
FOR
KIDS

chapter 13

Health

The Department of Health is committed to providing quality healthcare to all South Africans, to achieve a unified National Health System and to implement policies that reflect its mission, goals and objectives.

Departmental activities are guided by the *White Paper on the Transformation of the Health System*, adopted in 1997, and the Health-Sector Strategic Framework 1999 to 2004. These outline key objectives such as reducing morbidity and mortality, improving the quality of care, ensuring equity and access, revitalising public hospitals, improving primary healthcare (PHC) and the district health system, reforming legislation, and strengthening human resource development (HRD).

Statutory bodies

Statutory bodies for the health-service professions include the Health Professions Council of South Africa (HPCSA), the South African Dental Technicians' Council, the South African Nursing Council, the South African Pharmacy Council, Allied Health Professions Council of South Africa, and the Council for Social Service Professions.

Regulations in the private health sector are effected through the Statutory Council for Medical Schemes.

By June 2003, some 2662 young professionals were doing community service – contributing critically needed services to the public health sector.

The Medicines Control Council (MCC) is the statutory body charged with ensuring the safety, quality and effectiveness of medicines through a system of registration.

Health authorities

National

The Department of Health is responsible for:

- formulating health policy and legislation
- formulating norms and standards for healthcare
- ensuring appropriate utilisation of health resources
- co-ordinating information systems and monitoring national health goals
- regulating the public and private healthcare sectors
- ensuring access to cost-effective and appropriate health commodities at all levels
- liaising with health departments in other countries and international agencies.

Provincial

The provincial Health Departments are responsible for:

- providing and/or rendering health services
- formulating and implementing provincial health policy, standards and legislation
- planning and managing a provincial health-information system
- researching health services rendered in the province to ensure efficiency and quality
- controlling the quality of all health services and facilities

- screening applications for licensing and inspecting private health facilities
- co-ordinating the funding and financial management of district health authorities
- effective consulting on health matters at community level
- ensuring that delegated functions are performed.

Primary healthcare

Government is committed to providing basic healthcare as a fundamental right. To improve the quality of services and consistency of their availability, a comprehensive package of PHC services has been developed and costed, and is being progressively implemented in all health districts, now realigned with the new municipal boundaries. By April 2003, free PHC services were provided at about 3 500 public health clinics nationwide.

The constitutional definition of municipal health services is considerably narrower than the primary care package of services. Local government will therefore have to be engaged through service agreements to provide a more comprehensive service.

The services provided by PHC workers include immunisation, communicable and endemic disease prevention, maternity care, screening of children, Integrated Management of Childhood Illnesses (IMCI) and child healthcare, health promotion, youth health services, counselling services, chronic diseases, diseases of older persons, rehabilitation, accident and emergency services, family planning, and oral health services.

Patients visiting PHC clinics are treated mainly by PHC-trained nurses, or at some clinics, by doctors. Patients with complications are referred to higher levels of care, such as hospitals, if their condition cannot be treated at PHC level.

Persons who are members of a medical aid scheme are excluded from free services.

The National Drug Policy is, to a large extent, based on the essential drugs concept, and is aimed at ensuring the availability of essential drugs of good quality, safety and efficacy to all South Africans.

Health policy

In 1999, the Minister of Health published a reviewed strategic framework to guide work over the following five years. Relevant aspects identified in this 10-point plan are:

- reorganisation of support services
- improvement in the quality of care
- revitalisation of public hospitals
- further implementation of the district health system and primary care
- a decrease in the incidence of HIV/AIDS, sexually transmitted infections (STIs) and tuberculosis (TB)
- resource mobilisation and allocation
- HRD.

In recent years, substantial developments took place in several of these areas:

- a unified National Health Laboratory Service (NHLS) was established to provide laboratory services to the public health sector
- the National Planning Framework, provincial health plans and costing of services have progressed substantially, enabling a longer-term focused rehabilitation and revitalisation programme in the Department
- significant progress in HRD included the submission to the Cabinet of a draft human resource plan for the sector.

By June 2003, 2 662 young professional healthcare workers were doing community service, contributing critically to services in the public sector.

Other achievements of the healthcare system in South Africa include the work of the Medical Research Council (MRC), which responds to a broad spectrum of challenges. Clinics and hospitals have been deracialised, new facilities have been built and many of the existing institutions have been rehabilitated. The National Institute for Communicable Diseases (NICD), backed by increasingly

skilled outbreak teams in the provinces, ensures that government is able to respond to any outbreak of disease.

Telemedicine

The South African Government has identified telemedicine as a strategic tool for facilitating the delivery of equitable healthcare and educational services, irrespective of distance and the availability of specialised expertise, particularly in rural areas. In 1998, the Department of Health adopted the National Telemedicine Project Strategy. The Strategy called for the establishment of a National Telemedicine Research Centre and a network of telemedicine links to be implemented in three phases over a period of five years.

In September 1999, the National Telemedicine Research Centre was established as a joint venture of the Department and the MRC.

This exciting project will go a long way towards delivering a solution to the severe problem of inadequate services and geographical challenges that confront the South African healthcare system, as a result of long-standing, previously misplaced priorities.

Implementation of the project is ongoing.

Legislation

The National Health Bill was presented to Parliament in July 2003 and was expected to be passed in the latter half of 2003.

The Bill, which provides a legal framework for a national health system that encompasses public, private, non-governmental and other providers of health services, also sets out the rights and duties of healthcare providers, health workers, establishments and users.

It aims to promote the progressive realisation of South Africans' right to health services and an environment that is not harmful to their well-being. It will also promote the right of children to basic healthcare services.

The most contentious provision of the Bill has been that every health establishment, private or public, requires a certificate of need to operate. The establishment of new hospitals and the expansion of existing facilities would be subject to the issuing of such a certificate.

The central motivation for this provision is the protection of the health-service consumer, not only in terms of the standards of healthcare, but also in terms of the cost of healthcare.

The Mental Healthcare Act, 2002 (Act 17 of 2002), provides for the care, treatment, rehabilitation and administration of persons who are mentally ill. It also sets out the different procedures to be followed in the admission of such persons.

The Traditional Healers Bill was approved by the Cabinet in early 2003 before publication for public comment. It will provide for the registration of traditional healers and the establishment of a statutory body for the regulation of this area of practice.

The recommendations of a task team comprising the Department of Health and officials from the HPCSA and the South African Nursing Council are expected to lead to amendments to the Health Professions Act, 1974 (Act 56 of 1974), and the Nursing Act, 1978 (Act 50 of 1978).

The Medical Schemes Amendment Act, 2002 (Act 62 of 2002), amended the Medical Schemes Act, 1998 (Act 131 of 1998), to extend certain rights of members to their dependants. In addition, the Act:

- explicitly prohibits discrimination on the basis of age
- regulates the practice of reinsurance
- regulates the circumstances under which waiting periods may be applied
- improves the powers of the Council and the Registrar to act in the interest of beneficiaries.

Mandatory medical-scheme cover for certain chronic conditions was expected to come into effect in January 2004.

National School Health Policy

The Minister of Health, Dr Manto Tshabalala-Msimang, launched the National School-

Health Policy and Guidelines on 22 July 2003.

The comprehensive Policy and Guidelines aim to ensure that all children, irrespective of race, colour and location, have equal access to school-health services.

The Policy is in line with the United Nations (UN) Convention on the Rights of the Child recommendations, which affirm that the State has an obligation to ensure that all segments of society, in particular parents and children, are informed and have access to knowledge of child health and nutrition, hygiene, environmental sanitation, and the prevention of accidents.

Department of Health officials will visit all the provinces, especially those with a School-Health Programme, to embark on a major training campaign of PHC nurses.

The nurses will be trained to:

- give health education to children
- impart life skills
- screen children, especially at Grade R and Grade 1, for specific health problems, and at puberty stage as children undergo physiological changes
- detect disabilities at an early age
- identify missed opportunities for immunisation and other interventions.

The Programme, under the theme, *Healthy Children Are Successful Learners*, will be implemented in phases. Some 30% of districts in every province are expected to be covered by the end of 2004, at an estimated cost of about R10 million.

The programme will be extended to cover 60% of districts by 2005, and the whole country by the end of 2007.

Medicines administration

The Medicine and Related Substances Amendment Act, 2002 (Act 59 of 2002), makes provision for, among others, the:

- Definition of the search-and-seizure powers of the MCC in a way that is consistent with the Bill of Rights.
- Extension of regulations applicable to pharmacists to cover other health practitioners licensed to dispense and compound medicines. These include professional fees and the obligation to inform patients about generic drug options.

