Under investigation	467
Payments for computer training and consulting – Rhadzani and Xabiso	Under investigation	1 214
Total		**33 227**

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23.3 Details of irregular expenditure condoned

Incident	Condoned by (condoning authority)	2010/11
		R'000
Deloitte and Touch	Director-General	40
Translation services for hosting SADC meeting	Director-General	193
Roll up banners	Director-General	16
Roll up banners	Director-General	13
Placing of advertisements	Director-General	76
Repair of air conditioners	Director-General	12
Placing of advertisements in newspapers	Director-General	398
Resettlement cost	Director-General	397
Printing of cholera pamphlets	Director-General	379
Storage costs	Director-General	68
Set up of exhibition stand at Durban ICC	Director-General	201
Quotations not obtained	Director-General	225
Appointment of preferred supplier to manage World AIDS Day	Director-General	1 706
Banner	Director-General	11
Catering services	Director-General	9
Total		**3 744**

23.4 Details of irregular expenditure recoverable (not condoned)

Incident	Condoned by (condoning authority)	2010/11
		R'000
Communication – T-shirts	Not condoned by Director-General	49
Total		**49**

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23.5 Details of irregular expenditure under investigation

	2010/11
Incident	**R'000**
Lab Services	1 501
Appointment of KPMG	3 397
Procurement of non-profit volunteers for the 2010 FIFA World Cup	1 963
2010 World Day Commemoration – Ethekwini, KZN	1 990
National Traditional Medicine Day celebrations – Limpopo	300
Supply of antivirus software	211
Supply of software	405
IT integration	400
Purchase of furniture	113
Procurement of services	602
Annual midwife congress	190
Purchase of furniture	159
Layout, design and translation of Down Syndrome booklet	147
Venue hire	431
Conference (4 to 7 July 2001)	36
Conference company (12 to 13 August 2000)	59
Drug literacy workshop (1 to 3 August 2001)	38
Design, compile and edit of article (April & May 2001)	40
Transportation of furniture: Cape Town to Pretoria (2 March 2002)	35
Payment for a National Conference for Home/Community Based Care	76
Racing Against Malaria – Drummer International	73
Gender Focal Point launch	34
Utilizing a helicopter during a MINMEC meeting on 7 November 2002	55
Fraud Hotline	59
Replacement of detector assembly on water thermabeam: Microsept (Pty) Ltd	39
SADC Health Minister's meeting: 2 to 3 August 2004: Roodevallei	23
Department's celebration of women's month to honour women staff: 27 August 2004: Zoological Gardens – Pretoria	23
Women's Day Celebration Function – Umzumbe	55
Procurement of video material for RAM rally – Panache Productions	53
Printing of report – Pre Rand Printers	8
Freelancers writing services	56
Service of medical equipment	38
Meeting for the implementation of the Comprehensive Plan	43
Human Resource Plan for Health	74
Gender Focal Point launch	31
Purchase of furniture	42
Orb diagnostics: Mission consumables	87
Catering services – Theleze Investments	3

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Incident	2010/11 R'000
Accommodation	35
Cabinet Unit – Queens Lifestyle	11
Placements of advertisements – Independent News papers	48
Removal of office furniture – AP Sepokwane Construction	12
Venue hire: Hilton Sandton	12
Venue hire: SARB	3
Purchase of a scanner – Waymark Infotech	25
Workshop held at Protea Hotel Centurion	9
Blum and Hofmeyer: Hiring of temps	485
Utilizing of helicopter	74
Hiring of venue	279
Purchasing of drawer cabinet	11
Utilizing of helicopter	97
Purchasing of blue lights	5
Removal of furniture	63
Malaria day event in KZN: 14 November 2008	684
Malaria day event in KZN: 14 November 2008	116
Décor and labour – Bonisiwe marketing communication	60
Hiring of temporary workers – Express Personnel Services	94
Appointment of a preferred consultant – 2009/10	921
Failure to obtain three written quotations	5
Presidential launch of the HIC Counselling and Testing (HCT) campaigns as well as the Provincial launch – Gauteng and KZN – 25 and 30 April 2010 – Marquee	753
Appointment of preferred consultant – 2010/11	691
Travel agents	23 358
Payments not made in accordance with timesheets – Magauta Recruitment	467
Payments made for computer training and consulting – Rhadzani and Xabiso	1 214
SA Clinical Trials Register – Wits Health Consortium	855
Total	43 274

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24. Fruitless and wasteful expenditure

24.1 Reconciliation of fruitless and wasteful expenditure

	Note	2010/11 R'000	2009/10 R'000
Opening balance		128	-
Fruitless and wasteful expenditure – relating to prior year		196	-
Fruitless and wasteful expenditure – relating to current year		2 556	140
Less: Amounts condoned		(191)	(12)
Less: Amounts transferred to receivables for recovery		(5)	-
Fruitless and wasteful expenditure awaiting condonation		**2 684**	**128**

Analysis of awaiting condonement per economic classification

Current	2 684	128
Total	**2 684**	**128**

24.2 Analysis of Current year's fruitless and wasteful expenditure

Incident	Disciplinary steps taken/criminal proceedings	2010/11 R'000
Printing of Lesedi	Awaiting information	16
Telephone and data lines not in use	Awaiting information	2 479
Interest paid on Telkom account	Awaiting information	19
Payments made not in accordance with timesheets	Awaiting information	42
Total		**2 556**

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25. Related party transactions

The following entities fall under the Minister of Health's portfolio:

- Medical Research Council
- National Health Laboratory Services
- Medical Schemes Council
- Compensation Commissioner for Occupational Diseases and
- South African National Aids Council

The transfer payments made to the related parties are disclosed in Annexure 1C, as no other transactions were concluded between the department and the relevant entities during the 2010/2011 financial year. Transactions made on behalf of SANAC to the value of R12.43 million are included in the expenditure of the National Department of Health.

An employee of another department had entered into business under the business name Motsweding Health Care Solutions with this department to the amount of R 235 822.60.

26. Key management personnel

	No. of Individuals	2010/11	2009/10
		R'000	R'000
Political office bearers (provide detail below)	2	4 900	2 694
Officials:			
Level 15 to 16	13	15 733	7 975
Level 14 (incl. CFO if at a lower level)	20	21 517	15 910
Family members of key management personnel	1	390	-
Total		**42 540**	**26 579**

The Minister's salary was R1 811 141,85 for the financial year. The salary and leave gratuity paid to the late Deputy Minister Sefularo amounts to R223 125,75. The salary for the Deputy Minister Ramakgopa for the period November 2010 till March 2011 amounts to R621 464,08.

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27. Public Private Partnership

A PPP agreement was concluded on 30 May 2003 and the partnership has been valid from 1 April 2003. This PPP aims to revive human vaccines manufacturing in South Africa.

In terms of the agreements entered into in 2003, the South African Government through the National Department of Health holds 40% shares in The Biovac Institute Pty Ltd (Biovac) whilst the Biovac Consortium holds 60%. In exchange for the 40% equity the National Department of Health transferred the staff and assets of the directorate, which housed the State Vaccine Institute to The Biovac Institute.

The department foresees no significant future cash flow to the PPP entity.

Part of the PPP agreement allows The Biovac Institute to source and supply all EPI vaccines of good quality at globally competitive prices to the provincial health departments.

Both The Biovac Consortium and the department were requested to dilute their equity in order to allow Cape Biotech (part of Department of Science and Technology) to take up a 12,5 % equity stake. Cape Biotech has invested in excess of R35m into The Biovac Institute. This dilution has been approved by Treasury and implemented in 2010.

The transfers into the PPP was estimated to have a value of R13.5 million and a valuation done on the December 2010 annual financial statement on the net assets value method placed a value of R 26.1 million on the National Department of Health's stake in the PPP.

In 2009 a review of the PPP was initiated by departments of health and treasury. The review process was concluded in 2010 and an extension of the supply agreement was given to the PPP for a further period to December 2016 in order to allow the PPP to meet its obligations / undertakings.
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28. Impairment and other Provisions

	Note	**2010/11**	**2009/10**
		R'000	**R'000**
Impairment			
Debtors		516	884
Total		**516**	**884**

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29. Movable Tangible Capital Assets

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Opening balance	Curr Year Adjust-ments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**109 411**	**6 032**	**18 003**	**(3 335)**	**130 111**
Transport assets	2 280	-	1 364	-	3 644
Computer equipment	37 408	4 062	5 046	(7)	46 509
Furniture and office equipment	7 811	345	1 083	-	9 239
Other machinery and equipment	61 912	1 625	10 510	(3 328)	70 719
TOTAL MOVABLE TANGIBLE CAPITAL ASSETS	**109 411**	**6 032**	**18 003**	**(3 335)**	**130 111**

29.1 Additions

ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Cash	Non-cash	(Capital Work in Progress current costs and finance lease payments)	Received current, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**17 714**	**-**	**-**	**289**	**18 003**
Transport assets	1 364	-	-	-	1 364
Computer equipment	4 889	-	-	157	5 046
Furniture and office equipment	948	-	-	135	1 083
Other machinery and equipment	10 513	-	-	(3)	10 510
TOTAL ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS	**17 714**	**-**	**-**	**289**	**18 003**

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29.2 Disposals

DISPOSALS OF MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Sold for cash	Transfer out or destroyed or scrapped	Total disposals	Cash Received Actual
	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**-**	**3 335**	**3 335**	**-**
Computer equipment	-	7	7	-
Other machinery and equipment	-	3 328	3 328	-
TOTAL DISPOSAL OF MOVABLE TANGIBLE CAPITAL ASSETS	**-**	**3 335**	**3 335**	**-**

29.3 Movement for 2009/10

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2010

	Opening balance R'000	Additions R'000	Disposals R'000	Closing balance R'000
MACHINERY AND EQUIPMENT	**98 351**	**11 970**	**910**	**109 411**
Transport assets	1 067	1 213	-	2 280
Computer equipment	33 264	4 430	286	37 408
Furniture and office equipment	7 045	769	3	7 811
Other machinery and equipment	56 975	5 558	621	61 912
TOTAL MOVABLE TANGIBLE ASSETS	**98 351**	**11 970**	**910**	**109 411**

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29.4 Minor assets

MINOR ASSETS OF THE DEPARTMENT AS AT 31 MARCH 2011

	Intangible assets R'000	Machinery and equipment R'000	Total R'000
Opening balance	106	30 063	30 169
Current Year Adjustments to Prior Year Balances	-	2 600	2 600
Additions	13	1 620	1 633
Disposals	-		
TOTAL	**119**	**34 283**	**34 402**

	Intangible assets	Machinery and equipment	Total
Number of R1 minor assets	-	950	950
Number of minor assets at cost	56	33 171	33 227
TOTAL NUMBER OF MINOR ASSETS	**56**	**34 121**	**34 177**

MINOR ASSETS OF THE DEPARTMENT AS AT 31 MARCH 2010

	Intangible assets R'000	Machinery and equipment R'000	Total R'000
Minor assets	106	30 063	30 169
TOTAL	**106**	**30 063**	**30 169**

	Intangible assets	Machinery and equipment	Total
Number of R1 minor assets	-	-	-
Number of minor assets at cost	47	32 732	32 779
TOTAL NUMBER OF MINOR ASSETS	**47**	**32 732**	**32 779**

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30. Intangible Capital Assets

MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
COMPUTER SOFTWARE	62 994	-	259	-	63 253
TOTAL INTANGIBLE CAPITAL ASSETS	**62 994**	**-**	**259**	**-**	**63 253**

30.1 Additions

ADDITIONS TO INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Cash	Non-Cash	(Development work in progress – current costs)	Received current year, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
COMPUTER SOFTWARE	206	-	-	53	259
TOTAL ADDITIONS TO INTANGIBLE CAPITAL ASSETS	**206**	**-**	**-**	**53**	**259**

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30.2 Disposals

DISPOSALS OF INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Sold for cash R'000	Transfer out or destroyed or scrapped R'000	Total disposals R'000	Cash Received Actual R'000
COMPUTER SOFTWARE				
TOTAL DISPOSALS OF INTANGIBLE CAPITAL ASSETS				

30.3 Movement for 2009/10

MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2010

	Opening balance R'000	Additions R'000	Disposals R'000	Closing balance R'000
COMPUTER SOFTWARE	61 660	1 334	-	62 994
TOTAL INTANGIBLE CAPITAL ASSETS	**61 660**	**1 334**	**-**	**62 994**

