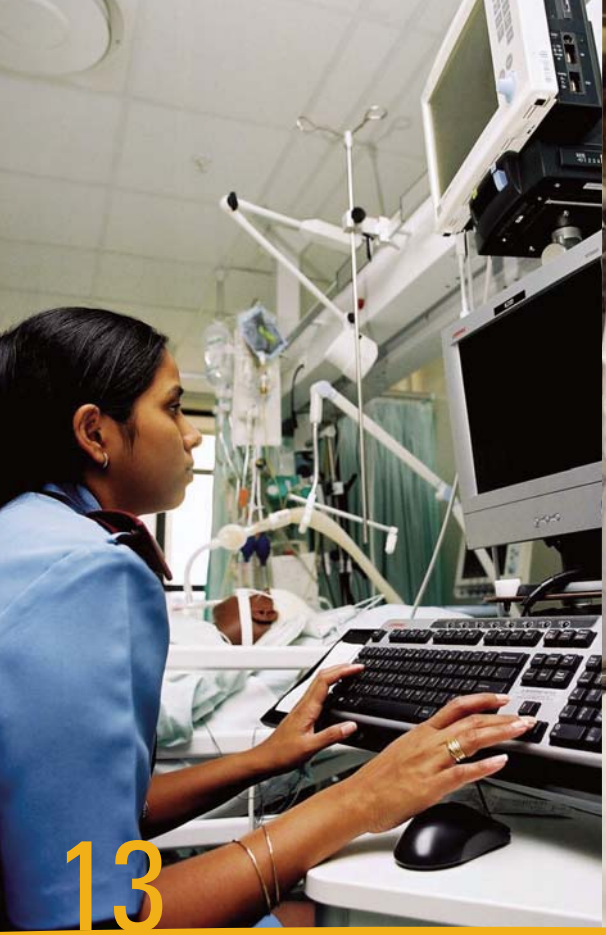

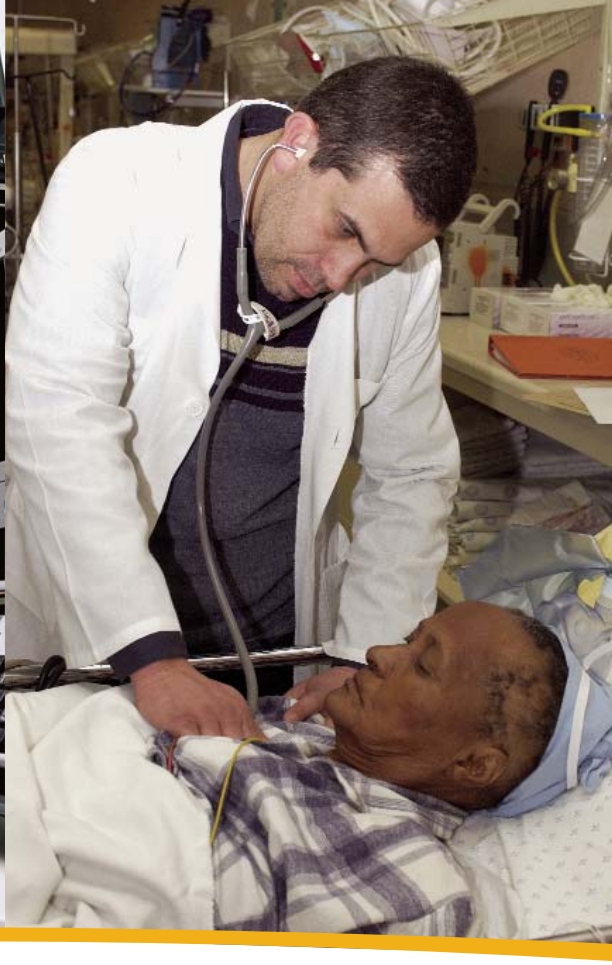

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Health

The Department of Health aims to promote the health of all people in South Africa through a caring and effective national health system (NHS) based on the primary healthcare (PHC) approach.