The Act further states that any party appealing against a decision of the Director-General on the granting of dispensing licences must approach the Minister of Health directly.

Any party appealing against a decision of the MCC on medicines registration will have recourse to an appeal committee established by the Minister.

The Act and its 1997 predecessor of the same name came into effect in May 2003, together with a comprehensive set of regulations.

Health team

Health personnel are a crucial component in realising the Department of Health's vision. Major challenges still exist in attracting health personnel to the rural areas.

Physicians

Some 30 153 doctors were registered with the HPCSA at the end of 2002. These include doctors working for the State, doctors in private practice, and specialists. The majority of doctors practise in the private sector. In selected communities, medical students render health services at clinics under the supervision of medical practitioners.

In terms of the Continuing Professional Development (CPD) system, all doctors, irrespective of earlier qualifications, must obtain a specified number of points to retain their registration. The system requires that doctors attend workshops, conferences, refresher courses, seminars, departmental meetings and journal clubs.

Non-compliance with the requirements of the system could result in the doctor being deregistered.

The use of foreign health professionals has

assisted in relieving the shortage of skilled medical practitioners in many parts of South Africa.

Applications are subject to assessment by the Examinations Committee of the Medical and Dental Professions Board. Those who are admitted have to write an examination, after which they can be registered in the particular category for which they applied and were assessed.

In 2002, there were some 7 203 foreign-qualified doctors working in South Africa.

Newly qualified interns are required to do remunerated compulsory community service at State hospitals for one year. Only after completion of this service are they allowed to register with the HPCSA, and only then are they entitled to practise privately.

The system of community service provides significant relief in rural areas. In 2003, the Department expanded community service to cover physiotherapists, radiographers, occupational therapists, speech and hearing therapists, clinical psychologists, dietitians and environmental health officers.

Oral health professionals

At the end of 2001, a total of 4 503 dentists, 11 dental and oral specialists, 849 oral hygienists and 347 dental therapists were registered with the HPCSA.

At the end of 2002, 4 499 dentists were registered. Since 1 January 1999, dentists have also been subject to the CPD system. The system of community service was extended to dentists in July 2000.

Oral health workers render services in the private as well as the public sectors.

Total of supplementary healthcare practitioners at end of December 2002

Basic ambulance assistants	9 806
Ambulance emergency assistants	3 466
Environmental health officers	2 228
Medical technologists	3 854
Occupational therapists	2 356
Optometrists	1 969
Physiotherapists	1 019
Psychologists	4 649
Radiographers	4 081

Source: Health Professions Council of South Africa

Pharmacists

The Pharmacy Amendment Act, 2000 (Act 1 of 2000), provides for all graduates who wish to register as pharmacists for the first time to work for the State as part of government's plan to provide health services to all communities. The provision came into effect on 20 November 2000. All pharmacists who have registered since that date are obliged to perform one year of remunerated pharmaceutical community service in a public-health facility. Those who have not completed this year of service are not allowed to practise independently as pharmacists. Some 366 pharmacists commenced community service in 2001, compared with 49 in 2000.

A section of the Pharmacy Amendment Act, 2000, which allows non-pharmacists to own pharmacies, came into effect at the same time.

This legislation aims to improve access to medicines, make them more affordable, improve marketing and dispensing practices, and promote consumer interests.

In 2001, 10 782 pharmacists were registered with the South African Pharmacy Council, approximately 7% of whom were employed in provincial and State hospitals.

Nurses

The South African Nursing Council controls nursing education and practice in South Africa.

The key role of the Nursing Council is to protect and promote public interest, including ensuring delivery of quality healthcare. It does so by prescribing minimum requirements for the education and training of nurses and midwives, approves training schools, and registers or enrols those who qualify in one or more of the basic or postbasic categories.

At the end of 2002, there were 172 869 registered and enrolled nurses and enrolled nursing auxiliaries on the registers and rolls of the Council. The nursing profession represents more than 50% of the total professional human resources of health services.

Similarly, 21 104 persons were registered as student and pupil nurses or pupil nursing auxiliaries on the registers and rolls of the Council.

Supplementary health services

South Africa has a dire shortage of health professionals such as physiotherapists, dietitians and radiographers. By mid-May 2001, there were 89 793 supplementary health professionals registered with the HPCSA.

Allied health professions

In July 2003, the following practitioners were registered with the Allied Health Professions Council of South Africa:

- Ayurveda 114
- Chinese medicine and acupuncture 638
- chiropractors 424
- homeopaths 652
- naturopaths 142
- osteopaths 60
- phytotherapists 23
- therapeutic aromatherapists 1 003
- therapeutic massage therapists 279
- therapeutic reflexologists 1 726

Provincial Health Departments

The function of the provincial Health Departments is to provide and manage comprehensive health services at all levels of care. The basis for these services is a district-based PHC model. The major emphasis in the development of health services in South Africa at provincial level has been the shift from curative hospital-based healthcare to that provided in an integrated community-based manner.

Registered medical interns, practitioners, pharmacists, nurses and dentists, 2001 – 2002

	2001	2002
Dentists	4 454	4 499
Medical interns	1 651	3 004
Medical practitioners	29 310	30 153
Nurses (students included)	190 449	193 973

Source: Health Professions Council of South Africa and South African Nursing Council

Clinics

A network of mobile clinics run by government forms the backbone of primary and preventive healthcare in South Africa. Clinics are being built or expanded throughout the country. Between 1994 and 2003, upgrading and new clinic-building resulted in 701 additional clinics.

Hospitals

According to the Department of Health, there were 357 provincial public hospitals in 2002.

Ongoing programmes are in place to improve the quality of hospital services. A charter of patients' rights has been developed, as well as procedures to follow when dealing with complaints and suggestions. A service package with norms and standards has been developed for district hospitals and is being extended to regional hospitals. Funding for tertiary health services has been reformed with the introduction of the National Tertiary Services Grant.

In the last two years, funding for the Hospital Revitalisation Programme has taken a great leap forward; the 2003 budget of R717 million, is set to increase by almost R200 million in 2004.

By 2003, there were 27 hospitals on the Department's list, with 18 of these hospital projects involving the construction of entirely new facilities, either to replace an existing hospital or to create a new service.

Hospital revitalisation also involves technology maintenance, replacement and innovation, the development of managers and management systems, and improving the quality of healthcare in general.

The Programme ensures that managers and health workers are able to respond to the

needs of clients and treat patients with care and respect in line with the principles of *batho pele* (people first) and the Patients' Rights Charter.

Various provincial budgets for health have increased capital expenditure substantially. This ensures that clinic-building and the routine maintenance of facilities continues even though the national funding is now focused on major projects at fewer hospitals.

According to the National Health Accounts (March 2001), there were 200 private hospitals and a total of 23 076 beds in use in South Africa in 1999. Many of these hospitals are owned and managed by consortia of private physicians or by large business organisations. Private hospital fees are generally higher than those of provincial hospitals.

Emergency medical services

Emergency medical services, which include ambulance services, are the responsibility of the provincial Departments of Health. Emergency care practitioners receive nationally standardised training through provincial colleges of emergency care. Some technikons also offer diploma and degree programmes in emergency care. Personnel can receive training to the level of advanced life-support.

These services also include aeromedical and medical-rescue services.

Personnel working in this field are required to register with the HPCSA, which has a Professional Board for Emergency Care.

The national Department of Health plays a co-ordinating role in the operation, formulation of policy and guidelines, and development of government emergency medical services.

Private ambulance services also provide services to the community, mainly on a private basis. Some of these also provide aeromedical services to the private sector.

The South African Health Services of the South African National Defence Force plays a vital supporting role in emergencies and disasters.

National Health Laboratory Service

The NHLS is a single national public entity that consists of personnel from provincial Health Departments and from the former South African Institute for Medical Research's (SAIMR) laboratory service. It consists of 234 laboratories. Unification of laboratories provides cost-effective and efficient health-laboratory services to all public-sector healthcare providers, private healthcare providers, and to any government institutions that may require such service.

The National Institute for Virology and a section of the SAIMR have been combined to form the NICD. This is also part of the NHLS. The research expertise and sophisticated laboratories at the NICD have made it a testing centre and resource for the African continent, in relation to several of the rarer communicable diseases.

South African Vaccine Producers and State Vaccine Institute

The strategic equity partnership, designed to re-establish the State Vaccine Institute as a local vaccine producer, was concluded in the first half of 2003. The private partner Blovac Consortium combines South African, British and Cuban interests and holds 49% of shares.