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31. STATEMENT OF CONDITIONAL GRANTS PAID TO THE PROVINCES

NAME OF PROVINCE / GRANT	GRANT ALLOCATION				TRANSFER			SPENT			2009/10
	Division of Revenue Act	Roll Overs	Adjustments	Total Available	Actual Transfer	Funds Withheld	Re-allocations by National Treasury or National Department	Amount received by department	Amount spent by department	% of available funds spent by department	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
National Tertiary Services											
Eastern Cape	557 137	-	-	557 137	557 137	-	-	557 137	557 137	100%	509 429
Free State	659 469	-	-	659 469	659 469	-	-	659 469	659 469	100%	642 835
Gauteng	2 561 154	-	-	2 561 154	2 561 154	-	-	2 561 154	2 561 009	100%	2 328 301
KwaZulu-Natal	1 102 585	-	-	1 102 585	1 102 585	-	-	1 102 585	1 102 517	100%	983 948
Limpopo	257 314	-	-	257 314	257 314	-	-	257 314	255 565	99%	176 871
Mpumalanga	91 879	-	-	91 879	91 879	-	-	91 879	90 769	99%	81 410
Northern Cape	225 948	-	-	225 948	225 948	-	-	225 948	219 651	97%	173 241
North West	179 280	-	-	179 280	179 280	-	-	179 280	179 249	100%	134 416
Western Cape	1 763 234	-	-	1 763 234	1 763 234	-	-	1 763 234	1 763 234	100%	1 583 991
HIV and AIDS											
Eastern Cape	690 940	-	1 000	691 940	691 940	-	-	691 940	691 940	100%	493 702
Free State	433 583	-	4 000	437 583	437 583	-	-	437 583	388 329	89%	298 931
Gauteng	1 277 683	-	4 000	1 281 683	1 281 683	-	-	1 281 683	1 281 683	100%	889 683
KwaZulu-Natal	1 498 811	-	20 000	1 518 811	1 518 811	-	-	1 518 811	1 500 926	99%	1 121 575
Limpopo	514 896	-	1 000	515 896	515 896	-	-	515 896	515 592	100%	402 133
Mpumalanga	383 646	-	4 000	387 646	387 646	-	-	387 646	387 646	100%	296 430
Northern Cape	182 306	-	4 000	186 306	186 306	-	-	186 306	183 493	98%	113 703
North West	475 838	-	1 000	476 838	476 838	-	-	476 838	476 838	100%	376 491
Western Cape	554 054	-	1 000	555 054	555 054	-	-	555 054	554 971	100%	383 538

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NAME OF PROVINCE / GRANT	GRANT ALLOCATION				TRANSFER			SPENT			2009/10
	Division of Revenue Act	Roll Overs	Adjust-ments	Total Available	Actual Trans-fer	Funds With-held	Re-alloca-tions by National Treasury or National De-partment	Amount received by de-partment	Amount spent by depart-ment	% of available funds spent by department	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Forensic Pathology Services											
Eastern Cape	69 345	-	-	69 345	69 345	-	-	69 345	63 070	91%	61 214
Free State	37 218	-	-	37 218	37 218	-	-	37 218	30 738	83%	32 855
Gauteng	92 421	-	-	92 421	92 421	-	-	92 421	50 772	55%	81 584
KwaZulu-Natal	152 406	-	-	152 406	152 406	-	-	152 406	152 406	100%	134 538
Limpopo	39 913	-	-	39 913	39 913	-	-	39 913	38 744	97%	35 233
Mpumalanga	50 107	-	-	50 107	50 107	-	-	50 107	46 016	92%	44 233
Northern Cape	22 868	-	-	22 868	22 868	-	-	22 868	20 131	88%	30 394
North West	26 433	-	-	26 433	26 433	-	-	26 433	26 433	100%	23 334
Western Cape	66 251	-	-	66 251	66 251	-	-	66 251	66 251	100%	58 484
Hospital Revitalisa-tion											
Eastern Cape	360 660	-	-	360 660	311 991	48 669	-	311 991	168 610	54%	238 611
Free State	378 426	-	-	378 426	332 533	45 893	-	332 533	244 634	74%	247 886
Gauteng	798 609	-	-	798 609	726 009	72 600	-	726 009	726 009	100%	755 190
KwaZulu/Natal	500 815	-	-	500 815	389 565	111 250	-	389 565	297 570	76%	449 558
Limpopo	323 425	-	-	323 425	274 256	49 169	-	274 256	234 309	85%	206 931
Mpumalanga	331 657	-	-	331 657	331 657	-	-	331 657	298 753	90%	457 941
Northern Cape	420 218	-	-	420 218	295 235	124 983	-	295 235	261 940	89%	340 197
North West	326 303	-	-	326 303	326 303	-	-	326 303	326 303	100%	254 644
Western Cape	580 554	-	-	580 554	580 554	-	-	580 554	580 554	100%	419 245

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DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2011

NAME OF PROVINCE / GRANT	GRANT ALLOCATION				TRANSFER			SPENT			2009/10
	Division of Revenue Act	Roll Overs	Adjustments	Total Available	Actual Transfer	Funds Withheld	Re-allocations by National Treasury or National Department	Amount received by department	Amount spent by department	% of available funds spent by department	Division of Revenue Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
Health Professional Training and Development											
Eastern Cape	160 444	-	-	160 444	160 444	-	-	160 444	160 444	100%	151 362
Free State	117 400	-	-	117 400	117 400	-	-	117 400	117 400	100%	110 755
Gauteng	651 701	-	-	651 701	651 701	-	-	651 701	651 701	100%	614 812
KwaZulu/Natal	235 771	-	-	235 771	235 771	-	-	235 771	235 771	100%	222 425
Limpopo	94 085	-	-	94 085	94 085	-	-	94 085	93 180	99%	88 759
Mpumalanga	76 149	-	-	76 149	76 149	-	-	76 149	76 149	100%	71 839
Northern Cape	61 802	-	-	61 802	61 802	-	-	61 802	61 802	100%	58 304
North West	83 324	-	-	83 324	83 324	-	-	83 324	83 324	100%	78 608
Western Cape	384 711	-	-	384 711	384 711	-	-	384 711	384 711	100%	362 935
2010 World Cup Health Preparations											
Eastern Cape	-	-	-	-	-	-	-	-	-		4 345
Free State	-	-	-	-	-	-	-	-	-		2 208
Gauteng	-	-	-	-	-	-	-	-	-		3 593
KwaZulu/Natal	-	-	-	-	-	-	-	-	-		3 581
Limpopo	-	-	-	-	-	-	-	-	-		4 345
Mpumalanga	-	-	-	-	-	-	-	-	-		4 345
North West	-	-	-	-	-	-	-	-	-		4 345
Western Cape	-	-	-	-	-	-	-	-	-		3 238
Disaster Response: Cholera											
Limpopo	-	-	-	-	-	-	-	-	-		50 000
	19 852 773	**-**	**40 000**	**19 892 773**	**19 440 209**	**452 564**	**-**	**19 440 209**	**18 867 743**	**97%**	**16 702 499**

National Health certifies that all transfers were deposited into the primary bank account of the province or where applicable, into the CPD account of the province.

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DISCLOSURE NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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32. WORLD CUP EXPENDITURE

	2010/11		2009/10
Purchase of world cup apparel	**Quantity**	**R'000**	**R'000**
Specify the nature of the purchase (e.g. t-shirts, caps, etc.)			
Reflective jackets	1 925	896	-
Reflective jackets	1 616	-	776
Lime caps	1 825	46	186
Non Profit Organisation volunteers	-	1 962	-
Department of Defence (training)	-	1 037	-
Total	**5 366**	**3 941**	**962**
Total world cup expenditure		**3 941**	**962**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1A
STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS

	TRANSFER ALLOCATION				TRANSFER		2009/10
DEPARTMENT/ AGENCY/ ACCOUNT	Adjusted Appro-priation	Roll Overs	Adjust-ments	Total Available	Actual Transfer	% of Available funds Transferred	Appro-priation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Compensation Fund	2 620	-	-	2 620	2 620	100%	3 679
Medical Research Council	270 509	-	6 000	276 509	276 509	100%	251 139
Medical Schemes Council	3 993	-	-	3 993	-		3 865
National Health Laboratory Services	77 709	-	47 200	124 909	124 909	100%	76 475
National Health Laboratory Services (Cancer Register)	415	-	-	415	-		392
Service Sector Education and Training Authority	370	-	-	370	370	100%	300
Human Science Research Council	-	-	4 600	4 600	4 600	100%	
	355 616	**-**	**57 800**	**413 416**	**409 008**		**335 850**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1B
STATEMENT OF TRANSFERS TO UNIVERSITIES AND TECHNIKONS

	TRANSFER ALLOCATION				TRANSFER			2009/10
UNIVERSITY/TECHNIKON	Adjusted Appropriation R'000	Roll Overs R'000	Adjust-ments R'000	Total Available R'000	Actual Transfer R'000	Amount not transferred R'000	% of Available funds Transferred %	Appro-priation Act R'000
University of Limpopo (MEDUNSA)	530	-	1 470	2 000	2 000	-	0%	500
University of Cape Town	530	-	(530)	-	-	-	-	500
University of Witwatersrand	-	-	2 000	2 000	-	2 000	100%	
	1 060	**-**	**2 940**	**4 000**	**2 000**	**2 000**	**50%**	**1 000**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1C
STATEMENT OF TRANSFERS/SUBSIDIES TO PUBLIC CORPORATIONS AND PRIVATE ENTERPRISES

	TRANSFER ALLOCATION				EXPENDITURE				2009/10
NAME OF PUBLIC CORPORATION/PRIVATE ENTERPRISE	Adjusted Appropriation Act	Roll Overs	Adjust-ments	Total Available	Actual Transfer	% of Available funds Transferred	Capital	Current	Appropria-tion Act
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	R'000
Public Corporations									
Non-Life Insurance	-	-	-	-	-		-	-	38
Total	**-**	**-**	**-**	**-**	**-**		**-**	**-**	**38**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1D
STATEMENT OF TRANSFERS TO NON-PROFIT INSTITUTIONS

	TRANSFER ALLOCATION				EXPENDITURE		2009/10
NON-PROFIT INSTITUTIONS	Adjusted Appropriation Act	Roll overs	Adjustments	Total Available	Actual Transfer	% of Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
Health Systems Trust	2 922	-	2 000	4 922	4 922	100%	2 757
Life Line	12 243	-	4 000	16 243	16 243	100%	11 550
Love Life	77 380	-	-	77 380	38 690	50%	94 000
SA Council for the Blind	585	-	-	585	585	100%	552
Soul City	16 960	-	-	16 960	16 960	100%	16 000
South African Aids Vaccine Institute	11 660	-	-	11 660	11 660	100%	13 000
South African Community Epidemiology Network on Drug Abuse	366	-	-	366	366	100%	508
South African Federation for Mental Health	261	-	-	261	258	99%	246
Health Promotion: NGO's	1 037	-	-	1 037	-	34%	982
National Council Against Smoking	-	-	-	-	350		-
Maternal, Child and Woman's Health: NGO's	1 149	-	-	1 149	-	0%	1 084
Tuberculosis: NGO 's	3 885	-	-	3 885	-	63%	3 665
TADSA	-	-	-	-	2 059		-
SARCS – National	-	-	-	-	380		-
Environmental Health: NGO's	95	-	-	95	-	0%	96
Mental Health and Substance Abuse: NGO's	148	-	-	148	-	100%	131
Down Syndrome SA	-	-	-	-	148		-
HIV and AIDS: NGO's	63 131	-	(2 000)	61 131	-	94%	61 444
ASHYO	-	-	-	-	1 548		
CATHCA Winterveld Office	-	-	-	-	2 973		-
Centre for Positive Care	-	-	-	-	3 260		-
Community Health Media Trust	-	-	-	-	1 495		-

ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1D
STATEMENT OF TRANSFERS TO NON-PROFIT INSTITUTIONS

	TRANSFER ALLOCATION				EXPENDITURE		2009/10
NON-PROFIT INSTITUTIONS	Adjusted Appropriation Act	Roll overs	Adjustments	Total Available	Actual Transfer	% of Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Cotlands	-	-	-	-	4 477		-
Disabled People SA	-	-	-	-	998		-
ECAP	-	-	-	-	600		-
Educational Support Service Trust	-	-	-	-	1 480		-
Friends for Life	-	-	-	-	1 205		-
Get Down Productions	-	-	-	-	1 064		-
HEAPS	-	-	-	-	4 901		-
Ikusasa Lesizwe	-	-	-	-	2 500		-
Khulisa Crime Prevention Initiative	-	-	-	-	1 495		-
Leandra Community Centre	-	-	-	-	1 490		-
Leseding Care Givers	-	-	-	-	2 108		-
Muslim Aida Programme	-	-	-	-	1 200		-
NAPWA	-	-	-	-	5 039		-
National Lesbian, Gay, Bisexual, Transsexual and Intersexual Health	-	-	-	-	600		-
NICDAM	-	-	-	-	1 300		-
SACBC	-	-	-	-	550		-
SAOP (for carers network project)	-	-	-	-	4 501		-
SARCS – National	-	-	-	-	4 503		-
Seboka Training & Support Network	-	-	-	-	1 807		-
South African Men's Action Group	-	-	-	-	2 000		-
Thusanang Youth Activity	-	-	-	-	1 688		-
Tshwaraganang	-	-	-	-	1 492		-
Zakheni Training & Development Centre	-	-	-	-	1 490		-
TOTAL	**191 822**	**-**	**4 000**	**195 822**	**150 385**	**77%**	**206 015**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1E
STATEMENT OF TRANSFERS TO HOUSEHOLDS