There has been significant expansion and improvement of health services since 1994 and there are numerous initiatives underway to achieve improved health status for all South Africans. These include new laws, investments in infrastructure, improved access to services, enhanced prevention efforts, advances in nutrition and increased availability of medicine.

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 (SANC), the South African Pharmacy Council and the Allied Health Professions Council of South Africa.

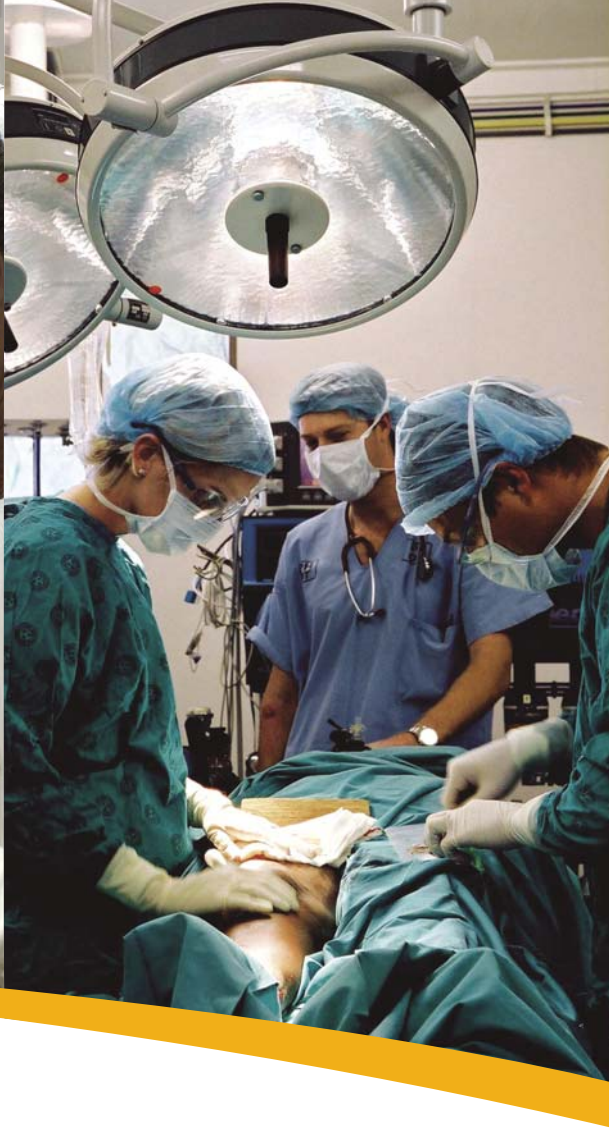
Regulations in the private health sector are effected through the Council for Medical Schemes.

The Medicines Control Council (MCC) is charged with ensuring the safety, quality and effectiveness of medicines.

Health authorities

National

The Department of Health is responsible for:



- formulating health policy, legislation, 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 to ensure efficiency and quality
- controlling quality of 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

Between 1994 and 2004, a total of over 1 200 new clinics were built. A further 252 clinics underwent major upgrading such as the building of new maternity units, and 2 298 clinics received new equipment and/or underwent minor upgrading.

Fifty-three health districts were established in line with the new metropolitan and district municipal boundaries. As a result of the expansion of facilities, the wider range of services on offer, and the free PHC policy, the number of PHC visits per person increased from an estimated 1,8 per year in 1992 to an estimated 2,3 per year in 2001, and in some provinces to 3,5 visits in 2003.

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, taking care of chronic diseases and 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 that cannot be treated at PHC level are referred to hospitals for higher levels of care.

Beneficiaries 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.

Community health

Government formalised the country's community health worker sector by launching the Community Health Worker Programme in February 2004.

It is estimated that there are 40 000 such workers in the country.

They will interact with community members, determine what health or other services are needed, and co-ordinate efforts to make these services available.

Health policy

The NHS aims to improve public health through the prevention of diseases and the promotion of a healthy lifestyle. It also strives to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.