The role of local government

Local government has been recognised as a separate sphere of government, thereby endorsing its constitutional status. Some of the services rendered at this level include the following:

- preventive and promotive healthcare, with some municipalities rendering curative care
- environmental health services, including the supply of safe and adequate drinking water, sewage disposal and refuse removal
- regulation of air pollution, municipal airports, fire-fighting services, licensing and abattoirs.

Many local authorities provide additional PHC services. In some instances, these are funded

by provincial health authorities, but in major metropolitan areas the councils carry some of the costs.

Government has recognised the need to formalise service agreements between provinces and councils for the running of these services.

Non-profit health sector

Non-governmental organisations (NGOs) at various levels play an increasingly important role in health, many of them co-operating with government to implement priority programmes. They make an essential contribution in relation to HIV, AIDS and TB and also participate significantly in the fields of mental health, cancer, disability, and the development of PHC systems.

The national Department of Health budgeted more than R75 million in 2003/04 for NGOs. Provincial Health Departments also set aside funding for NGOs operating within their borders. Health NGOs also receive funding from international donors and from the private sector.

Two particularly high-profile and innovative non-profit organisations are Soul City and loveLife. Both focus on health promotion and the use of the mass media to raise awareness on the prevention of illness, and to enable people to manage their health more effectively. Soul City pioneered one of the most successful multimedia edutainment initiatives on any continent and is known for its sound research-based approach. Over a period of nine years, it has addressed a wide range of health issues relevant to all age groups. The centrepiece of its multimedia strategy is the television drama series broadcast on SABC1. The radio series is broadcast on all nine SABC regional stations (in nine of South Africa's official languages). It is also broadcast on many community radio stations. The booklets are serialised in newspapers throughout South Africa in synergy with electronic media. They are also distributed through clinics and other channels. At least three million booklets are distributed per series. The sixth Soul City television series commenced in 2003.

loveLife focuses more on teenage sexuality and relationships and their critical role in the prevention of HIV infection and related conditions. Apart from mass-media advertising campaigns backed by a helpline, loveLife focuses on services for young people. It has a programme to transform existing reproductive-health and communicable-infection services to make them more 'youth friendly', and it has developed drop-in centres where young people can get information and support.

Both Soul City and loveLife have been sponsored by the Global Fund to Fight HIV, AIDS and malaria. They also have a relationship with government and are funded or contracted to provide expertise in developing AIDS awareness programmes (in the case of Soul City) and 'youth-friendly' public facilities (in the case of loveLife).

The Health Systems Trust is another significant health NGO, which conducts research and helps build appropriate delivery systems for PHC. It is funded partly by the Department of Health and has done important work in supporting the development of the district health system, monitoring the quality of care at public-sector clinics and facilitating the introduction of services to reduce mother-to-child transmission of HIV.

The South African Cancer Association and the Council Against Smoking share government's approach to the prevention of many chronic non-communicable diseases. They partnered government in the development of tobacco-control measures and their implementation. The health-promotion activities of these organisations augment government's own, somewhat limited, capacity in these areas.

The more established national health NGOs – such as the St John Ambulance and the South African Red Cross – continue to play an important role. They still focus on emergency care and first-aid capacity but have adapted their services to take account of changing needs, particularly the impact of HIV and AIDS.

Several important organisations in relation to HIV and AIDS are run by people living with HIV or AIDS. The biggest of these is the National Association of People Living with AIDS, which has branches in many areas. There are also many unaffiliated support groups that serve local communities.

Human-rights and health-rights issues in relation to HIV and AIDS have given rise to groups such as the AIDS Law Project and the Treatment Action Campaign, which has pursued a high-profile campaign in support of expanded treatment.

Faith-based organisations (FBOs) are one of the mainstays of hospice, and institutional and home-based care for those infected and affected by HIV and AIDS. The Salvation Army was perhaps the first to become meaningfully involved, but in recent years organisations of other faiths and denominations have become increasingly significant sources of care. Many FBOs are also involved in HIV-prevention programmes.

Traditional 'service' organisations, like the Lions and Rotary, have health projects that boost the public health sector. Fields in which they have made a particular mark are mass immunisation – particularly the Polio-Free Initiative – and reducing the national backlog for cataract surgery.

The involvement of NGOs extends from the national level, through provincial structures, to small local organisations rooted in individual communities. All are vitally important and bring different qualities to the healthcare network.

Chris Hani-Baragwanath Hospital in Soweto, Gauteng, the world's largest hospital, will receive state-of-the-art facilities as part of a R700-million project which is to be undertaken over a period of six years.

Phase one of the project has commenced and includes the establishment of a new renal dialysis unit, a speech therapy and audiology centre, a paediatric admission ward, and bulk stores.

During 2002, the Hospital acquired two new computed tomography scanners, a cardiac catherisation laboratory and a R25-million digital angiography suite, and undertook extensive modernisation of equipment for the Intensive Care Unit.

Costs and medical schemes

The Council for Medical Schemes regulates the private medical-scheme industry in terms of the Medical Schemes Act, 1998 and is funded mainly through levies on the industry in terms of the Council for Medical Schemes Levies Act, 2000 (Act 58 of 2000). In addition, it receives funding from the Department, which will increase from R2,6 million in 2002/03 to R3,0 million in 2005/06.

Tariffs for admission to private and provincial hospitals differ. Cost differences also exist between various provincial hospitals, depending on the facilities offered. All provincial-hospital patients pay for examinations and treatment on a sliding scale in accordance with their income and number of dependants. If a family is unable to bear the cost in terms of the standard means test, the patient is classified as a hospital patient. His or her treatment is then partly or entirely financed by the particular provincial government or the health authorities of the administration concerned.

By April 1999, 168 private medical schemes were registered in terms of the provisions of the Medical Schemes Act, 1967 (Act 72 of 1967).

The Medical Schemes Amendment Act, 2001 (Act 55 of 2001), improves the regulatory capacity of the Registrar for Medical Schemes and regulates reinsurance. It provides for:

- Improved protection for members. The Act addresses the problem area of medical insurance, by revisiting the provision on waiting periods, and specifically protecting patients against discrimination on grounds of age.
- Promoting efficient administration and good governance of medical schemes by insisting on the independence of individuals in certain key positions.

- Introducing mechanisms to address problematic practices in the marketing of medical schemes and brokerage of services.

The consumer is further protected by additional powers that are assigned to the Minister in terms of the Act. These include the power to:

- regulate managed-healthcare contracts
- impose penalties on medical schemes or administrators for the late payment of claims.

Community health

The most common communicable diseases in South Africa are TB, malaria, measles and STIs.

The appropriate and timeous immunisation of children against infectious diseases is one of the most cost-effective and beneficial preventive measures known.

The mission of the South African Expanded Programme on Immunisation is to reduce death and disability from vaccine-preventable diseases by making immunisation accessible to all children. Immunisations against TB, whooping cough, tetanus, diphtheria, polio myelitis, hepatitis B, hermafluous influenza type-B and measles are available free of charge to all children up to the age of five years. A tetanus vaccine is administered to women at risk during pregnancy, to protect their newborn infants against neonatal tetanus. Other services include the control of rabies and certain endemic diseases, such as malaria.

In 2002, 72% of children were fully immunised at one year of age, representing a significant increase compared with 63% in 1998.

Polio and measles

All suspected measles cases are actively investigated. Blood and urine specimens are collected to confirm whether the cases are real measles. To date, less than 5% of suspected measles cases proved to be real measles.

Measles decreased dramatically from about 22 000 cases and 53 deaths in 1992, to 37 laboratory-confirmed cases and no deaths in 2000, a direct result of the Measles Elimination Strategy. Polio remains a major problem in Africa, although the last confirmed case in South Africa occurred in 1989.

The year 2003 was a crucial year in South Africa's bid to be declared polio-free in 2005, as it had to sustain certain standards set by the World Health Organisation (WHO) for three consecutive years.

On 30 May 2003, the Minister of Health launched the countdown to a polio-free South Africa as part of a global initiative to heighten awareness about efforts to eradicate polio by 31 December 2005.

The South African Government has implemented the necessary strategies, as recommended by the WHO, to become certified free of polio.

National immunisation campaigns were conducted in 1995, 1996, 1997 and 2000, and a polio-focused campaign is expected to take place throughout the country in 2004.

Three committees have been formed, as required by the WHO, to monitor the polio-eradication process. These are the National Certification Committee, the Laboratory Containment Committee, and the Polio Expert Committee.