	TRANSFER ALLOCATION				EXPENDITURE		2009/10
	Adjusted Appropriation Act	Roll Overs	Adjust-ments	Total Available	Actual Transfer	% of Available funds Transferred	Appro-priation Act
HOUSEHOLDS	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**
Transfers							
Leave Gratuities	-	-	406	406	396	98%	933
	-	**-**	**406**	**406**	**396**	**98%**	**933**

ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1F
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2010/11 R'000	2009/10 R'000
Received in kind			
GlaxoSmithKline	Conference	-	24
GMP Applicants	Inspection of Good Manufacturing Practice	254	102
South African Developing Countries	Meetings, workshops, National Malaria Review	158	851
UNICEF	Travel and subsistence	128	102
USAIDS	Equipment and meetings	55	404
World Health Organisation	Various meetings, workshops, conferences, investigation, printing, training	1 705	1 650
Other	Conferences, meetings, training, workshops, etc	157	172
Department of International Development	Nursing campaign	2 105	3 284
US Department of Agriculture	Workshop, meeting	101	71
PEPFAR and PATH	Conference, travel, accommodation and recordings	1 418	32
Centre for Disease Control, Atlanta	Meetings, Workshop	2 597	324
Atlantic Philanthropies	Consultants	-	893
Bundeskriminalamt	Training	-	36
Convention Secretariat	Meeting	-	65
Council of Europe	Conference	-	40
Department of Health, Taiwan	Forum	-	37
DG Trade	Training	-	92
Family Health International	Meetings	-	44
Elizabeth Glazer Paediatrics AIDS Foundation	Hiring of equipment, catering, consultants	-	247
International Atomic Energy Agency	Travel and subsistence	60	61
International Organization for Migration	Meeting	-	44
International Training Centre of International Training	Workshop	-	33
Italian Government	Vehicle	-	92
London School of Hygiene and Tropical Medicine	Conference	-	46
Medi-Clinic	Catering	-	60

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1F
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2010/11 R'000	2009/10 R'000
Migration Dialogue for SA	Workshop	-	37
NEPAD	Meetings	-	54
NICD	Conference, printing	-	126
Office of International Programme	Workshop	-	54
People's Republic of China	Training	4	84
PHSDSBC	Travel and subsistence	44	81
Policy Centre for Inclusive Growth	Forum	-	62
Roche	Congress	-	44
Society for Family Health	Study tour	-	30
Swedish International Development Agency	Training	24	120
UNFPA and FIGO	Travel and subsistence	26	99
University Research Corporation	Conference, forum, seminar, 2009 Health Awards	-	1 093
Zambian Ministry	Summit	-	30
Abu Dhabi Food Control Authority	Travel and subsistence	21	-
AU/IBAR	Travel and subsistence	22	-

ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1F
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2010/11 R'000	2009/10 R'000
Bill and Melinda Gates Foundation	Travel and subsistence	384	-
Commonwealth Secretariat	Travel and subsistence	21	-
Global Business Coalition	Travel and subsistence	23	-
Global Health Group	Travel and subsistence	22	-
University of Cape Town	Travel and subsistence	35	-
International Centre for AIDS Care and Treatment	Travel and subsistence	400	-
International Council for Nurses	Travel and subsistence	100	-
IPAS	Travel and subsistence	41	-
International Training and Education Centre for Health, SA	Conference	368	-
Roll Back Malaria Secretariat	Travel and subsistence	93	-
Sanofi Pasteur	Vaccines	11 203	-
TOTAL		**21 569**	**10 720**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1G
STATEMENT OF AID ASSISTANCE RECEIVED

NAME OF DONOR	PURPOSE	OPENING BALANCE	REVENUE	EXPENDI-TURE	CLOSING BALANCE
		R'000	R'000	R'000	R'000
Received in kind					
Local					
University of Cape Town	Travel and subsistence	-	35	35	-
International Training and Education Centre for Health, SA	Conference	-	368	368	-
PHSDSBC	Travel and subsistence	-	44	44	-
Medicines Control Council	Catering	-	10	10	-
Foreign					
GMP Applicants	Inspection of Good Manufacturing Practice	-	254	254	-
South African Developing Countries	Meetings, workshops, National Malaria Review	-	158	158	-
UNICEF	Travel and subsistence	-	128	128	-
USAIDS	Equipment and meetings	-	55	55	-
World Health Organisation	Various meetings, workshops, conferences, investigation, printing, training	-	1 705	1 705	-
Other	Conferences, meetings, training, work-shops, etc	-	147	147	-
Department of International Development	Nursing campaign	-	2 105	2 105	-
US Department of Agriculture	Workshop, meeting	-	101	101	-
PEPFAR and PATH	Conference, travel, accommodation and recordings	-	1 418	1 418	-
Centre for Disease Control, Atlanta	Meetings, workshop	-	2 597	2 597	-
International Atomic Energy Agency	Travel and subsistence	-	60	60	-
People's Republic of China	Training	-	4	4	-
Swedish International Development Agency	Training	-	24	24	-
UNFPA and FIGO	Travel and subsistence	-	26	26	-
Abu Dhabi Food Control Authority	Travel and subsistence	-	21	21	-

NATIONAL DEPARTMENT OF HEALTH
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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1G
STATEMENT OF AID ASSISTANCE RECEIVED

NAME OF DONOR	PURPOSE	OPENING BALANCE	REVENUE	EXPENDI-TURE	CLOSING BALANCE
		R'000	R'000	R'000	R'000
AU/IBAR	Travel and subsistence	-	22	22	-
Bill and Melinda Gates Foundation	Travel and subsistence	-	384	384	-
Commonwealth Secretariat	Travel and subsistence	-	21	21	-
Global Business Coalition	Travel and subsistence	-	23	23	-
Global Health Group	Travel and subsistence	-	22	22	-
International Centre for AIDS Care and Treatment Programmes	Travel and subsistence	-	400	400	-
International Council for Nurses	Travel and subsistence	-	100	100	-
IPAS	Travel and subsistence	-	41	41	-
Roll Back Malaria Secretariat	Travel and subsistence	-	93	93	-
Sanofi Pasteur	Vaccines	-	11 203	11 203	-
TOTAL		**-**	**21 569**	**21 569**	**-**

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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 1H
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS MADE AND REMMISSIONS, REFUNDS AND PAYMENTS MADE AS AN ACT OF GRACE

NATURE OF GIFT, DONATION OR SPONSORSHIP (Group major categories but list material items including name of organisation	2010/11 R'000	2009/10 R'000
Made in kind		
Donation to Stellenbosch University: Desmond Tutu TB Centre	-	2 000
Donation to TB Conference, June 2010	214	-
Subtotal	**214**	**2 000**
Remissions, refunds, and payments made as an act of grace		
Refund as an act of grace – payment for blood tests	-	1
Act of grace – damage to private vehicle	2	-
Act of grace – loss of official passport while on official trip	8	-
Subtotal	**10**	**1**
TOTAL	**224**	**2 001**

NATIONAL DEPARTMENT OF HEALTH
ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 2A
STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2011 – LOCAL

Guarantor institution	Guarantee in respect of	Original guaranteed capital amount	Opening balance 1 April 2010	Guarantees draw downs during the year	Guarantees repayments/ cancelled/ reduced/ released during the year	Revaluations	Closing balance 31 March 2011	Guaranteed interest for year ended 31 March 2011	Realised losses not recoverable i.e. claims paid out
		R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
	Motor vehicles								
Stannic		589	190	299	206	-	283		
	Subtotal	**589**	**190**	**299**	**206**	**-**	**283**		
	Housing								
ABSA		56	56	-	-	-	56		
Nedbank (NBS and BOE)		87	87	-	-	-	87		
First Rand Bank (FNB)		250	250	-	-	-	250		
Nedbank		154	154	-	12	-	142		
Old Mutual (Permanent Bank)		31	31	-	13	-	18		
People Bank		17	17	-	-	-	17		
Standard Bank		151	151	-	86	-	65		
	Subtotal	**746**	**746**	**-**	**111**	**-**	**635**		
	TOTAL	**1 335**	**936**	**299**	**317**	**-**	**918**		

NATIONAL DEPARTMENT OF HEALTH
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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 2B
STATEMENT OF CONTINGENT LIABILITIES AS AT 31 MARCH 2011

Nature of Liability	Opening Balance 01/04/2010	Liabilities in-curred during the year	Liabilities paid / cancelled / reduced during the year	Liabilities recover-able (Provide details hereunder)	Closing Balance 31/03/2011
	R'000	R'000	R'000	R'000	R'000
Claims against the department					
CCMA case against the Depart-ment: OSD: Mr. Mcuba	-	199	-	-	199
Total	-	199	-	-	199

NATIONAL DEPARTMENT OF HEALTH
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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 3

CLAIMS RECOVERABLE

Government Entity	Confirmed balance out-standing		Unconfirmed balance out-standing		Total	
	31/03/2011	31/03/2010	31/03/2011	31/03/2010	31/03/2011	31/03/2010
	R'000	R'000	R'000	R'000	R'000	R'000
Department						
Provincial Health: Eastern Cape	4 542	1 240	-	-	4 542	1 240
Provincial Health: Gauteng	416	388	-	-	416	388
Provincial Health: KwaZulu-Natal	1 546	1 570	-	-	1 546	1 570
Provincial Health: Mpumalanga	1 030	1 005	-	-	1 030	1 005
Provincial Health: Northern Cape	496	496	-	-	496	496
Provincial Health: Limpopo	98	32	-	-	98	32
Provincial Health: North West	17	423	-	-	17	423
Provincial Health: Free State	-	87	-	-	-	87
National Department of Justice and Constitutional Development	-	11	-	-	-	11
Presidency	102	146	-	-	102	146
Provincial Education, Gauteng	-	20	-	-	-	20
National Department of Foreign Affairs (DIRCO)	1 007	20 457	-	-	1 007	20 457
Provincial Social Development, Gauteng	-	19	-	-	-	19
National Department of Agriculture and Forestry	10	-	-	-	10	-
National Department of Environmental Affairs	9	-	-	-	9	-
Government Employee Pension Fund	15	-	-	-	15	-
Home Affairs	16	-	-	-	16	-
National Department of Tourism	17	-	-	-	17	-
National Department of Water Affairs and Forestry	20	-	-	-	20	-
Provincial Department of Public Works, KwaZulu/Natal	18	-	-	-	18	-
Provincial Health, Western Cape	13	-	-	-	13	-
TOTAL	**9 372**	**25 894**	**-**	**-**	**9 372**	**25 894**

NATIONAL DEPARTMENT OF HEALTH
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ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 4
INTER-GOVERNMENT PAYABLES

GOVERNMENT ENTITY	Confirmed balance outstanding		Unconfirmed balance out-standing		TOTAL	
	31/03/2011	31/03/2010	31/03/2011	31/03/2010	31/03/2011	31/03/2010
	R'000	R'000	R'000	R'000	R'000	R'000
DEPARTMENTS						
Current						
Provincial Health: Eastern Cape	1 558	3 192	-	-	1 558	3 192
Provincial Health: KwaZulu/ Natal	2 319	3 944	-	-	2 319	3 944
Provincial Health: Mpumalanga	1 018	1 712	-	-	1 018	1 712
Provincial Health: Limpopo	6 737	14 539	-	-	6 737	14 539
Provincial Health: Northern Cape	2 636	3 410	-	-	2 636	3 410
Provincial Health: North West	3 270	4 471	-	-	3 270	4 471
National Department of Foreign Affairs (DIRCO)	-	2 058	-	-	-	2 058
Public Works			37 524		37 524	
Subtotal	**17 538**	**33 326**	**37 524**	**-**	**55 062**	**33 326**
Total	**17 538**	**33 326**	**37 524**	**-**	**55 062**	**33 326**
OTHER GOVERNMENT ENTITY						
Current						
Communication Responsive Programme	-	410	-	-	-	410
GE Health Care	-	37	-	-	-	37
Subtotal	**-**	**447**	**-**	**-**	**-**	**447**
Total	**-**	**447**	**-**	**-**	**-**	**447**

ANNEXURES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2011

ANNEXURE 5
INVENTORY

	Note	2010/11 Quantity	2010/11 R'000	2009/10 Quantity	2009/10 R'000
Inventory					
Opening balance		15 696	1 358	793	1 149
Add/(Less): Adjustments to prior year balances		(270)	(6)	-	-
Add/(Less): Additions/Purchases – Cash		5 184 983	166 284	491 645 580	351 584
(Less): Disposals		-	-	(493)	(72)
(Less): Issues		(5 156 168)	(166 276)	(491 630 184)	(351 303)
Closing balance		**44 241**	**1 360**	**15 696**	**1 358**

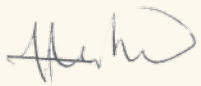
Damaged Oseltamivir for the outbreak of the H1N1 was disposed off during 2009/10.