The strategic priorities for the NHS for 2004 to 2009 are:

- improving the governance and management of the NHS
- promoting a healthy lifestyle
- contributing towards human dignity by improving the quality of care
- improving the management of communicable and non-communicable diseases
- strengthening PHC, emergency medical services and hospital service-delivery systems
- strengthening support services
- human resource planning, development and management
- planning, budgeting, monitoring and evaluation
- drafting and implementing health legislation
- strengthening international relations.

In recent years, substantial developments took place:

- The 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 human resource development (HRD) has been achieved.

By January 2004, nearly 11 000 young professional healthcare workers had done community service since the NHS's inception in 1999, contributing 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.

A total of 966 hospital rehabilitation projects were undertaken and some 18 new hospitals built.

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.

The Patients' Rights Charter was introduced, with the provinces gradually initiating complaint systems, help desks and incentives for good service.

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.

By mid-2004, the PHC telemedicine testbed in the Nkomazi district in Mpumalanga had been operational for two years. According to research by the Telemedicine Research Centre, there were 85 video-conference sessions during the first year, of which 75 were teleconsultations.

The Telemedicine Research Centre is proposing to offer Doppler wave form analysis (DWA) services to a rural community in Mpumalanga, using cellular telephone technology. DWA is very useful to diagnose intrauterine growth retardation.

Research has shown that the survival rate of foetuses has increased from 48 to 80% after active intervention following growth detection by DWA.

A useful form of DWA technology, called Umbiflow, was developed by scientists of the MRC's Business Technology Development Directorate, the MRC's Perinatal Mortality Research Unit and the Council for Scientific and Industrial Research (CSIR).

A site will be established at the antenatal clinic at Shongwe Hospital in Mpumalanga. Potentially hazardous pregnancies will have their information sent via this technology to experts at the Tygerberg Hospital in Cape Town for assessment.

The Research Centre also collaborated with the Department of Defence to investigate the application of telemedicine in the South African Military Health Service (SAMHS).

The Telemedicine Research Centre received R6 million from the Innovation Fund to develop a computer electronic interface for the PHC telemedicine workstation, suitable for South Africa and other developing countries.

Legislation

The National Health Act, 2003 (Act 61 of 2003), gives effect to government's constitutional duty to ensure progressive access to essential health services for all.

The Act is a wide-ranging framework that deals with patients' rights, the structure of the public health system, human resource issues, the setting of standards, and the certification of all health establishments.

The Certificate of Need, which will in future be a requirement for all health establishments, is intended to promote efficiency, prevent unnecessary duplication of services, and ensure that resources are put to best use.

The Traditional Healers Practitioners Bill was approved by the Cabinet in 2003. It provides for the registration of traditional healers and the establishment of a statutory body for the regulation of this area of practice. It was expected that the Bill would be processed by Parliament in 2004.

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

National School Health Policy

The National School Health 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 which affirms that the State is obliged 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 those in 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 were 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.

Social Health Insurance (SHI)

SHI is expected to facilitate access to contributory health cover for families of all employed people. SHI will embrace three major principles:

- risk-related cross subsidies
- income-related cross subsidies
- mandatory cover.

Important groundwork for SHI was done in 2003 and 2004.

Total of supplementary healthcare practitioners at the end of December 2003

Basic ambulance assistants	21 548
Ambulance emergency assistants	4 576
Environmental health officers	2 544
Medical technologists	4 738
Occupational therapists	2 665
Optometrists	4 604
Physiotherapists	2 354
Psychologists	5 607
Radiographers	5 033

Source: Health Professions Council of South Africa

Medicines administration

Progress is being made to improve the supply and availability of affordable medicines. The Medicines Pricing Committee investigated international practices and made recommendations to the Minister early in 2004 on Pricing Regulations.

The Regulations were finalised after a period of public comment and came into effect in May 2004.

Among other things, the Regulations require the manufacturer – not government – to set the exit price for each medicine. However, they do establish a ceiling for the original exit price and provide that the price may be increased only once a year – while it may be reduced any number of times, in the spirit of competition. The Regulations also stipulate the maximum fee a pharmacist can charge for dispensing.