South Africa, Lesotho and Swaziland have established an Intercountry Certification Committee to ensure that polio-free certification in the region occurs before December 2005.

A toll-free line is available for the reporting of any suspected polio cases: 0800 111 408.

Integrated Management of Childhood Illnesses

IMCI promotes child health and improves child survival as part of the National Plan of Action for Children. It is being instituted as part of the Department of Health's policy on the National Health System for Universal Primary Care.

The core intervention is integrated case management of the five most important causes of childhood deaths and of common associated conditions.

Implementation of the IMCI strategy in South Africa involves improvement in:

- the case-management skills of health staff through the provision of locally adapted guidelines on IMCI, and activities to promote their use
- the health system required for effective management of childhood illnesses
- family and community practices.

The IMCI material has been adapted for South Africa, and implementation and training are ongoing.

South Africa was the first country to include prevention and management of HIV and AIDS in its IMCI guidelines.

Malaria

Malaria is endemic in the low-altitude areas of Limpopo, Mpumalanga and north-eastern KwaZulu-Natal. The highest-risk area is a strip of about 100 km along the Zimbabwe, Mozambique and Swaziland border. The disease should therefore be viewed as a regional rather than a country-specific problem. The risk areas are divided into high-, intermediate- and low-risk areas.

The number of malaria cases and related deaths in South Africa started to rise from approximately 27 000 cases and 160 deaths, in the mid-1990s, peaking at 62 000 cases and 420 deaths in 2000.

To deal with the problem, the Department of Health first identified problem areas that needed to be addressed, including parasite resistance, vector-insecticide resistance and community-compliance issues. The Department took drastic measures to address these factors, which included changing the drugs and insecticides used, as well as massive education and awareness campaigns within the affected communities.

As a result of these actions, the number of malaria cases dropped by 59% in 2001 and a further 42% in 2002. The malaria deaths in 2001 declined by 74% and a further 21% in 2002 compared with the 2000 malaria season.

Malaria-control teams of the provincial Departments of Health are responsible for measures such as education, treatment of patients, residual spraying of all internal surfaces of dwellings situated in high-risk areas, and detection and treatment of all parasite carriers. It was decided to continue with a programme of controlled and restricted use of DDT because of the growing resistance to pyrethroid insecticides.

The MRC has produced the first district malaria-distribution maps for the country, which have direct implications for focused and cost-effective control measures.

Nearly 35 000 homesteads and facilities have been plotted in collaboration with the Department of Health. The risk map for the entire country is updated annually in collaboration with the Department. The MRC maintains a website (*www.mrc.ac.za*) containing, among others, maps compiled by the Mapping Malaria Risk in Africa project. The initiative has seven regional centres throughout Africa.

The MRC's South African Traditional Medicines Research Group is investigating plants used by traditional healers for the treatment of malaria, TB, skin disorders and immune-system stimulation. Two plants that are effective against malaria parasites have been identified, and the active compounds in one of the plants have been identified and isolated. Anti-TB chemical entities, in traditional medicines, have also been isolated.

The Department of Health is in the process of implementing the Rollback Malaria Strategic Plan. The goal of the Plan is to integrate the Malaria-Control Programme into PHC so that community and district malaria activities can be strengthened and sustained.

South Africa is one of the signatories to the Abuja Declaration, committing itself to reducing malaria morbidity and mortality by 50% by 2010.

Since the onset of the Lubombo Spatial Development Initiative (SDI), of which South Africa is a partner with Mozambique and

Swaziland, there has been an overall reduction of 40% in malaria cases in 2001, followed by a 70% reduction in 2002 from the baseline study conducted in 2000 in the Lubombo SDI areas.

The South African Government has pledged the amount of R5 million to the project for two years and will continue to support the project in 2004. The project managed to secure a five-year grant to the value of US $22 million from the Global Fund to Fight AIDS, TB and malaria.

These resources will be used to intensify the project, including the expansion of the spraying programme in Mozambique, introducing more effective malaria drugs in all the partner countries, increasing malaria control infrastructure, and training scientists and officials in effective malaria control.

The WHO honoured South Africa for its role in the Lubombo SDI with an award for best malaria control in southern Africa. South Africa has committed itself to playing a role in the New Partnership for Africa's Development (NEPAD) and malaria control is one of the major programmes in this regard.

The *Race Against Malaria* Campaign, launched on 10 April 2003, is one of the initiatives to bring partners across southern Africa together in pursuit of better health.

South Africa's rally team joined counterparts from the nine malaria-affected countries of southern Africa, on a two-week drive to Dar es Salaam in Tanzania, during which the teams raised awareness about malaria and distributed insecticide-treated nets, drugs, and education and communication material.

Preliminary negotiations have started with Zimbabwe to explore the possibility of cross-border malaria control, and malaria-control experts are being sent to other Southern African Development Community countries to provide technical assistance and strengthen control programmes in the subregion.

Tuberculosis

South Africa has to cope with 188 000 new TB cases a year. The country remains one of the 22 high-burden TB countries, even though free testing is available at public clinics countrywide.

On World TB Day on 24 March 2003, South Africa's first National TB advocacy and social-mobilisation campaign was launched – it was also the first such campaign globally. It was announced that more than R8 million would be made available over a period of two years to address the problem of HIV/TB infection.

The Department of Health has implemented the Directly Observed Treatment Strategy (DOTS), advocated by the International Union against TB and the WHO. The focus is on curing infectious patients at the first attempt, by ensuring that:

- they are identified by examining their sputum under a microscope for TB bacilli
- they are then supported and monitored to ensure that they take their tablets
- the treatment, laboratory results and outcome are documented
- the right drugs are given for the correct period
- TB control receives special emphasis in terms of political priority, finances and good district health management.

Treatment is free of charge at all public clinics and hospitals in South Africa.

A TB team has been set up at national level, while all provinces have TB co-ordinators. A reporting system, which tracks the outcome of all infectious patients, has been implemented countrywide.

Demonstration and training areas have been set up countrywide. Training manuals, posters and charts have been developed, and courses presented. Communication between clinics and laboratories has improved, and treatment guidelines for drug-resistant TB have been developed.

Government's National Medium-Term Development Plan for the National TB Control Programme aims to achieve the following specific targets by 2005:

- a cure rate of between 80 and 85% among smear-positive TB cases

- decreasing the treatment interruption rate to less than 10%
- detecting 70% of estimated new smear-positive TB cases.

HIV/AIDS

The Government's policy on HIV and AIDS is set out in the five-year Strategic Plan adopted in 2000 and the Cabinet statements of 17 April 2002, 9 October 2002 and 8 August 2003.

The national action system is defined as the Partnership Against AIDS. The Partnership is represented by the South African National AIDS Council (SANAC), which has contributed substantially to co-ordinating various sectors at the highest level.

Government's commitment to intensifying implementation of the Plan is backed by very large budgets for the HIV/AIDS programme. In 2002/03, government provided large additional allocations for an enhanced response to HIV/AIDS and TB. These allocations, estimated at more than R1 billion for 2002/03, were again strengthened in the 2003 Budget.

Additional allocations of R3,4 billion for the next three financial years strengthen key national programmes (such as condom distribution), as well as bolster provincial budgets to extend prevention programmes and treatment. Dedicated funding for HIV/AIDS (excluding allocations from the provincial equitable shares) is set to increase more than tenfold from R342 million in 2001/02 to R3,6 billion in 2005/06.

The Cabinet convened a special meeting on 8 August 2003 to consider the Report of the Joint Health and Treasury Task Team on treatment options to enhance comprehensive care for HIV/AIDS in the public sector.

The Cabinet decided that the Department of Health should, as a matter of urgency, develop a detailed operational plan on an anti-retroviral (ARV) treatment programme.

The Task Team was assisted by a team of experts from the Clinton Foundation AIDS Initiative.

On 19 November 2003, Cabinet, in principle, approved the Operational Plan for Comprehensive Treatment and Care for HIV and AIDS, which it had requested the Department of Health to prepare. Among others, the Plan provides for ARV treatment in the public health sector as part of government's comprehensive strategy to combat HIV and AIDS.

Awareness and life skills campaigns

Government campaigns are continuously increasing awareness about HIV, AIDS, STIs and TB.

Research surveys indicate a high level of awareness among South Africans. The Human Sciences Research Council (HSRC) study, released in November 2002, showed that prevention messages regarding condom-use were working, especially as the young are taking abstinence and faithfulness to heart.