FINANCIAL STATEMENTS OF SOUTH AFRICAN NATIONAL AIDS TRUST
for the year ended 31 March 2011

CONTETS

Approval of the financial statements

The annual financial statements are approved by the Board of Trustees on 31 May 2011 and are signed on its behalf by:



Ms MP Matsoso

Accounting Authority for Board of Trustees

SOUTH AFRICAN NATIONAL AIDS TRUST

REPORT OF THE BOARD OF TRUSTEES

in respect of the year ended 31 March 2011-09-27

General Review

The Trust was established in September 2002. The deed stipulates that the Trust is to be controlled by a Board of Trustees who should administer all moneys obtained by way of donations, grants, loans, or subsidies in such a manner as to further the objective of the Trust subject to the terms of conditions of the Trust deed.

The Trust was dormant during the year under review and thus performance information is not available for the reporting period.

Financial result and state of affairs

The financial results for the year under review are reflected in the Income Statement and the financial position of the Fund at 31 March 2011 is set out in the Balance Sheet.

No material fact or circumstances have occurred between the Balance Sheet and date of this report.

Trustees

The members of the Board for 2010/2011 were:

Dr T Mbengashe

Dr N Simelela

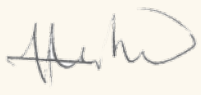
Mr V Madonsela

Mr B Ncqwaneni

Mr M Heywood

Prof. H Rees

Rev. D Lambrechts



Ms MP Matsoso
Accounting Authority for Board of Trustees
Date: 31-05-2011

REPORT OF THE AUDITOR-GENERAL TO PARLIAMENT ON THE SOUTH AFRICAN NATIONAL AIDS TRUST

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the accompanying financial statements of the South African National Aids Trust (SANAT), which comprise the statement of financial position as at 31 March 2011, and the statement of financial performance, statement of changes in net assets and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory information, as set out on pages 236 to 242.

Accounting authority's responsibility for the financial statements

2. The accounting officer is responsible for the preparation and fair presentation of these financial statements in accordance with South African Standards of Generally Recognised Accounting Practice (SA Standards of GRAP) and the requirements of the Public Finance Management Act of South Africa (PFMA), and for such internal control as management determines necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-General's responsibility

3. As required by section 188 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996) and, section 4 of the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), my responsibility is to express an opinion on these financial statements based on my audit.

4. I conducted my audit in accordance with International Standards on Auditing and *General Notice 1111 of 2010* issued in *Government Gazette 33872 of 15 December 2010*. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

5. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

6. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

7. In my opinion, the financial statements present fairly, in all material respects, the financial position of the South African National Aids Trust as at 31 March 2011, and its financial performance and cash flows for the year then ended in accordance with SA Standards of GRAP and the requirements of the PFMA.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

8. 8. In accordance with the PAA and in terms of *General notice 1111 of 2010*, issued in *Government Gazette 33872 of 15 December 2010*, I include below my findings on the annual performance report and material non-compliance with laws and regulations applicable to the South African National Aids Trust.

Predetermined objectives

9. Due to the entity being dormant during the year the trust did not prepare a strategic plan and therefore did not report any performance information.

Compliance with laws and regulations

10. There are no findings concerning material non-compliance with laws and regulations applicable to the South African National Aids Trust.

Internal Control

11. In accordance with the PAA and in terms of *General notice 1111 of 2010*, issued in *Government Gazette 33872 of 15 December 2010*, I considered internal control relevant to my audit, but not for the purpose of expressing an opinion on the effectiveness of internal control. There are no significant deficiencies in internal control that resulted in a qualification of the auditor's opinion on the financial statements and/or material non-compliance with laws and regulations.

Auditor - General

Pretoria

29 July 2011

AUDITOR-GENERAL SOUTH AFRICA

Auditing to build public confidence

SOUTH AFRICAN AIDS TRUST (IT64881/02)

STATEMENT OF FINANCIAL POSITION

as at 31 March 2011

	Notes	2010/2011	2009/2010
		R	R
Assets			
Current assets			
Cash and cash equivalents	3	43 462 708	41 735 500
Lessor deposit receivable	4	32 358	32 358
Accrued Interest		29 173	34 692
Total assets		**43 524 239**	**41 802 550**
Net Assets and Liabilities			
Accumulated funds		**43 524 239**	41 802 550
Total Net Assets		**43 524 239**	**41 802 550**

SOUTH AFRICAN AIDS TRUST(IT64881/02)

STATEMENT OF FINANCIAL PERFORMANCE

for the year ended 31 March 2011

	Notes	2010/2011	2009/2010
		R	R
Income			
Interest received		1 722 671	2 259 875
Net income		**1 722 671**	**2 259 875**
Expenses			
Administrative	**1**	982	832
Net expenses		**982**	**832**
Net surplus		**1 721 689**	**2 259 044**

SOUTH AFRICAN AIDS TRUST(IT64881/02)

STATEMENT OF CHANGES IN NET ASSETS

for the year ended 31 March 2011

	2010/2011	2009/2010
Accumulated funds at the beginning of the year	41 802 550	39 543 506
Net surplus for the year	1 721 689	2 259 044
	1 721 689	**2 259 044**
Accumulated funds at the end of the year	**43 524 239**	**41 802 550**

SOUTH AFRICAN AIDS TRUST(IT64881/02)

CASH FLOW STATEMENT

for the year ended 31 March 2011

	Notes	**2010/2011**	**2009/2010**
		R	**R**
Cash flows from operating activities			
Cash paid to suppliers and employees		982	832
Cash utilised in operations	*2*	(982)	(832)
Cash flows from investing activities			
Interest received		1 728 190	2 225 183
Net cash from investing activities		**1 727 208**	**2 224 351**
Net increase in cash and cash equivalents		**1 727 208**	**2 224 351**
Cash and cash equivalents at beginning of period		41 735 500	39 511 148
Cash and cash equivalents at end of period	*3*	**43 462 708**	**41 735 500**

SOUTH AFRICAN NATIONAL AIDS TRUST (IT64881/02)

NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 March

1 Accounting Policies

The financial statemens have been prepared in accordance with the effective Standards of Generally Recognised Accounting Practices (GRAP) including any interpretations, guidelines and directives issued by the Accounting Standards Board. During the year under review the Trust changed its accounting policy from SA GAAP to GRAP in order to comply with the requirements of the 2011 Audit Directive. The change in the basis of preparation did not result in any changes in accounting policies and did not result in any restatement of comparative figures.

2 Trade debtors and other receivables

Accounts receivables are carried at fair value less provisions made for impairment in the fair value of these receivables. Where circumstances reveal doubtful recovery of amounts outstanding, a provision for impaired receivables is made and charged to the income statement.

3 Trade creditors and other payables

Trade and other payables are recognised at the fair value of the consideration to be paid in future for the goods and services that have been received or supplied and invoiced or formally agreed with the supplier.

4 Revenue

Comprises of interest received on bank deposits. Interest is recognised using the effective interest rate.

5 Comparatives

Were necessary prior year comparative figures have been reclassified to conform to changes in presentation in the current year

6. Going concern

The financial position of the Trust is such that the Accounting Authority is of the view that its operations will continue for as long as its mandate remains.

7. Taxation

No provision for taxation is made because the Trust is exempt from income tax in terms of section 10(1) (cA). of the Income Tax Act, 1962 (Act No: 58 of 1962).

SOUTH AFRICAN NATIONAL AIDS TRUST (IT64881/02)

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2011

		2010/2011	2009/2010
		R	R
1	**Administrative expenses**		
	Bank charges	982	832
		982	832
2	**Net Cash Flow Generated by Operating Activities**		
	Net Surplus as per Income Statement	1 721 689	2 259 044
	Adjustment for:		
	Non-Cash Items		
	Interest Received	(1 722 671)	(2 259 875)
	Operating surplus before working capital changes	(982)	(832)
	Working capital changes:		
	Increase / (decrease) in accounts payable		
	(Increase) / decrease in accounts receivable		
	Cash utilised in operations	**(982)**	**(832)**
3	**Cash and Cash Equivalents**		
	Corporate Bank Account	43 462 708	41 735 500
		43 462 708	**41 735 500**
4	**Trade and other receivables**		
	Deposit held by lessor	32 358	32 358
		32 358	**32 358**

SOUTH AFRICAN NATIONAL AIDS TRUST (IT64881/02)

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2011

This amount was required by the lessor as a deposit at the inception of the lease contract. It is repayable on 28 February 2006 at the end of the lease contract. The amount will only be deposited back into trust account under financial year 2010-11 when the account is in operation

5 Financial instruments

Exposure to credit and interest rates risk arises in the normal course of the Trust's business

	Weighted avarage effective interest rate	Floating interest rate	Fixed interest rate	Non interest bearing	Total
Assets					
Trade receivables	-	-	-	32 358	**32 358**
Cash and Cash Equivalents	-	43 462 708	-	-	**43 462 708**

4. HUMAN RESOURCE MANAGEMENT

Table 1.1 - Main service for service delivery improvement and standards

Main services	Actual customers	Potential customers	Standard of service	Actual achievement against standards
Improving performance management and development of human resource	Employees of the NDoH	DPSA, Cabinet	All senior managers should have individual performance agreements, from which other employees should have individual workplans that stipulate desired objectives to be achieved	Senior managers are submitting individual performance agreements. The performance management and development system has been reviewed and an e-appraisal system has been developed
Ensuring that posts are correctly graded to ensure adequate remuneration	Employees of the NDoH	DPSA, organised labour organisations	A job evaluation system that is applied to ensure equal pay for work of equal value	The developed job evaluation policy is complied with
Ensuring that critical posts are filled	Management of the NDoH	DPSA, provincial health departments, private organisations, public	Effective recruitment and retention of human resources	The developed recruitment and selection policy is complied with
Ensuring ongoing consultation with stakeholders on matters of mutual interest	Organised labour organisations	PHSDSBC	Functioning bargaining structures in place	Regular engagement with stakeholders takes place in the bargaining chamber

Table 1.2 - Consultation arrangements for customers

Type of arrangement	Actual customer	Potential customer	Actual achievements
Accessibility to all HR services and information	All employees in the NDoH	Other state departments and organs of state	Information is accessible on request, but also on a regularly updated departmental intranet site and circulars
Active engagement with organised labour in the PHSDSBC on matters of mutual interest	Organised labour organisations	PHSDSBC	Regular engagement with stakeholders takes place in the bargaining chamber

Table 1.3 - Service delivery access strategy

Access strategy	Actual achievements
Personal interaction, circulars, briefings to management, induction sessions and workshops	Information is available and accessible based on the requirements from the client

Table 1.4 - Service information tool

Type of information tool	Actual achievements
Quarterly reporting	Quarterly reporting
Publishing of strategic plan	Annual reporting
Intranet	Regularly updated intranet

Table 1.5 - Complaint mechanism

Complaint mechanism	Actual achievements
Grievance and complaints procedure	HR related grievances are addressed in collaboration with employment relations and the relevant line managers

Table 2.1 - Personnel costs by programme

Programme	Total voted expenditure (R'000)	Compensation of employees expenditure (R'000)	Training expenditure (R'000)	Professional and special services (R'000)	Compensation of employees as percent of total expenditure *1	Average compensation of employees cost per employee (R'000) *2	Employment *3
Dhl: Administration	260 272	105 880	649	148 758	40.7	271	391
Dhl: Health planning and monitoring	391 347	60 259	523	40 448	15.4	213	283
Dhl: Health services	11 072 393	43 571	553	57 999	0.4	220	198
Dhl: Human resource management and development	1 883 283	13 685	392	4 055	0.7	187	73
Dhl: International relations, health trade and product regulation	78 379	43 458	632	34 380	55.4	126	275
Dhl: Strategic health programmes	7 232 905	86 801	669	258 921	1.2	472	184
Z=Total as on financial systems (BAS)	**20 918 580**	**353 654**	**3 418**	**544 561**	**1.7**	**240**	**1 404**

* 1: Compensation of employees expenditure per programme divided by total voted expenditure multiplied by 100

* 2: Compensation of employees expenditure per programme divided by number of employees in programme

* 3: Employment in numbers

Table 2.2 - Personnel costs by salary band

Salary bands	Compensation of employees cost (R'000)	Percentage of total personnel cost for department *1	Average compensation cost per employee (R) *2	Total personnel cost for department including goods and transfers (R'000)	Number of employees
Lower skilled (levels 1-2)	8 568	2.4	164 769	353 654	52
Skilled (levels 3-5)	33 382	9.4	112 777	353 654	296
Highly skilled production (levels 6-8)	75 806	21.4	202 149	353 654	375
Highly skilled supervision (levels 9-12)	122 022	34.5	351 648	353 654	347
Senior management (levels 13-16) *	57 648	16.3	711 704	353 654	81
Contract (levels 1-2)	1 345	0.4	149 444	353 654	9
Contract (levels 3-5)	5 528	1.6	115 167	353 654	48
Contract (levels 6-8)	4 046	1.1	238 000	353 654	17
Contract (levels 9-12)	9 621	2.7	356 333	353 654	27
Contract (levels 13-16)	22 929	6.5	917 160	353 654	25
Periodical remuneration	12 759	3.6	100 465	353 654	127
Total	**353 654**	**100**	**251 890**	**353 654**	**1 404**