During 2002/03, awareness advanced mainly through the *Khomanani* Campaign and the life skills and HIV/AIDS education programme in schools.

The *Khomanani* Campaign, for which government provided R98 million, aims to move the nation to act, so that individuals see themselves as part of a caring community, proactively addressing the HIV, AIDS and TB epidemics.

Condom supplies

Condoms are available free of charge at all clinics.

During 2002, government distributed 350 million male condoms free of charge. This rose to 400 million in 2003/04. Government will increase the supply through non-traditional outlets – like clubs, shebeens and spaza shops – and double the number of sites where female condoms are available (the number of such sites has already increased from 27 in 2000 to over 200 in 2002).

In 2003, government spent R123 million on the distribution of approximately 22 million

male condoms and 100 000 female condoms every month.

Improved access to voluntary HIV counselling and testing (VCT)

Ensuring access to confidential and voluntary HIV counselling and testing is one of the essential elements of the Strategic Plan, as it provides an important entry into other health interventions, e.g. TB and STI treatment. This goal focuses on expanding access to VCT in both the private and public sectors.

By the end of 2002, VCT was available at 982 sites throughout the country, including the sites of the Preventing Mother-to-Child Transmission (PMTCT) programme. VCT services were expected to be available in 80% of public health facilities by the end of 2003/04. To this end, the conditional grant for HIV/AIDS to the provinces, including expanding VCT and PMTCT, was increased from R210 million in 2002/03 to R334 million in 2003/04.

Preventing mother-to-child transmission of HIV

The PMTCT programme that provides Nevirapine to mother and baby is expanding. The original research sites continue to function, providing a full package of care, and helping to answer critical operational questions such as the impact of infant-feeding options and the significance of drug resistance.

Most provinces are extending this comprehensive package to more facilities. By 2003, about 658 hospitals and clinics were providing the service.

All doctors working in the public-sector maternity services may offer Nevirapine to HIV-positive pregnant women, provided that adequate HIV testing and counselling facilities exist. Provinces are therefore also focusing on upgrading testing and counselling services to take into account the needs of PMTCT.

Rape survivors

The decision taken by the Cabinet in April 2002, to offer ARVs to victims of sexual assault as part of a comprehensive package of support, is being implemented. The post-exposure prophylaxis programme includes counselling on the effectiveness and risks of using ARVs for this purpose.

Supplementary funding was approved for this programme in 2002 and increased funding was included in 2003 in the conditional grants to provinces.

All provinces are working according to national protocols. In some provinces, the focus is on multidisciplinary crisis or victim-empowerment centres, while in others, the service is offered through the emergency rooms of general hospitals.

Vaccine

The South African AIDS Vaccine Initiative (SAAVI) was established in 1999 to develop and test an effective, affordable and locally relevant vaccine for South Africa. The SAAVI has made unusually fast progress for a biotechnology project of this nature.

The Cabinet received a report in July 2003 on the progress of SAAVI with regard to developing a vaccine against HIV and AIDS. Clinical trials on South African products are expected to start in 2004, while trials on other products developed in collaboration with international partners were expected to start in 2003 – pending approval from the MCC and Ethics Committee.

The Department of Health has increased its funding to SAAVI from R5 million to R10 million a year. This is matched by R10 million a year from the Department of Science and Technology (bringing the total Government contribution to R20 million annually), while Eskom contributes R15 million a year.

South Africa is also involved in trials of candidate vaccines that have been developed outside the country.

Training

The Integrated Training Grant for 2003/04

helped ensure collaboration between provincial and academic institutions to standardise both undergraduate and in-service training.

Through a partnership with the Foundation for Professional Development, health workers will be trained in issues relating to HIV, AIDS, STIs and TB. This includes a component on managing patients on ARVs. This training will target 100 health workers per province annually for three years.

Government began setting up Centres of Excellence in 2003. Their main function will be to develop curricula on HIV, AIDS and TB care, and to align the skills of healthcare workers with the requirements of national treatment guidelines.

Home/community-based care

By March 2003, there were 466 Home/Community-Based Care Programmes in the country, reaching some 370 170 people. There were 9 553 volunteers attached to these programmes.

Additional funds were made available in 2003/04 through the conditional grants for strengthening the Home/Community-Based Care Programmes. Apart from the health grant, a conditional grant of R66 million was allocated to the Department of Social Development to focus on home/community-based care, specifically addressing the issues of orphans and vulnerable children; and social relief including food parcels, counselling and child care.

Reproductive health

According to the Maternal Mortality Report, released by the Minister of Health in February 2003, HIV/AIDS, malnutrition, substandard healthcare and other non-pregnancy related infections are the chief contributing factors to the country's increasing death rate among pregnant women.

HIV/AIDS remains the most common cause of maternal deaths, responsible for 31,4% of all cases.

The release of the Report coincided with International Women's Day.

Entitled, *Saving Mothers 1999 – 2001*, the Report was commissioned by the Health Ministry four years ago because of the growing concern about rising maternal deaths.

The Report shows that women in their first pregnancy and those who have had five or more pregnancies are at as much risk of maternal death as 35-year-olds and older women.

High blood-pressure complications are responsible for 20% of maternal deaths during pregnancy, uncontrolled bleeding (obstetric haemorrhage) 13,9%, pregnancy-related sepsis 12,4%, and pre-existing medical conditions account for 7% of maternal deaths.

Other factors include lack of emergency transport, especially in predominantly rural areas, substandard healthcare, and lack of adequate health personnel, resources and information.

The Report recommends, as part of the remedial treatment to reduce maternal deaths, that staffing and equipment norms be improved, emergency-transport facilities and termination-of-pregnancy services be made available to pregnant women, and blood be made available at all health centres where Caesarean services are performed.

The Department of Health has developed a card for women's reproductive health to improve continued care and to promote healthy lifestyles. The card is retained by the patient and facilitates communication between health services.

Antenatal care is provided free of charge. However, some women do not use this service effectively. The Department is convinced that a lack of information could be a contributing factor. Therefore, the Department is addressing the problem by empowering women with quality information that will enable them to make informed choices and decisions affecting their reproductive rights and health.

A Pregnancy Education Week is held annually in February, during which talks and

workshops are conducted in rural and urban areas to educate women on their reproductive rights and related issues.

The Contraception and the Youth and Adolescent Health Policy Guidelines promote access to health services for the vulnerable groups, by improving the capacity of health and other workers to care for women and children.

The Guidelines are aimed at the provision of quality care, preventing and responding to the needs of the youth, and promoting healthy lifestyles among all youths. The promotion of a healthy lifestyle includes programmes or activities on issues such as:

- life skills
- prevention of substance and alcohol abuse
- provision of a smoke-free environment.

The focus is on the positive potential of young people as opposed to the problems they manifest.

Eight critical areas within the Youth and Adolescent Health Policy Guidelines have been identified, namely:

- sexual and reproductive health
- mental health
- substance abuse
- violence
- unintentional injuries
- birth defects and inherited disorders
- nutrition
- oral health.

The Guidelines for Maternity Care deal with the prevention of opportunistic infections in HIV-positive women, and the provision of micro-nutrient supplements to help ensure the well-being of mothers. They also require health workers to delay the rupture of membranes in labour, avoid suctioning of the newborn by using scalp electrodes, and avoid traumatic procedures such as amniocentesis.

The Guidelines for the Cervical Cancer-Screening Programme are set to reduce the incidence of cervical cancer by detecting and treating the pre-invasive stages of the disease. According to the Cancer Registry, cervical cancer is the second most common cancer in women, comprising 16,6% of all cancers. It is the most common cancer in black (31,2%) and coloured women (22,9%), second most common cancer in Asian women (8,9%), and fourth most common cancer in white women (2,7%).

The Cancer-Screening Programme is set to screen at least 70% of women in their early thirties within 10 years of initiating the Programme. The policy allows for three free pap tests with a 10-year interval between each test. Pilot sites for the screening of cervical cancer have been set up in Limpopo, Gauteng and the Western Cape. The project will be rolled out to all provinces.

The Department is also involved in a programme promoting the participation of men in reproductive health and in the prevention of domestic violence and HIV/AIDS.

The Choice on Termination of Pregnancy Act, 1996 (Act 93 of 1996), allows abortion on request for all women in the first 12 weeks of pregnancy, and in the first 20 weeks in certain cases. The Act came into effect on 1 February 1997. Designated facilities have to meet the minimum criteria as recommended by the Minister of Health. These include trained staff, the availability of an operating theatre and appropriate surgical equipment, drugs, and infection-control measures. Termination-of-pregnancy services are provided free of charge within the comprehensive reproductive health services.

A total of 45 449 abortions were performed in State hospitals during 2001. There was a significant decrease in the maternal mortality rate from unsafe abortions – from over 64% in 1994 to 9,5% in March 2002. However, deaths from septic abortions do still occur and this is cause for concern. Amendments to the Choice on Termination of Pregnancy Act, 1996 are planned to facilitate better access to termination services.

The Department of Health continues to support training in abortion care and contraception provision. There was an increase from

239 trained providers in March 2001 to 366 trained providers in March 2002. There was also an increase in the number of functioning designated facilities, from 33% in March 2001 to 48% in March 2002.

The Subdirectorate: Women's Health has developed Contraception Service-Delivery Guidelines. The Subdirectorate is reviewing the National Guidelines on the Management of Survivors of Sexual Offences, and developing a policy on the management of survivors of sexual offences.

Traditional medicine

In August 2003, South Africa launched the Institute for African Traditional Medicines to research African herbs, and evaluate their medicinal value as part of the Government's campaign to fight HIV, AIDS, TB and other debilitating diseases.

The Institute serves as a reference centre at the Council for Scientific and Industrial Research (CSIR) and will work in partnership with the MRC and the WHO.

The launch of the Institute was the result of a research programme initiated by the Department of Health and the MRC to test the effectiveness, safety and quality of traditional medicines, as well as to protect people from unscrupulous conduct and unproven medical claims within the traditional healing sector.

According to the MRC, an estimated 80% of the population in southern Africa use traditional therapies, with many people reportedly deriving benefits from their use.

The WHO has stated that traditional medicines need to be evaluated for safety and effectiveness before they can be incorporated into or excluded from national health policies. The MRC has put in place systems to safeguard the intellectual property rights of individuals or communities who may bring forward such agents for evaluation.

The MRC will conduct tests to evaluate such medicines, develop substances that could be used for chronic conditions – including immune boosters – and provide information on these medicines to the general public.

Tobacco control

It is estimated that about 25 000 South Africans die each year from tobacco-related diseases.

Regulations of the Tobacco Products Control Amendment Act, 1999 (Act 12 of 1999), include:

- a ban on all advertising for tobacco products from 23 April 2001
- all public places must be smoke-free, but employers and restaurateurs can set aside 25% of their space for smokers, and this space must be separated by a solid partition
- a fine of R10 000 for those who are caught selling or giving cigarettes to children.

The Tobacco Products Control Amendment Act, 1999 has earned the Ministry of Health notable worldwide recognition with the awarding of the Luther L. Terry Award in August 2000.

The Department of Health has set up a tobacco hotline for the general public to lodge smoking-related complaints. More than 12 500 complaints were received in less than a year.

Complaints can be lodged at the hotline on (012) 312 0180. People who want to quit smoking can contact the National Council Against Smoking's Quit Line on (011) 720 3145.

The Department's approach to reducing tobacco is multipronged. While encouraging communities and individuals to take control of their health, government has also assumed a greater responsibility through education, policy and law enforcement.

The results of these interventions are encouraging. In 1998, South Africa recorded a significant drop in adult tobacco consumption. According to the South African Demographic Health Survey Report, adult smoking dropped from 34% in 1996 to 24% in 1998.

A similar trend was noted among high-school-leavers in two surveys conducted by the MRC in 1999 and 2002, (as part of the Global Youth Tobacco Survey).

The 2002 Survey showed that schoolgoing teenagers were less likely to smoke than they had been in 1999.

This was attributed to a halt in exposure to the advertising, promotion and sponsorship of tobacco products.

The Survey revealed, among other things, that the percentage of:

- teenagers interviewed who had ever smoked (even one or two puffs) dropped from 46,7% in 1999 to 37,6% in 2002
- frequent smokers (who had smoked on at least 20 days in the 30 days preceding the interview) dropped from 10,1% in 1999 to 5,8% in 2002
- those who recalled seeing tobacco adverts dropped from 77,9% (magazines and newspapers) and 85% (billboards) in 1999 to 69,5% and 78% in 2002
- those who had been offered free cigarettes by a tobacco-industry representative was down from 29,7% to 22%.

By the year 2006, the levels of nicotine and tar contents of cigarettes will be reduced even further.

Restrictions on the tar level will be reduced from the current 15 milligrams (mg) to 12 mg, while nicotine will decrease from 1,5 mg to 1,2 mg in all cigarettes sold in South Africa.

South Africa has strongly endorsed, and was one of the first signatories to the Global Framework Convention on Tobacco Control. The Convention is the first global health treaty and was adopted by 192 countries of the World Health Assembly in May 2003.

Alcohol and substance abuse

Foetal Alcohol Syndrome (FAS) is one of South Africa's most common birth defects. It is caused by a mother's consumption of alcohol during pregnancy. Rates in South Africa are the highest recorded anywhere in the world. In the Northern Cape, one in 10 children starting school shows signs of the Syndrome and in the Western Cape, one in 20.

According to a report by the MRC's Alcohol and Drug Abuse Research Group, released in April 2002, alcohol remains the dominant substance of abuse in South Africa. Across the five sites in the South African Community Epidemiology Network on Drug Use, between 46% (Cape Town) and 69% (Mpumalanga) of patients in specialist substance-abuse treatment centres have alcohol as their primary substance of abuse. In Port Elizabeth in 2001, 57% of trauma patients had breath-alcohol concentrations at or above 0,05 grams (g) per 100 millilitres (ml) (the legal limit for driving), compared to 31% in Cape Town and 22% in Durban. Up to 74% of violence-related trauma patients were alcohol-positive in Port Elizabeth, and in Cape Town, up to 45% of persons injured in transport accidents tested positive for alcohol.

Use of cannabis (dagga) and mandrax (methaqualone) alone or in combination (white pipes) continues to be high. The increase in treatment-demand for cocaine addiction which was reported in Cape Town, Durban and Gauteng, has not continued and there has been a levelling off in treatment demand. In Gauteng, however, there has been an increase in the proportion of females reporting cocaine/crack as their primary drug of abuse. Nine per cent of trauma patients in Cape Town tested positive for cocaine in 2001 (up from 3% in 1999/00). An increase in arrests for dealing in cocaine were reported in three of the four sites for which data were available, and large seizures were reported by the South African Police Service's Forensic Science Laboratory in the Western Cape (166 kilograms (kg)).

Over time, there has been a dramatic increase in treatment demand for heroin as the primary drug of abuse in Cape Town and Gauteng. In Cape Town, this is particularly evident among females younger than 20 years of age. Heroin is mainly smoked, but an increasing proportion of patients with heroin as their primary drug of abuse report some

injection (36% of patients in Gauteng and 51% of patients in Cape Town).

The abuse of over-the-counter and prescription medicines such as slimming tablets, analgesics (especially products containing codeine), and benzodiazepines (e.g. valium) continues to be an issue across sites, but treatment-demand indicators are stable, except in Mpumalanga where an increase was reported. All sites for which age data are available have shown an increase in treatment-demand by persons younger than 20 years of age.

The Central Drug Authority was established in 2000 and is in the process of operationalising the Drug Master Plan. Key government departments are represented on this body, which reports to Parliament annually. (See chapter 19: *Social development).*

Violence against women

The Department has implemented a series of concrete measures to eliminate violence against women and children.

The Department is raising awareness and promoting intersectoral and interregional co-operation in this area. On 25 November 2003, Government launched the *16 Days of Activism on No Violence Against Women and Children* Campaign.

On 20 March 2003, the Foundation for Human Rights launched a fund for the money raised during the Campaign. The money will be disbursed through the Foundation for Human Rights to NGOs assisting victims and survivors of violence.

The Domestic Violence Act, 1998 (Act 116 of 1998), was enacted in December 1999, and mass campaigns have been held to create community awareness of the Act. Sexual-offence guidelines have been distributed to provinces for implementation.

Training of health providers in victim empowerment and trauma management is ongoing. A national pilot project on secondary-level services for victims of violence and other psychological crises is ongoing in Mpumalanga, KwaZulu-Natal and the Eastern Cape.

Violence prevention

The Department of Health is playing an important role in violence prevention. PHC professionals are being trained in victim empowerment and trauma support and advanced training of healthcare professionals for the management of complicated cases of violence is being carried out in the Secondary-Level Victim Empowerment Centres, established by the Department in some provinces. Violence-prevention programmes in schools are also running in some provinces.