* Includes minister and deputy minister

* 1: Compensation of employees per salary band divided by total multiplied by 100

* 2: Compensation of employees per salary band divided by number of employees per salary band (in hundreds)

Table 2.3 - Salaries, overtime, home owners allowance and medical aid by programme

Programme	Salaries (R'000)	Salaries as % of personnel cost *1	Overtime (R'000)	Overtime as % of personnel cost *2	HOA (R'000)	HOA as % of personnel cost *3	Medical ass. (R'000)	Medical ass. as % of personnel cost *4	Total personnel cost per programme (R'000)
Dhl: Administration	70 124	66	937	1	3 202	3	4 278	4	105 880
Dhl: Health planning and monitoring	40 756	68	1 416	2	1 382	2	2 524	4	60 259
Dhl: Health services	28 980	67	478	1	1 520	3	1 998	5	43 571
Dhl: Human resource management and development	9 191	67	0	0	439	3	565	4	13 685
Dhl: International relations, health trade and product regulation	27 759	64	15	0	925	2	1 297	3	43 458
Dhl: Strategic health programmes	59 908	69	254	0	2 070	2	3 263	4	86 801
Total	**236 718**	67	**3 100**	1	**9 538**	3	**13 924**	4	**353 654**

* 1: Salaries divided by total compensation of employees expenditure in Table 2.1 multiplied by 100

* 2: Overtime divided by total compensation of employees expenditure in Table 2.1 multiplied by 100

* 3: Home owner allowance divided by total compensation of employees' expenditure in Table 2.1 multiplied by 100

* 4: Medical assistance divided by total compensation of employees expenditure in Table 2.1 multiplied by 100

Table 2.4 - Salaries, overtime, home owners allowance and medical aid by salary band

Salary bands	Salaries (R'000)	Salaries as % of personnel cost *1	Overtime (R'000)	Overtime as % of personnel cost *2	HOA (R'000)	HOA as % of personnel cost *3	Medical ass. (R'000)	Medical ass. as % of personnel cost *4	Total personnel cost per salary band (R'000)
Lower skilled (levels 1-2)	5 601	65.4	610	7.1	627	7.3	704	8.2	8 568
Skilled (levels 3-5)	21 467	64.3	984	2.9	2 063	6.2	2 882	8.6	33 382
Highly skilled production (levels 6-8)	53 882	71.1	1 148	1.5	2 363	3.1	4 578	6	75 806

Highly skilled supervision (levels 9-12)	79 987	65.6	358	0.3	2 182	1.8	3 523	2.9	122 022
Senior management (levels 13-16)	46 787	81.2	0	0	1 098	1.9	809	1.4	57 648
Contract (levels 1-2)	331	24.6	0	0	0	0	0	0	1 345
Contract (levels 3-5)	1 060	19.2	0	0	495	9	0	0	5 528
Contract (levels 6-8)	1 907	47.1	0	0	308	7.6	0	0	4 046
Contract (levels 9-12)	6 884	71.6	0	0	90	0.9	27	0.3	9 621
Contract (levels 13-16)	18 812	82	0	0	312	1.4	208	0.9	22 929
Periodical remuneration *5	0		0		0		0		12 759
Total	**236 718**	**66.9**	**3 100**	**0.9**	**9 538**	**2.7**	**12 731**	**3.6**	**353 654**

* 1: Salaries divided by total compensation of employees in Table 2.2 multiplied by 100

* 2: Overtime divided by total compensation of employees in Table 2.2 multiplied by 100

* 3: Home owner allowance divided by total compensation of employees in Table 2.2 multiplied by 100

* 4: Medical assistance divided by total compensation of employees in Table 2.2 multiplied by 100

* 5: Payments are only made for Medicine Control Council stipends and not a salary

Table 3.1 - Employment and vacancies by programme at end of period

Programme	Number of posts	Number of posts filled	Vacancy rate *1	Number of posts filled additional to the establishment
Dhl: Administration	546	391	28.4	18
Dhl: Health planning and monitoring	413	283	31.5	23
Dhl: Health services	300	198	34	4
Dhl: Human resource management and development	211	73	65.4	24
Dhl: International relations, health trade and product regulation	197	148	24.9	3
Dhl: Strategic health programmes	245	184	24.9	23
Total	1 912	**1 277**	**33.2**	95

* 1: Number of posts minus number of posts filled divided by number of posts multiplied by 100

Table 3.2 - Employment and vacancies by salary band at end of period

Salary band	Number of posts	Number of posts filled	Vacancy rate *1	Number of posts filled additional to the establishment
Lower skilled (levels 1-2), Permanent	68	52	23.5	0
Lower skilled (levels 1-2), Temporary	5	5	0	0
Skilled (levels 3-5), Permanent	386	297	23.1	0
Skilled (levels 3-5), Temporary	0	0	0	0
Highly skilled production (levels 6-8), Permanent	555	377	32.1	0
Highly skilled production (levels 6-8), Temporary	2	1	50	0
Highly skilled supervision (levels 9-12), Permanent	565	351	37.9	0
Highly skilled supervision (levels 9-12), Temporary	1	1	0	0
Senior management (levels 13-16), Permanent	131	97	26	0
Senior management (levels 13-16), Temporary	1	1	0	0
Contract (levels 1-2), Permanent	4	4	0	4
Contract (levels 3-5), Permanent	149	47	68.5	47
Contract (levels 6-8), Permanent	14	14	0	14
Contract (levels 9-12), Permanent	23	22	4.3	22
Contract (levels 13-16), Permanent	8	8	0	8
Total	**1 912**	**1 277**	**33.2**	**95**

* 1: Number of posts minus number of posts filled divided by number of posts multiplied by 100

Table 3.3 - Employment and vacancies by critical occupation at end of period

Critical occupations	Number of posts	Number of posts filled	Vacancy rate *1	Number of posts filled additional to the establishment
Administrative related, Permanent	2		100	0
Auxiliary and related workers, Permanent	7		100	0
Chemists, Permanent	11		100	0
Computer programmers, Permanent	1		100	0
Financial and related professionals, Permanent	4		100	0

Financial clerks and credit controllers, Permanent	21		100	0
Information technology related, Permanent	4		100	0
Messengers porters and deliverers, Permanent	1		100	0
Other administration and related clerks and organisers, Permanent	1		100	0
Other information technology personnel, Permanent	1		100	0
Physicists, Permanent	7		100	0
Secretaries and other keyboard operating clerks, Permanent	1		100	0
Security officers, Permanent	5		100	0
Senior managers, Permanent	4		100	0
Total	**70**	**0**	**100**	**0**

* 1: Number of posts minus number of posts filled divided by number of posts multiplied by 100

Office note: Vacant positions were identified as critical. These posts have been listed per occupational classification

Table 4.1 - Job evaluation

Salary band	Number of posts	Number of jobs evaluated	% of posts evaluated *1	Number of posts upgraded	% of upgraded posts evaluated *2	Number of posts downgraded	% of downgraded posts evaluated *3
Lower skilled (levels 1-2)	68	1	1.5	0	0	0	0
Contract (levels 1-2)	9	0	0	0	0	0	0
Contract (levels 3-5)	149	0	0	0	0	0	0
Contract (levels 6-8)	16	0	0	0	0	0	0
Contract (levels 9-12)	24	0	0	0	0	0	0
Contract (Band A)	5	0	0	0	0	0	0
Contract (Band B)	1	0	0	0	0	0	0
Contract (Band C)	2	0	0	0	0	0	0
Contract (Band D)	1	0	0	0	0	0	0
Skilled (levels 3-5)	386	185	47.9	175	94.6	0	0
Highly skilled production (levels 6-8)	555	28	5	0	0	0	0
Highly skilled supervision (levels 9-12)	565	44	7.8	2	4.5	2	4.5
Senior management service Band A	93	3	3.2	0	0	0	0

Senior management service Band B	27	1	3.7	0	0	0	0
Senior management service Band C	7	0	0	0	0	0	0
Senior management service Band D	4	0	0	0	0	0	0
Total	**1 912**	**262**	**13.7**	**177**	**67.6**	**2**	**0.8**

* 1: Number of jobs evaluated divided by number of posts multiplied by 100

* 2: Number of posts upgraded divided by number of jobs evaluated multiplied by 100

* 3: Number of posts downgraded divided by number of jobs evaluated multiplied by 100

Table 4.2 - Profile of employees whose positions were upgraded due to their posts being upgraded

Beneficiaries	African	Asian	Coloured	White	Total
Female	23	1	1	0	25
Male	8	0	1	0	9
Total	31	1	2	0	34
Employees with a disability	0	0	0	0	0

Table 4.3 - Employees whose salary level exceed the grade determined by job evaluation [i.t.o PSR 1.V.C.3]

Occupation	Number of employees	Job evaluation level	Remuneration level	Reason for deviation	Number of employees in department
Private Secretary	1	12	13	Ministerial appointment	
Parliamentary Officer	1	12	13	Ministerial appointment	
Deputy Director: Health Technology Assessment	1	12	13	Internal transfer from Ministry	
Deputy Director: Administration	1	11	12	Internal transfer from Ministry	
Deputy Director: SANAC Sectoral Support	1	11	12	Retention of services	
Deputy Director: Administration	1	11	12	Retention of services	
Deputy Director: Administration	1	11	12	Internal transfer from Ministry	
Assistant Director: NGO-Co-ordinator	1	9	10	Retention of services	
Assistant Director: Administration	1	9	10	Transferred with manager to NDoH	
Chief Logistics Clerk	1	7	8	Resolution 2 of 2009	1 912
Chief Logistics Clerk	1	7	8	Resolution 2 of 2009	
Chief Transport Clerk	1	7	8	Resolution 2 of 2009	
Principal Personnel Officer	1	7	8	Resolution 2 of 2009	
Principal Personnel Officer	1	7	8	Resolution 2 of 2009	
Chief Administration Clerk	1	7	8	Resolution 2 of 2009	
Principal Personnel Officer	1	7	8	Resolution 2 of 2009	
Senior Network Controller	1	6	8	Retention of services	
Security Officer Grade II	1	3	6	Retention of services	
Senior Security Officer Grade II	1	5	6	Retention of services	
Total	19				
Percentage of Total Employment	0.99%				1 912

* 1: Total divided by number of employees in the department multiplied by 100

Table 4.4 - Profile of employees whose salary level exceeded the grade determined by job evaluation [i.t.o. PSR 1.V.C.3]

Beneficiaries	African	Asian	Coloured	White	Total
Female	3	0	0	6	9
Male	8	0	1	1	10
Total	11	0	1	7	19
Employees with a disability	0	0	0	0	0

Table 5.1 - Annual turnover rates by salary band

Salary band	Employment at beginning of period (April 2010)	Appointments	Terminations	Turnover rate (%) *1
Lower skilled (levels 1-2),	58	11		0.00
Skilled (levels 3-5),	319	3	5	1.57
Highly skilled production (levels 6-8),	381	6	10	2.62
Highly skilled supervision (levels 9-12),	373	1	18	4.83
Senior management service Band A	73		3	4.11
Senior management service Band B	16			0.00
Senior management service Band C	6		1	16.67
Senior management service Band D	2		1	50.00
Contract (levels 1-2)	16	10	15	93.75
Contract (levels 3-5)	10	21	5	50.00
Contract (levels 6-8)	11	6	4	36.36
Contract (levels 9-12)	14	12	3	21.43
Contract (Band A)	5	2	3	60.00
Contract (Band B)	1	1		0.00
Contract (Band C)	0			0.00
Contract (Band D)	0	2		0.00
TOTAL	**1 285**	**75**	**68**	5.29

* 1: Terminations divided by employment at beginning of period multiplied by 100

* Inclusive of Dr Sefularo that passed away

Table 5.2 - Annual turnover rates by critical occupation

Occupation	Employment at beginning of period (April 2010)	Appointments	Terminations	Turnover rate (%) *1
Administrative related, Permanent	2			0.00
Auxiliary and related workers, Permanent	7			0.00
Chemists, Permanent	11			0.00
Computer programmers, Permanent	1			0.00
Financial and related professionals, Permanent	4			0.00
Financial clerks and credit controllers, Permanent	21			0.00
Information technology related, Permanent	4			0.00
Messengers porters and deliverers, Permanent	1			0.00
Other administration and related clerks and organisers, Permanent	1			0.00
Other information technology personnel, Permanent	1			0.00
Physicists, Permanent	7			0.00
Secretaries and other keyboard operating clerks, Permanent	1			0.00
Security officers, Permanent	5			0.00
Senior managers, Permanent	4			0.00
TOTAL	**70**			0.00

* 1: Terminations divided by employment at beginning of period multiplied by 100

Office note: Vacant positions were identified as critical. These posts have been listed per occupational classification

Table 5.3 - Reasons why staff are leaving the department

Termination type	Number	Percentage of total resignations *1	Percentage of total employment *2	Total	Total employment at beginning of period
Death, Permanent	5	7.35	0.39		
Resignation, Permanent	36	52.94	2.80		
Expiry of contract, Permanent	17	25.00	1.32	68	1 285
Dismissal-misconduct, Permanent	4	5.88	0.31		
Retirement, Permanent	6	8.82	0.47		
TOTAL	**68**	**100.00**	**5.29**	**68**	**1 285**

*1: Number per termination type divided by total terminations multiplied by 100

* 2: Total of terminations per termination type divided by total employment from Table 5.1 multiplied by 100

* 3: Employment in numbers

Resignations as % of employment
5.29

Table 5.4 - Granting of employee initiated severance packages

Category	Number of applications received	Number of applications referred to the MPSA	Number of applications supported by MPSA	Number of packages approved by department
Lower skilled (salary level 1-2)				
Skilled (salary level 3-5)				
Highly skilled production (salary level 6-8)				
Highly skilled production (salary level 9-12)				
Senior management (salary level 13 and higher)				
Total	0	0	0	0

Table 5.5 - Promotions by critical occupation

Occupation	Employ-ment at beginning of period (April 2010)	Promotions to another salary level	Salary level promotions as a % of employment *1	Progressions to another notch within salary level	Notch pro-gressions as a % of em-ployment *2
Administrative related, Per-manent	2		0		0
Auxiliary and related work-ers, Permanent	7		0		0
Chemists, Permanent	11		0		0
Computer programmers, Permanent	1		0		0
Financial and related profes-sionals, Permanent	4		0		0
Financial clerks and credit controllers, Permanent	21		0		0
Information technology related, Permanent	4		0		0
Messengers porters and deliverers, Permanent	1		0		0
Other administration and related clerks and organis-ers, Permanent	1		0		0
Other information technol-ogy personnel, Permanent	1		0		0
Physicists, Permanent	7		0		0

Secretaries and other keyboard operating clerks, Permanent	1		0		0
Security officers, Permanent	5		0		0
Senior managers, Permanent	4		0		0
Total	**70**		0		0

*1: Promotions to another salary level divided by employment at the beginning of the period multiplied by 100

* 2: Progressions to another notch within salary level divided by employment at beginning of the period multiplied by 100

Office note: Vacant positions were identified as critical. These posts have been listed per occupational classification

Table 5.6 - Promotions by salary band

Salary band	Employment at beginning of period (April 2010)	Promotions to another salary level	Salary level promotions as a % of employment *1	Progressions to another notch within salary level	Notch progressions as a % of employment *2
Lower skilled (levels 1-2),	58		0	46	79.3
Skilled (levels 3-5),	319	60	18.8	215	67.4
Highly skilled production (levels 6-8),	381	7	1.8	275	72.2
Highly skilled supervision (levels 9-12),	373	6	1.6	205	55
Senior management (levels 13-16),	97	1	1	60	61.9
Contract (levels 1-2),	16		0		0
Contract (levels 3-5),	10		0	1	10
Contract (levels 6-8),	11		0	4	36.4
Contract (levels 9-12),	14	1	7.1	2	14.3
Contract (levels 13-16),	6	1	16.7		0
Total	**1 285**	**76**	**5.9**	**808**	**62.9**

*1: Promotions to another salary level divided by employment at the beginning of the period multiplied by 100

* 2: Progressions to another notch within salary level divided by employment at beginning of the period multiplied by 100

Table 6.1 - Total number of employees (incl. employees with disabilities) per occupational category (SASCO)

Occupational categories	Male, African	Male, Co-loured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Co-loured	Female, Indian	Female, Total Blacks	Female, White	Total
Legislators, senior officials and managers, Permanent	20	2	5	27	10	26	1	4	31	4	72
Professionals, Permanent	103	5	4	112	22	117	10	13	140	32	306
Professionals, Temporary	4	0	0	4	2	7	0	0	7	4	17
Technicians and associate professionals, Permanent	93	4	3	100	9	140	4	0	144	28	281
Technicians and associate professionals, Temporary	4	0	1	5	0	7	1	1	9	1	15
Clerks, Permanent	113	1	2	116	6	160	13	5	178	64	364
Clerks, Temporary	16	2	0	18	0	29	5	0	34	3	55
Service and sales workers, Permanent	35	0	0	35	1	11	0	0	11	0	47
Craft and related trades workers, Permanent	1	0	0	1	0	0	0	0	0	0	1
Plant and machine operators and assemblers, Permanent	0	0	0	0	1	1	0	0	1	0	2
Elementary occupations, Permanent	43	2	0	45	0	54	7	0	61	0	106
Elementary occupations, Temporary	5	1	0	6	0	5	0	0	5	0	11
TOTAL	**437**	**17**	**15**	**469**	**51**	**557**	**41**	**23**	**621**	**136**	**1 277**

	Male, African	Male, Co-loured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total
Employees with disabilities	1	0	0	1	2	2	0	0	2	4	**9**

Table 6.2 - Total number of employees (incl. employees with disabilities) per occupational bands

Occupational bands	Male, African	Male, Coloured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total
Top management, Permanent	3	0	2	5	0	4	0	1	5	1	11
Senior management, Permanent	30	3	3	36	12	30	2	3	35	7	90
Professionally qualified and experienced specialists and mid-management, Permanent	76	3	6	85	20	93	8	10	111	25	241
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	150	5	1	156	13	217	15	7	239	87	495
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Temporary	0	0	0	0	0	0	0	0	0	0	0
Semi-skilled and discretionary decision making, Permanent	128	3	2	133	3	129	10	1	140	8	284
Unskilled and defined decision making, Permanent	18	0	0	18	0	34	0	0	34	0	52
Contract (top management), Permanent	1	0	0	1	0	2	0	0	2	1	4
Contract (senior management), Permanent	2	0	0	2	2	1	0	0	1	1	6
Contract (professionally qualified), Permanent	5	0	1	6	0	8	1	1	10	3	19
Contract (skilled technical), Permanent	5	0	0	5	1	11	0	0	11	2	19
Contract (semi-skilled), Permanent	14	2	0	16	0	25	5	0	30	1	47
Contract (unskilled), Permanent	5	1	0	6	0	3	0	0	3	0	9
Total	**437**	**17**	**15**	**469**	**51**	**557**	**41**	**23**	**621**	**136**	**1 277**

Table 6.3 - Recruitment

Occupational bands	Male, African	Male, Coloured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total
Top management, Permanent				0					0		0
Professionally qualified and experienced specialists and mid-management, Permanent				0		1			1		1
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	1			1		5			5		6
Semi-skilled and discretionary decision making, Permanent				0		3			3		3
Unskilled and defined decision making, Permanent	6			6		5			5		11
Contract (top management), Permanent				0		3			3		3
Contract (senior management), Permanent	1			1					0	1	2
Contract (professionally qualified), Permanent	2		1	3	1	3	1		4	4	12
Contract (skilled technical), Permanent				0		6			6		6

Contract (semi-skilled), Permanent	6	1		7		8	5		13	1	21
Contract (unskilled), Permanent	5	1		6		4			4		10
Total	**21**	**2**	**1**	**24**	**1**	**38**	**6**	**0**	**44**	**6**	**75**

Table 6.4 - Promotions

Occupational bands	Male, African	Male, Coloured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total
Top management, Permanent	1			1					0		1
Senior management, Permanent	1			1					0		1
Professionally qualified and experienced specialists and mid-management, Permanent	1		1	2		5			5	1	8
Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	7			7		16	1	1	18		25
Semi-skilled and discretionary decision making, Permanent	15	1		16		23			23		39
Unskilled and defined decision making, Permanent				0					0		0

Contract (top management), Permanent				0		1			1		1
Contract (senior management), Permanent				0					0		0
Contract (professionally qualified), Permanent				0		1			1		1
Contract (skilled technical), Permanent				0					0		0
Contract (semi-skilled), Permanent				0					0		0
Total	**25**	**1**	**1**	**27**	**0**	**46**	**1**	**1**	**48**	**1**	**76**

Table 6.5 - Terminations

Occupational bands	Male, African	Male, Coloured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total
Top management, Permanent				0		1			1		1
Senior management, Permanent	2			2		1			1		3
Professionally qualified and experienced specialists and mid-management, Permanent	2			2	2	12			12	2	18

Skilled technical and academically qualified workers, junior management, supervisors, foremen, Permanent	2			2		4			4	4	10
Semi-skilled and discretionary decision making, Permanent	2			2	1	2			2		5
Contract (top management), Permanent	1			1					0		1
Contract (senior management), Permanent	1			1					0	2	3
Contract (professionally qualified), Permanent				0	1	1			1	1	3
Contract (skilled technical), Permanent	3			3		1			1		4
Contract (semi-skilled), Permanent	2			2		3			3		5
Contract (unskilled), Permanent	8			8		7			7		15
TOTAL	**23**	**0**	**0**	**23**	**4**	**32**	**0**	**0**	**32**	**9**	**68**

Table 6.6 - Disciplinary action

Disciplinary action	Male, African	Male, Coloured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total	Not Available
Total	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**

Table 6.7 - Skills development

Occupational categories	Male, African	Male, Coloured	Male, Indian	Male, Total Blacks	Male, White	Female, African	Female, Coloured	Female, Indian	Female, Total Blacks	Female, White	Total
Legislators, senior officials and managers	51	1	4	56	4	64	1	5	70	3	133
Professionals	22	0	0	22	0	20	0	1	21	4	47
Technicians and associate professionals	12	1	0	13	5	4	1	0	5	3	26
Clerks	82	0	2	84	0	101	0	1	102	4	190
Service and sales workers	0	0	0	0	0	0	0	0	0	0	0
Skilled agriculture and fishery workers	0	0	0	0	0	0	0	0	0	0	0
Craft and related trades workers	0	0	0	0	0	0	0	0	0	0	0
Plant and machine operators and assemblers	0	0	0	0	0	0	0	0	0	0	0
Elementary occupations	32	1	0	33	0	28	0	0	28	0	61
Total	**199**	**3**	**6**	**208**	**9**	**217**	**2**	**7**	**226**	**14**	**457**
Employees with disabilities	1	0	0	1	0	0	0	0	0	1	2

Table 7.1 - Performance rewards by race, gender and disability

Demographics	Number of beneficiaries	Total employment	Percentage of total employment *1	Cost (R'000)	Average cost per beneficiary (R) *2
African, Female	286	557	51.35	1 945	6 802
African, Male	181	437	41.42	1 233	6 811
Asian, Female	17	23	73.91	211	12 401
Asian, Male	9	15	60.00	101	11 185
Coloured, Female	21	41	51.22	161	7 648
Coloured, Male	12	17	70.59	132	11 033
Total Blacks, Female	**324**	**621**	**52.17**	**2 317**	**7 151**
Total Blacks, Male	**202**	**469**	**43.07**	**1 466**	**7 257**
White, Female	94	136	69.12	780	8 296

White, Male	25	51	49.02	283	11 308
Total	**645**	**1 277**	**50.51**	**8 628**	**13 377**
Disabled	**2**	**9**	**22.22**	**30**	15 174

* 1: Number of beneficiaries divided by total employment multiplied by 100

* 2: Cost divided by number of beneficiaries (in hundreds)

Table 7.2 - Performance rewards by salary band for personnel below senior management service

Salary band	Number of beneficiaries	Total employment	Percentage of total employment *1	Cost (R'000)	Average cost per beneficiary (R) *2
Lower skilled (levels 1-2)	28	52	53.85	48	1 713
Skilled (levels 3-5)	122	296	41.22	298	2 446
Highly skilled production (levels 6-8)	256	375	68.27%	1 348	5 265
Highly skilled supervision (levels 9-12)	204	347	58.79	2 536	12 432
Contract (levels 1-2)		9	0.00		0
Contract (levels 3-5)		48	0.00		0
Contract (levels 6-8)		17	0.00		0
Contract (levels 9-12)		27	0.00		0
Total	**610**	**1 171**	**52.09**	**4 230**	**6 935**

* 1: Number of beneficiaries divided by total employment multiplied by 100

* 2: Cost divided by number of beneficiaries (in hundreds)

Table 7.3 - Performance rewards by critical occupation

Critical occupations	Number of beneficiaries	Total employment	Percentage of total employment	Cost (R'000)	Average cost per beneficiary (R)
Administrative related, Permanent	0	2	0	0	0
Auxiliary and related workers, Permanent	0	7	0	0	0
Chemists, Permanent	0	11	0	0	0
Computer programmers, Permanent	0	1	0	0	0
Financial and related professionals, Permanent	0	4	0	0	0
Financial clerks and credit controllers, Permanent	0	21	0	0	0
Information technology related, Permanent	0	4	0	0	0

Messengers porters and deliverers, Permanent	0	1	0	0	0
Other administration and related clerks and organisers, Permanent	0	1	0	0	0
Other information technology personnel, Permanent	0	1	0	0	0
Physicists, Permanent	0	7	0	0	0
Secretaries and other keyboard operating clerks, Permanent	0	1	0	0	0
Security officers, Permanent	0	5	0	0	0
Senior managers, Permanent	0	4	0	0	0
Total	**0**	**70**	**0**	**0**	**0**

* 1: Number of beneficiaries divided by total employment multiplied by 100

* 2: Cost divided by number of beneficiaries (in hundreds)

Office note: Vacant positions were identified as critical. These posts have been listed per occupational classification.