A Crime, Violence and Injury Lead Programme, co-directed by the MRC and University of South Africa's Institute for Social and Health Sciences, has been designed to improve the population's health status, safety, and quality of life, through public health-orientated research aimed at preventing death, disability and suffering arising from crime, violence and unintentional incidents of injury. The Lead Programme's overall goal is to produce research on the extent, causes, consequences and costs of injuries, and on best practices for primary prevention and injury control.

Birth defects

It is estimated that 150 000 children born annually in South Africa are affected by a significant birth defect or genetic disorder.

The Department of Health's four priority conditions are albinism, Down's syndrome, FAS and neural tube defects. Implementation of policy guidelines for the management and prevention of genetic disorders, birth defects and disabilities will reduce morbidity and mortality resulting from genetic disorders and birth defects. This will involve decentralisation of training, expansion of the sentinel sites for birth-defect monitoring, and collaboration with NGOs in creating awareness.

South Africa, through the Birth Defects Surveillance System, is a member of the

International Clearing House for Birth Defects Monitoring Systems. In the long term, this should result in diagnoses being more accurate and the data collected on birth defects more reliable. Links have been made with those sentinel sites reporting on perinatal mortality, as congenital anomalies have been shown to be among the top three causes of perinatal mortality at some sentinel sites.

The Department of Health participates in various campaigns to create awareness, including:

- Albinism Awareness Month (September)
- National Inherited Disorders Day (1 October)
- Down's Syndrome Day (20 October)
- World Haemophilia Day (17 April)
- World TB Day (24 March)
- World Breastfeeding Week (1 – 17 August)
- World No-Tobacco Day (31 May).

Regular meetings are held with NGOs to discuss collaborative issues.

Chronic diseases, disabilities and geriatrics

The Department continues to focus on the development of guidelines for the clinical management of priority chronic diseases, diseases of lifestyle, eye care, cancers, and cataract surgery. Patient education and information, including education on their rights and responsibilities, are also emphasised. Booklets, posters, audiotapes and videotapes with appropriate informative health messages are available at clinics.

The Department promotes the rights of patients as well as the need for them to take responsibility for their own health. This includes a new area to be researched, i.e. therapeutic education, whereby barriers to patient compliance will be identified and addressed.

Healthcare professionals from each province have been trained in the management of asthma, hypertension, diabetes and eye health. This includes training in a health-compliance model to improve patient compliance.

The Department aims to reduce avoidable blindness by increasing the cataract-surgery rate.

Government introduced free health services for people with disabilities in July 2003.

Beneficiaries of the new policy include people with permanent, moderate or severe disabilities, as well as people who have been diagnosed with chronic irreversible psychiatric disabilities.

Frail older people and long-term institutionalised State-subsidised patients also qualify for these free services.

People with temporary disabilities or a chronic illness that does not cause a substantial loss of functional ability, and disabled people who are employed and/or covered by relevant health insurance, are not entitled to these free services.

Beneficiaries receive all in-and-out-patient hospital services free of charge. Specialist medical interventions for the prevention, cure, correction or rehabilitation of a disability are provided, subject to motivation from the treating specialist and approval by a committee appointed by the Minister of Health.

All assistive devices for the prevention of complications, cure or rehabilitation of a disability are provided. These include orthotics and prosthetics, wheelchairs and walking aids, hearing aids, spectacles and intra-ocular lenses. The Department of Health is also responsible for maintaining and replacing these devices.

There is still a backlog in the supply of wheelchairs and hearing aids. The National Department of Health spent about R30 million to ensure that people who were on the waiting list received these devices during 2003/04.

The population of older persons (60 years and older) was estimated to be over three million in 2001. Over 60% were women. The Department continues to develop national policy guidelines on the management and control of priority diseases/conditions of older persons to improve their quality of life and

accessibility to healthcare services. These include the development of exercise posters and pamphlets and the development of guidelines that focus specifically on older persons, e.g. National Guidelines on Falls in Older Persons, Guidelines on Active Ageing, National Guidelines on Stroke and TIA (transient ischemic attacks), and National Guidelines on Osteoporosis. The National Strategy on Elder Abuse, together with the National Guidelines on the Management of Physical Abuse of Older Persons, have been implemented in all the provinces. These raise awareness of abuse in all its subtle forms.

Occupational health

The introduction of legislation such as the Occupational Health and Safety Act, 1993 (Act 181 of 1993), and the Mines Health and Safety Act, 1996 (Act 29 of 1996), has done much to focus the attention of employers and employees alike on the prevention of work-related accidents and diseases. The Compensation for Occupational Injuries and Diseases Act, 1993 (Act 30 of 1993), places the onus on medical practitioners who diagnose conditions which they suspect might be a result of workplace exposure, to report these to the employer and relevant authority.

The Medical Bureau for Occupational Diseases has a statutory function under the Occupational Diseases in Mines and Works Act, 1973 (Act 78 of 1973), to monitor former mineworkers and evaluate present miners for possible compensational occupational lung diseases until they either die or are compensated maximally.

Mental health

The promotion of mental health is one of the cornerstones of the health policy of South Africa.

There are 18 State institutions with some 10 000 beds.

Private psychiatric hospitals and clinics cater for patients requiring hospitalisation for less severe psychiatric illnesses. General hospitals have some psychiatric beds. A further 7 000 beds are hired from the private sector for treatment of long-term chronic psychiatric and severely intellectually disabled patients.

In keeping with government policy of promoting care of the severely intellectually disabled within the community, these persons receive care-dependency grants to reimburse their families for out-of-pocket expenses, thus allowing the person to remain with his or her family in the community. These grants are administered by the Department of Social Development. In recent years, the focus of treatment has shifted from medication only, except where necessary, to patient rehabilitation.

A comprehensive psychiatric community service is managed by health authorities countrywide. Where possible, consultations are undertaken by multidisciplinary teams comprising psychiatrists, psychiatric nurse practitioners, psychologists, pharmacists, social workers and occupational therapists.

According to the Mental Healthcare Act, 2002, mental health is to become a health issue like any other. The purpose is to bring community services closer to mentally-ill patients instead of simply placing them in institutions.

The Act focuses on a strong human rights approach to mental health. It also makes the process of certifying a person more complex, and introduces a 72-hour assessment period before a person can be certified. Previous legislation relied on psychiatrists and doctors to make the decision, but the new Act recognises that there are not enough psychiatrists, especially in rural areas. According to the Act, a mental healthcare practitioner may make such a decision. It also introduces a review board, comprising a mental healthcare practitioner, a legal expert and a community representative to examine the certified patient's case. The patient and their family will be able to appeal to the board, and all certified cases will be reviewed at least once a year.

Quarantinable diseases

The Port Health Service is responsible for the prevention of the introduction of quarantinable diseases into the country as determined by the International Health Regulations Act, 1974 (Act 28 of 1974). These services are rendered at sanitary airports (Johannesburg, Cape Town and Durban International Airports) and approved ports.

An aircraft entering South Africa from an epidemic yellow-fever area must make its first landing at a sanitary airport, and passengers travelling from such areas must be in possession of a valid yellow-fever vaccination certificate. Every aircraft or ship on an international voyage must also obtain a pratique from a port health officer upon entering South Africa.

During the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, the Port Health Service played a key role in creating awareness among travellers arriving from affected countries.

South Africa had one possible case of SARS, a traveller returning from China who showed many clinical signs of SARS, but who died without any laboratory confirmation of this.

Consumer goods

Another function of the Department, in conjunction with municipalities and other authorities, is to prevent, control and reduce possible risks to public health from hazardous substances or harmful products present in foodstuffs, cosmetics, disinfectants and medicines; from the abuse of hazardous substances; or from various forms of pollution.

Food is controlled to safeguard the consumer against any harmful, injurious or adulterated products, or misrepresentation as to their nature, as well as against unhygienic manufacturing practices, premises and equipment.

Nutrition

The Department of Health has instituted various interventions to address micronutrient deficiencies and to enhance households' access to nutritious foods.

During 2002, the Department started providing Vitamin A supplements to all children aged between six and 60 months and all mothers, within six to eight weeks after delivery. These supplements are also provided to pre-school children who suffer from severe undernutrition, persistent diarrhoea, measles and severe eye infection. Iron supplementation and anti-helminth treatment are also provided to anaemic pre-school children as part of the IMCI.

Folic acid supplements are provided to women within the first three months of pregnancy, and all pregnant women receive iron supplements.

Breast milk is a rich source of micronutrients, especially Vitamin A. The Department is taking various actions to promote, support and protect breast-feeding. These include the Baby-Friendly Hospital Initiative, which seeks to create an enabling environment for breast-feeding. By April 2003, there were 59 baby-friendly health facilities where mothers were encouraged and supported with the process of breast-feeding.

The Department is also busy drafting regulations on the marketing of breast-milk substitutes, with the view of curbing the sometimes irresponsible marketing of infant formulae by some baby-food manufacturers.

The Food Fortification Programme was launched in April 2003.

With effect from 7 October 2003, millers are compelled by law to fortify their white and brown-bread flour and maize meal with specific micronutrients.

The regulations on food fortification stipulate mandatory fortification of all maize meal and wheat flour with six vitamins and two minerals, including Vitamin A, thiamine, riboflavin, niacin, folic acid, iron and zinc.

Environmental health practitioners at local government level will be responsible for com-

pliance monitoring and law enforcement. Fines of up to R125 000 can be imposed upon millers who fail to comply.

The Department received a grant of US$2,8 million from the Global Alliance for Improved Nutrition. The money will be used to improve implementation of the Programme, including providing support to small-scale millers to comply with fortification requirements, and training environmental officers to monitor implementation of the Programme

The Food Fortification Programme is a result of a long and intensive process of stakeholder consultation and preparatory studies. The contribution of members of the Fortification Task Group, especially the milling and baking industry, consumer organisations, professional food and nutrition organisations, and various academics, has been invaluable in developing this Programme.

In selecting food vehicles, the Department also considered the organisation and capacity of the industry that should fortify and deliver fortified foods to consumers. An industry situation analysis showed that at least 85% of maize meal and 97% of wheat flour could be fortified centrally. Furthermore, a database of 580 small millers was compiled. These millers were visited to discuss the Programme and to determine their technical and capacity constraints. Extensive stability tests and organoleptic trials on fortified maize meal and bread were also conducted.

The Department has ensured that the fortification levels as indicated in the regulations do not change the taste and colour of food. The levels are consistent with those in other countries.

In formulating the Programme, the Department also consulted consumers to establish their views on fortification. Consumer research conducted in 2002 indicated that 81% of consumers in peri-urban, rural and deep rural areas were positive about fortification.

Provision has been made for the use of a voluntary food-fortification logo and an officially approved claim, *Fortified for Better Health,* to indicate that a particular maize meal or wheat flour is fortified according to the regulations.

This means that fortification levels will provide, per 200 g raw maize meal or wheat flour, at least 25% of the daily requirement of most nutrients for a person 10 years or older.

For instance, fortified maize meal will provide a child of between four and six years with an additional 46% (from the previous 36%) of the daily requirement of Vitamin A, bringing it to 82% of the total daily requirement.

The Primary School Nutrition Programme has proved its worth in delivery over a period of nine years. In 2002, the Cabinet made a series of recommendations to strengthen this Programme. As a result, the budget allocation for the Programme was increased substantially from R592 million to R809 million.

An estimated five million children in 15 000 schools have benefitted from this Programme.

It is within this context that the Integrated Nutrition Programme (INP) aims to ensure optimum nutrition for all South Africans by preventing and managing malnutrition. A co-ordinated and intersectoral approach, focusing on the following areas or broad strategies, is thus fundamental to the success of the INP:

- disease-specific nutrition support, treatment and counselling
- growth monitoring and promotion
- nutrition promotion
- micronutrient malnutrition control
- food-service management
- promotion, protection and support of breast-feeding
- contribution to household-food security.

The INP targets nutritionally vulnerable/at-risk communities, groups and individuals for nutrition interventions, and provides appropriate nutrition education and promotion to all.

Acknowledgements

Allied Health Service Professions Council of South Africa
Department of Health
Estimates of National Expenditure 2003, published by the National Treasury
Health Professions Council of South Africa
Medical Research Council website
National Health Laboratory Service
South African Nursing Council
South African Pharmacy Council
www.gov.za

Suggested reading

Arden, N. *African Spirits Speak: A White Woman's Journey into the Healing Tradition of the Sangoma*. Rochester, Vermont: Destiny Books, 1999.
Baldwin-Ragaven, L., De Gruchy, J. and London, L. *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa*. Cape Town: University of Cape Town Press, 1999.
Barnett, T. and Whiteside, A. *AIDS in the Twenty-First Century. Disease and Globalisation*. Hampshire: Palgrave Macmillan, 2002.
Bayer, R. and Oppenheimer, G.M. *AIDS Doctors: Voices from the Epidemic*. Cape Town: Oxford University Press, 2002.
Booysens, S.W. ed. *Introduction to Health Services Management*. Kenwyn: Juta, 1996.
Campbell, C. *Letting Them Die – Why HIV/AIDS Intervention Programmes Fail*. London: International African Institute and Cape Town: Double Storey Books, 2003
Campbell, S. *Called to Heal: Traditional Healing Meets Modern Medicine in Southern Africa*. Halfway House: Zebra Press, 1998.
Couvadia, H. M. and Benatar, S. eds. *Tuberculosis With Special Reference to Southern Africa*. Cape Town: Oxford University Press, 1992.
Crewe, M. *AIDS in South Africa: The Myth and the Reality*. London: Penguin, 1992.
De Haan, M. *Health of Southern Africa*. 6th ed. Cape Town: Juta, 1988.
De Miranda, J. *The South African Guide to Drugs and Drug Abuse*. Cresta, Randburg: Michael Collins Publications, 1998.
Dennil, K. and others. *Aspects of Primary Health Care*. Halfway House, Gauteng: Southern Book Publishers, 1995.
Dreyer, M. and others. *Fundamental Aspects of Community Nursing*. 2nd ed. Halfway House: International Thomson Publishing, 1997.
Engel, J. *The Complete South African Health Guide*. Halfway House, Gauteng: Southern Book Publishers, 1996.
Evian, C. *Primary AIDS Care: A Practical Guide for Primary Health Care Personnel*. 3rd ed. Johannesburg: Jacana, 2003.
Felhaber, T. ed. *South African Traditional Healers' Primary Health Care Handbook*. Traditional aspects compiled by I. Mayeng. Cape Town: Kagiso, 1997.
Gow, J. and Desmond C. eds. *Impacts and Interventions: the HIV/AIDS Epidemic and the Children of South Africa*. Pietermaritzburg: University of Natal Press, 2002.
Gumede, M.V. *Traditional Healers: A Medical Doctor's Perspective*. Johannesburg: Skotaville, 1990.
Hammond-Tooke, W.D. *Rituals and Medicines: Traditional Healing in South Africa*. Johannesburg: Donker, 1989.
Hattingh, S. and others. *Gerontology: A Community Health Perspective*. Johannesburg: International Thomson Publishing, 1996.
Holland, H. *African Magic: Traditional Ideas that Heal a Continent*. Sandton: Penguin, 2001.
Kibel, M. and Wagstaff, L. eds. *Child Health for All: A Manual for Southern Africa*. Cape Town: Oxford University Press, 1992.
Kok, P. and Pietersen, J. *Health*. Pretoria: Human Sciences Research Council (HSRC), 2000.
Mashaba, T.G. *Rising to the Challenge of Change: A History of Black Nursing in South Africa*. Kenwyn: Juta, 1995.
Mbuya, J. *The AIDS Epidemic in South Africa*. Johannesburg: The Author, 2000.
Mendel, G. *A Broken Landscape: HIV and AIDS in Africa*. Johannesburg: M & G Books, 2002.

Nadasen, S. *Public Health Law in South Africa: An Introduction.* Durban: Butterworths, 2000.
Reddy, S.P. and Meyer-Weitz, A. *Sense and Sensibilities: The Psychosocial and Contextual Determinants of STD-Related behaviour.* Pretoria: Medical Research Council and HSRC, 1999.
South African First Aid Manual: The Authorised Manual of the St John's Ambulance and the South African Red Cross Society. 3rd ed. Cape Town: Struik, 1997.
Van Rensburg, H.C.J. *Health Care in South Africa: Structure and Dynamics*. Pretoria: Academica, 1992.
Van Wyk, B.E. and Gericke, N. *Medicinal Plants of South Africa*. Pretoria: Briza Publications, 1999.
Webb, D. *HIV and AIDS in Africa.* London: Pluto; Cape Town: David Philip, 1997.
Whiteside, A. and Sunter, C. *AIDS: The Challenge for South Africa*. Cape Town: Human & Rousseau, 2000.
Wood, M. *No Turning Back.* London: Michael Wood Memorial Fund, 2001.