Table 7.4 - Performance related rewards (cash bonus) by salary band for senior management service

SMS band	Number of beneficiaries	Total employment	Percentage of total employment *1	Cost (R'000)	Average cost per beneficiary (R)
Band A (salary level 13)	24	74	32.43	352	14 646.66
Band B (salary level 14)	11	20	55.00	263	23 937.38
Band C (salary level 15)	0	7	0.00		0.00
Band D (salary level 16)	0	5	0.00		0.00
Total	**35**	**106**	**33.02**	**615**	**17 566.60**

* 1: Number of beneficiaries divided by total employment multiplied by 100

* 2: Cost divided by number of beneficiaries (in hundreds)

* 3: Cost divided by compensation of employees on level 13 – 16 multiplied by 100

Office Note: No evaluation for Band C and Band D for the year under review

Table 8.1 - Foreign workers by salary band

Salary band	Employment at beginning period	Percentage of total *1	Employment at end of period	Percentage of total *2	Change in employment	Percentage of total *3	Total employment at beginning of period	Total employment at end of period	Total change in employment
Highly skilled supervision (levels 9-12)	1	14.3	1	25	0	0	7	4	-3
Senior management (levels 13-16)	1	14.3	0	0	-1	33.3	7	4	-3
Contract (levels 13-16)	2	28.6	2	50	0	0	7	4	-3
Periodical remuneration	3	42.9	1	25	-2	66.7	7	4	-3
Total	**7**	**100**	**4**	**100**	**-3**	**100**	**7**	**4**	**-3**

* 1: Employment at beginning of period per salary band divided by total multiplied by 100

* 2: Employment at end of period per salary band divided by total multiplied by 100

* 3: Change in employment per salary band divided by total multiplied by 100

Table 8.2 - Foreign workers by major occupation

Major occupation	Employment at beginning period	Percentage of total *1	Employment at end of period	Percentage of total *2	Change in employment	Percentage of total *3	Total employment at beginning of period	Total employment at end of period	Total change in employment
Professionals and managers	7	100	4	100	-3	100	7	4	-3
TOTAL	**7**	**100**	**4**	**100**	**-3**	**100**	**7**	**4**	**-3**

* 1: Employment at beginning of period per salary band divided by total multiplied by 100

* 2: Employment at end of period per salary band divided by total multiplied by 100

* 3: Change in employment per salary band divided by total multiplied by 100

Table 9.1 - Sick leave for January 2010 to December 2010

Salary band	Total	% days with medical certification *1	Number of employees using sick leave	% of total employees using sick leave *2	Average days per employee *3	Estimated cost (R'000) *4	Total number of employees using sick leave	Total number of days with medical certification
Lower skilled (levels 1-2)	368	70.1	48	4.5	8	81	1 055	258
Skilled (levels 3-5)	2 407.5	78.4	257	24.4	9	689	1 055	1 887
Highly skilled production (levels 6-8)	3 228	78.2	349	33.1	9	1 684	1 055	2 525
Highly skilled supervision (levels 9-12)	2 042.5	75.1	293	27.8	7	2 348	1 055	1 534
Senior management (levels 13-16)	322	89.1	48	4.5	7	846	1 055	287
Contract (levels 1-2)	10	50	6	0.6	2	1	1 055	5
Contract (levels 3-5)	56	78.6	16	1.5	4	16	1 055	44
Contract (levels 6-8)	65	87.7	13	1.2	5	33	1 055	57
Contract (levels 9-12)	52	75	13	1.2	4	66	1 055	39
Contract (levels 13-16)	57	73.7	12	1.1	5	152	1 055	42
TOTAL	**8 608**	**77.6**	**1 055**	**100**	**8**	**5 916**	**1 055**	**6 678**

* 1: Total number of days with medical certification divided by total number of days per salary band multiplied by 100

* 2: Number of employees using sick leave divided by total number of employees using sick leave multiplied by 100

* 3: Total days per salary band divided by number of employees using sick leave

* 4: Notch OR package divided by 261 multiplied by number of days

Table 9.2 - Disability leave (temporary and permanent) for January 2010 to December 2010

Salary band	Total days	% days with medical certification *1	Number of employees using disability leave	% of total employees using disability leave *2	Average days per employee *3	Estimated cost (R'000) *4	Total number of days with medical certification	Total number of employees using disability leave
Lower skilled (levels 1-2)	26	100	1	6.3	26	6	26	16
Skilled (levels 3-5)	160	100	5	31.3	32	51	160	16

Highly skilled production (levels 6-8)	106	100	7	43.8	15	56	106	16
Highly skilled supervision (levels 9-12)	42	100	2	12.5	21	39	42	16
Senior management (levels 13-16)	42	100	1	6.3	42	64	42	16
Total	**376**	**100**	**16**	**100**	**24**	**216**	**376**	**16**

* 1: Total number of days divided by total number of days per salary band multiplied by 100

* 2: Number of employees using sick leave divided by total number of employees using sick leave multiplied by 100

* 3: Total days per salary band divided by number of employees using sick leave

* 4: Notch OR package divided by 261 multiplied by number of days

Table 9.3 - Annual leave for January 2010 to December 2010

Salary band	Total days taken	Average days per employee *1	Number of employees who took leave
Lower skilled (levels 1-2)	1 265	24	53
Skilled (levels 3-5)	6 297.92	21	298
Highly skilled production (levels 6-8)	8 832.68	22	402
Highly skilled supervision (levels 9-12)	7 808.48	21	373
Senior management (levels 13-16)	1 711	20	84
Contract (levels 1-2)	59	4	15
Contract (levels 3-5)	205	7	29
Contract (levels 6-8)	223	17	13
Contract (levels 9-12)	326	15	22
Contract (levels 13-16)	372	17	22
Total	**27 100.08**	**21**	**1 311**

* 1: Total days taken per salary band divided by number of employees in salary band who took leave

Table 9.4 - Capped leave for January 2010 to December 2010

	Total days of capped leave taken	Average number of days taken per employee *1	Average capped leave per employee as at 31 December 2010 *2	Number of employees who took capped leave	Total number of capped leave available at 31 December 2010	Number of employees as at 31 December 2010
Lower skilled (levels 1-2)	4	4	43	1	1 021	24

Skilled (levels 3-5)	70	4	36	18	3 626	102
Highly skilled production (levels 6-8)	119	5	31	25	5 273	172
Highly skilled supervision (levels 9-12)	73	6	35	13	5 917	167
Senior management (levels 13-16)	10	5	60	2	2 696	45
Contract (levels 13-16)	0	0	21	1	85	4
Total	**276**	**5**	**36**	**60**	**18 618**	**514**

* 1: Total days of capped leave taken divided by number of employees as at 31 December 2009

* 2: Total number of capped leave available as at 31 December 2009 divided by number of employees as at 31 December 2009

Table 9.5 - Leave payouts

Reason	Total amount (R'000)	Number of employees	Average payment per employee (R) *1
Capped leave payouts on termination of service for 2010/2011	77	4	19 217.65
Current leave payout on termination of service for 2010/2011	948	63	15 053.68
Total	**1 025**	**67**	**15 302.28**

* 1: Total amount divided by number of employees

Table 10.1 - Steps taken to reduce the risk of occupational exposure

Units/categories of employees identified to be at high risk of contracting HIV and related diseases (if any)	Key steps taken to reduce the risk
None	None

Table 10.2 - Details of health promotion and HIV/AIDS programmes [tick Yes/No and provide required information]

Question	Yes	No	Details, if yes
1. Has the department designated a member of the SMS to implement the provisions contained in Part VI E of Chapter 1 of the Public Service Regulations, 2001? If so, provide her/his name and position	X		Adv MT Ngake; Director: Employment Relations, Equity and Employee Wellness is the chairperson of the integrated employee health and wellness committee

2. Does the department have a dedicated unit or have you designated specific staff members to promote health and well being of your employees? If so, indicate the number of employees who are involved in this task and the annual budget that is available for this purpose	X		2 employees and budget is available
3. Has the department introduced an employee assistance or health promotion programme for your employees? If so, indicate the key elements/ services of the programme	X		The EAP core service is to identify troubled employees, offer counselling, do referrals and follow-up and look at prevention programmes that will enhance productivity
4. Has the department established (a) committee(s) as contemplated in Part VI E.5 (e) of Chapter 1 of the Public Service Regulations, 2001? If so, please provide the names of the members of the committee and the stakeholder(s) that they represent.	X		All clusters are represented, together with NEHAWU representative, PSA representative and the chairperson
5. Has the department reviewed the employment policies and practices of your department to ensure that these do not unfairly discriminate against employees on the basis of their HIV status? If so, list the employment policies/practices so reviewed.	X		Yes. All departmental policies/ workplace guidelines are developed to ensure that no discrimination exists against employees on the basis of HIV/AIDS status, for example recruitment and leave policies
6. Has the department introduced measures to protect HIV-positive employees or those perceived to be HIV-positive from discrimination? If so, list the key elements of these measures.	X		Employee policy on HIV and Aids and STI and TB in the workplace has been reviewed and is waiting for management approval. Employees and prospective employees have the right to confidentiality with regard to their HIV/AIDS status, if an employee informs an employer of their HIV/AIDS status
7. Does the department encourage its employees to undergo Voluntary Counselling and Testing? If so, list the results that you have achieved.	X		On consultation with the employee assistance programme officer and the departmental nurse, employees are counselled and encouraged to subject themselves to voluntary testing. HIV testing was organised as part wellness days during May 2010 to celebrate Worker's Day and in December 2009 as part of the commemoration of World AIDS Day

8. Has the department developed measures/indicators to monitor and evaluate the impact of your health promotion programme? If so, list these measures/indicators.		X	The integrated employee health and wellness committee is presently busy with measures to evaluate health and wellness programmes. Condom usage in the department is being promoted. Male and female condoms are available. An integrated committee is also being established that will look at issues that cut across wellness issues like EAP, HIV, STI, TB and other health issues that affect employees

Table 11.1 - Collective agreements

Subject matter	Date
PHSDSBC Resolution 1 of 2010: Agreement on the Addendum to PHSDSBC Resolution 3 of 2009: Occupational Specific Dispensation (OSD) for medical officers, medical specialists, dentists, dental specialists, pharmacologists, pharmacists and emergency care practitioners	8 October 2010
PHSDSBC Resolution 2 of 2010: Occupational Specific Dispensation for therapeutic, diagnostic and related allied health professionals	29 October 2010

Table 11.2 - Misconduct and discipline hearings finalised

Outcomes of disciplinary hearings	Number	Percentage of total	Total
Three months suspension without pay	1	50.00	2
Dismissal	1	50.00	2
Total	**2**	100.00	**2**

Table 11.3 - Types of misconduct addressed and disciplinary hearings

Type of misconduct	Number	Percentage of total	Total
Unauthorised possession of state property	1	50.00	2
Misrepresentation and gross insubordination	1	50.00	2
Total	**2**	**100.00**	**2**

Table 11.4 - Grievances lodged

Number of grievances addressed	Number	Percentage of total	Total
Number of grievance addressed	28	50.00	56
Number of grievance resolved	7	12.50	56

Number of grievance not resolved	21	37.50	56
Total	**56**	**100.00**	**56**

Table 11.5 - Disputes lodged

Number of disputes addressed	Number	% of total
Number of dispute addressed	10	71.43
Number of dispute upheld	1	7.14
Number of dispute dismissed	3	21.43
Total	**14**	**100.00**

Table 11.6 - Strike actions

Strike actions	_
Total number of person working days lost	18
Total cost of working days lost *1	7 650.96
Amount recovered as a result of no work no pay	7 650.96

*1: Total deduction for all employees as implemented leave without pay

Table 11.7 - Precautionary suspensions

Precautionary suspensions	_
Number of people suspended	1
Number of people whose suspension exceeded 30 days	1
Average number of days suspended	485
Cost of suspensions	337 953.28

Table 12.1 - Training needs identified

Occupational categories	Gender	Employment	Learnerships	Skills programmes and other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	35	0	132	18	150
	Male	37	0	97	7	104
Professionals	Female	183	0	71	1	72
	Male	140	0	83	2	85
Technicians and associate professionals	Female	182	0	45	15	60
	Male	114	0	41	11	52
Clerks	Female	279	0	143	36	179
	Male	140	0	98	27	125

Service and sales workers	Female	11	0	0	0	0
	Male	36	0	0	0	0
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	0	0	0	0	0
	Male	1	0	0	0	0
Plant and machine operators and assemblers	Female	1	0	0	0	0
	Male	1	0	0	0	0
Elementary occupations	Female	66	0	21	23	44
	Male	51	0	5	9	14
Gender sub totals	Female	757	0	412	93	505
	Male	520	0	324	56	380
Total		1 277	0	736	149	885

Table 12.2 - Training provided

Occupational categories	Gender	Employment	Learnerships	Skills programmes and other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	35	0	54	19	73
	Male	37	0	50	10	60
Professionals	Female	183	0	13	12	25
	Male	140	0	16	6	22
Technicians and associate professionals	Female	182	0	8	0	8
	Male	114	0	16	2	18
Clerks	Female	279	0	74	32	106
	Male	140	0	60	24	84
Service and sales workers	Female	11	0	0	0	0
	Male	36	0	0	0	0
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	0	0	0	0	0
	Male	1	0	0	0	0

Plant and machine operators and assemblers	Female	1	0	0	4	4
	Male	1	0	0	0	0
Elementary occupations	Female	66	0	23	5	28
	Male	51	0	29	0	29
Gender sub-totals	Female	757	0	172	72	244
	Male	520	0	171	42	213
Total		1 277	0	343	114	457

Table 13.1 - Injury on duty

Nature of injury on duty	Number	% of total
Required basic medical attention only	6	100
Temporary total disablement	0	0
Permanent disablement	0	0
Fatal	0	0
Total	6	

Table 14.1 - Report on consultant appointments using appropriated funds

Project title	Total number of consultants that worked on the project	Duration: Work days	Contract value in Rand
Preferred consultant at NHI	1	365	921 054.00
Manage the revitalisation project at all government health facilities for a period of three years	1	121	1 250 000.00
Drug supply management system	1	250	544 712.00
Hospitals and training	1	365	492 000.00
The development of Environmental Health Regulations as required under the National Health Act 61 of 2003	1	365	325 000.00
Review, update and alignment of the Environmental Health Impact Assessment Guidelines of the department in terms of Chapter 5 of the National Environmental Management Act 107 of 1998 (NEMA)	1	240	1 005 867.00
Roll-out of the National Health and Hygiene Education Strategy (NHHES) to the nine provinces	1	180	1 352 739.00
Training of officials on healthcare waste management and hazardous substances in all nine provinces	1	240	872 739.54
To develop guidelines for the monitoring of indoor air quality (IAQ) in South Africa	1	300	1 575 152.08
Training of environmental health practitioners and environmental health officials on water quality monitoring	1	180	888 119.49
Training of Mental Health Review Boards	2	4	44 000.00
Development of screening tools and a framework for psychological and mental health problems among learners	1	92	475 000.00

Development of integrated core guidelines for the management of common chronic conditions. Mental and substance abuse disorders at primary healthcare	4	260	772 083.00
Implementation and monitoring if screening and brief interventions for alcohol use disorders among tuberculosis patients	5	300	2 890 244.00
National Health Insurance	1	288	921 054.00
Total number of projects	**Total individual consultants**	**Total duration: Work days**	**Total contract value in Rand**
15	23	3 550	14 329 764.11

Table 14.2 - Analysis of consultant appointments using appropriated funds, i.t.o. HDIs

Project title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of consultants from HDI groups that work on the project
Compliance audit	50	50	1
Risk audit	50	50	1
Development of screening tools and a framework for psychological and mental health problems among learners	100	100	1

Table 14.3 - Report on consultant appointments using donor funds

Project title	Total number of consultants that worked on the project	Duration: Work days	Donor and contract value in Rand
The development of Environmental Health Regulations as required under the National Health Act 61 of 2003	1	365	162 500.00
Review, update and alignment of the Environmental Health Impact Assessment Guidelines of the Department of Health in terms of Chapter 5 of the National Environmental Management Act 107 of 1998 (NEMA)	1	240	1 005 867.00
Roll-out of the National Health and Hygiene Education Strategy (NHHES) to the nine provinces	1	180	1 352 739.00
Training of officials on healthcare waste management and hazardous substances in all nine provinces	1	240	872 739.54
To develop guidelines for the monitoring of indoor air quality (IAQ) in South Africa.	1	300	1 575 152.08
Training of environmental health practitioners and environmental health officials on water quality monitoring	1	180	888 119.49
Screening of applications from NGOs seeking government funding	1	12	65 840.00

Providing of NQF Level 4 Project Management in the Northern Cape Upington and Kimberley	3	40	499 250.00
Providing of NQF Level 4 Financial Management in the Northern Cape Upington and Kimberley.	2	40	499 250.00
Conducting of a NPO post funding assessment in four districts of KwaZulu-Natal as well as extended investigation assignment	3	128	499 250.00
Infection and control prevention progamme	1	365	473 205.00
Patience safety progamme	1	300	541 700.00
Capacity building in the department	1	330	259 934.00
Backlog project	72	183	11 200 000.00
SAHPRA project	7	243	847 907.00
Drug supply management system	1	63	120 000.00
Total number of projects	**Total individual consultants**	**Total duration: Work days**	**Total contract value in Rand**
16	98	3 209	20 863 453.11

Table 14.4 - Analysis of consultant appointments using donor funds, i.t.o. HDIs

Project title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of consultants from HDI groups that work on the project
The development of Environmental Health Regulations as required under the National Health Act 61 of 2003	100	100	1
Review, update and alignment of the Environmental Health Impact Assessment Guidelines of the department in terms of Chapter 5 of the National Environmental Management Act 107 of 1998 (NEMA)	30	0	1
Roll-out of the National Health and Hygiene Education Strategy (NHHES) to the nine provinces	100	100	1
Training of officials on healthcare waste management and hazardous substances in all nine provinces	100	100	1
To develop guidelines for the monitoring of indoor air quality (IAQ) in South Africa	100	100	1
Training of environmental health practitioners and environmental health officials on water quality monitoring	25	25	1
Compliance audit	50	50	2
Risk audit	0	0	1
Screening of applications from NGOs seeking government funding	100	100	1

Providing of NQF Level 4 Project Management in the Northern Cape Upington and Kimberley.	0	100	3
Providing of NQF Level 4 Financial Management in the Northern Cape Upington and Kimberley.	100	100	2
Conducting of a NPO post funding assessment in four districts of KwaZulu-Natal as well as extended investigation assignment	100	100	3

Category	Number of applications received	Number of application referred to the MPSA	Number of applications supported by MPSA	Number of packages approved by department
Lower skilled (salary level 1-2)	0			
Skilled (salary level 3-5)	0			
Highly skilled production (salary level 6-8)	0			
Highly skilled production (salary level 9-12)	0			
Senior management (salary level 13 and higher)	0			

Table 15.1 - Signing of performance agreements by SMS members

SMS level	Total number of funded SMS posts per level	Total number of SMS members per level	Total number of signed performance agreements per level	Signed performance agreements as % of total number of SMS members per level
Director-General / Head of Department	1	1	1	100
Salary Level 16, but not HOD	4	4	*0	0
Salary Level 15	9	7	**4	57
Salary Level 14	28	20	16	80
Salary Level 13	98	74	***65	88
Total	140	106	17	81

* Excluding minister, deputy minister and SANAC

** Excluding SANAC

*** Excluding SANAC

Table 15.2 - Reasons for not having concluded performance agreements for all SMS members

1. Unclear understanding of functions and responsibilities

Table 15.3 - Disciplinary steps taken against SMS members for not having concluded performance agreements

1. Verbal and written warnings were issued

Table 15.4 - SMS post information as on 31 March 2010

SMS level	Total number of funded SMS posts per level	Total number of SMS posts filled per level	% of SMS posts filled per level	Total number of SMS posts vacant per level	% of SMS posts vacant per level
Director –General/Head of Department	1	1	100.00	0	0.00
Salary level 16 but not HOD	4	4	100.00	0	0.00
Salary level 15	9	7	77.78	2	22.22
Salary level 14	28	20	71.43	8	28.57
Salary level 13	98	74	75.51	24	24.49
Total	**140**	**106**	75.71	34	24.29

Table 16.5 - Advertising and filling of SMS posts

SMS level	Advertising	Filling of posts	
	Number of vacancies per level advertising in 6 months of becoming vacant	Number of vacancies per level filled in 6 months after becoming vacant	Number of vacancies per level not filled in 6 months but filled in 12 months
Director –General/ Head of Department	0	0	1
Salary level 16 but not HOD	0	0	0
Salary level 15	2	0	1
Salary level 14	8	1	0
Salary level 13	24	4	7
Total	**34**	**5**	**9**

Table 15.6 - Reasons for not having complied with the filling of funded vacant SMS advertised within 6 months and filled within 12 months after becoming vacant

Reasons for vacancies not advertised within six months
1. Financial constraints
2. Skills shortage
Reasons for vacancies not filled within 12 months
1. Financial constraints
2. Skills shortage
3. Unavailability of panel members (CFO position)

Table 15.7 - Disciplinary steps taken for not complying with the prescribed timeframes for filling SMS posts within 12 months

1
2
3
4

5. OTHER INFORMATION

Acronyms

AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
AMC	Academic Medical Center
APP	Annual Performance Plan
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
ATM	African traditional medicine
AU	African Union
BoD	Burden of Disease
CCOD	Compensation Commissioner for Occupational Diseases
CEmOC	Comprehensive Emergency Obstetric Care
CEO	Chief Executive Officer
CHC	Community Health Center
CHW	Community Health Worker
CRA	Comparative Risk Assessment
CTOP	Choice of Termination of Pregnancy
DBSA	Development Bank of Southern Africa
DHC	District Health Council
DHIS	District Health Information System
DHP	District Health Plan
DoH	Department of Health
DoRA	Division of Revenue Act
DOT	Directly Observed Treatment
DPSA	Department of Public Service and Administration
DRC	Democratic Republic of Congo
DST	Department of Science and Technology
ECT	Emergency Care Technician
EDL	Essential Drug List
EDMS	Electronic Document Management System
EHP	Environmental Health Practitioner
EmOC	Emergency Obstetric Care
EMS	Emergency Medical Services
FBO	Faith-Based Organisation
GCIS	Government Communication and Information System
GDP	Gross Domestic Product
HAART	Highly Active Anti-retroviral Therapy

HCT	HIV Counselling and Testing
HDACC	Health Data Advisory and Co-ordination Committee
HHCC	Household and Community Component
HIER	Health Information Evaluation Monitoring and Research
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HRH	Human resources for health
HSRC	Human Science Research Council
HST	Health Systems Trust
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illnesses
MBOD	Medical Bureau for Occupational Diseases
MCC	Medicines Control Council
MDG	Millennium Development Goal
MDR	Multi Drug Resistant
MMR	Maternal Mortality Rate
MOU	Memorandum of Understanding
MRC	South African Medical Research Council
MSC	Medical Schemes Council
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NCD	Non-Communicable Disease
NDoH	National Department of Health
NEMA	National Environmental Management Act
NGO	Non-Governmental Organisation
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NHRC	National Health Research Council
NHREC	National Health Research Ethics Council
NHS	National Health Systems
NICD	National Institute for Communicable Diseases
NSDA	Negotiated Service Delivery Agreement
NTSG	National Tertiary Service Grant
PAAB	Patient Administration and Billing System
OSD	Occupation Specific Dispensation
PFMA	Public Finance Management Act
PHC	Primary Healthcare
PHSDSBC	Public Health and Social Development Sectoral Bargaining Council

PMTCT	Prevention of Mother to Child Transmission
PPIP	Perinatal Problem Identification Programme
PPP	Public Private Partnership
QIP	Quality Improvement Plan
RPL	Reference Price List
SABS	South African Bureau of Standards
SADHS	South African Demographic Health Survey
SADTC	South Africa Dental Technicians Council
SAHPRA	South African Health Products Regulatory Authority
SALGA	South African Local Government Association
SAMHS	South African Medical Health Services
SANAC	South African National AIDS Council
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SAQA	South Africa Qualifications Authority
SDC	Step Down Care
SMS	Senior Management Services
StatsSA	Statistics South Africa
STI	Sexually Transmitted Infection
STP	Service Transformation Plan
TAC	Technical Advisory Committee
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Session
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
XDR	Extreme Drug Resistant
YFS	Youth-Friendly Services
COPD	Chronic Obstructive Pulmonary Disease
CBO	Community-based Organisation
IMC	Inter-ministerial Committee
RDP	Reconstruction and Development Programme
NCHF	National Consultative Health Forum
CANSA	Cancer Association of South Africa
NCE	New Chemical Entities
EU	European Union
SADC	Southern African Development Corporation
PEPFAR	President's Emergency Plan for AIDS Relief (US)

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