Section 18A of the Medicines and Related Substances Control Amendment Act, 1997 (Act 90 of 1997), came into effect on 2 May 2004. It prohibits the supply of medicines through incentive schemes. The single exit price and regulated fee system were expected to become effective at the same time, thus aiming to ensure that all consumers pay less for medicines.

In June 2004, several organisations challenged the regulation of the dispensing fee through action in the Cape High Court.

On 27 August 2004, the application was turned down.

The Medicines and Related Substances Control Amendment Act, 1997 also requires that all health professionals (other than pharmacists) who dispense medicines must be licensed. The provision was due to come into effect in May 2004 but was delayed by two months due to a court challenge by dispensing doctors. The Pretoria High Court upheld the licensing requirement which is intended to ensure high standards of dispensing practice.

The Department has established the Pharmaco-Economic Directorate to improve intelligence on medicine pricing. Components dealing with the licensing of pharmacies are being strengthened.

Important progress has been made, in association with the pharmaceutical industry, in making antiretroviral (ARV) medicines more affordable and accessible.

A survey found that the Essential Drug Programme was widely implemented, with 86% of essential drugs found in facilities, 90% of medicines prescribed being from the Essential Drug List (EDL), and 97% of facilities having copies of the *Standard Treatment Guideline* booklets, compared with 59% in previous surveys.

The third edition of the PHC *Standard Treatment Guidelines* and EDL was launched in September 2004.

Funding

The National Department received R8,7 billion for the 2004/05 financial year, representing an increase of 4,8% compared with 2003/04.

Some R7, 7 billion – or 88% – was in the form of conditional grants, which were allocated mainly to the nine provinces for the following activities:

- the Integrated Nutrition Programme (INP)
- the management of HIV, AIDS and tuberculosis (TB)
- national tertiary services
- training of health professionals and research
- hospital revitalisation and improving hospital-management capacity and quality of care.

There is also an allocation for the development of medico-legal services in the provinces. This includes the transfer of responsibility for forensic mortuary services from the South African Police Service to provincial Health departments.

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.

The Minister of Health announced in January 2004 that government had allocated R500 million to recruit and retain scarce health professionals and attract new recruits to rural areas.

The Medium Term Expenditure Framework provides for some expansion (R750 million in 2004/05 and R1 billion in 2005/06) for the recruitment and retention of health workers.

In January 2004, the Department reached agreement with key trade unions on allowances for health professionals who serve people in the rural areas, and also for specific professional categories that are in short supply across the public sector.

The allowances address the dual inequity in the distribution of health professionals between private and public sectors and between rural and urban areas. They also apply much more widely than previous allowances, cover more rural areas, and for the first time acknowledge the critical role of professional nurses in such areas.

The rural allowance applies to 33 000 full-time health professionals, including professional nurses working in designated areas. These are areas previously covered by a more limited form of rural allowance, the nodes presently designated in terms of the Integrated Sustainable Rural Development Programme and areas requested for inclusion by provincial departments. The allowances range from 8% to 22% of annual salary, depending on area and occupational category.

The scarce skills allowance applies to 62 000 full-time health professionals in specified categories regardless of the geographic area in which they work. The categories include medical officers, dentists, medical and dental specialists, pharmacists, radiographers, various types of therapists, and nurses specialising in the areas of operating-theatre technique, critical or intensive care, and oncology. The allowances range from 10% to 15% of the health worker's annual salary, depending on occupational category.

Certain health professionals will qualify for both allowances. For example, a doctor, dentist or pharmacist working in the deepest rural area will be eligible for both allowances and would receive 37% of his/her annual salary in allowances.

Physicians

Some 30 578 doctors were registered with the HPCSA at the end of 2003. These included

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.

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

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

In 2004, about 3 900 young professionals did community service.

Medical assistants

A plan to introduce medical assistants was launched by the Minister of Health in March 2004. The medical/physician assistant will be part of a team in different units in a district hospital, that is, the Emergency Unit, Maternity and Outpatient departments, or Medical and Surgical units.

Registered medical interns, practitioners, pharmacists, nurses and dentists, 2002 – 2003

	2002	2003
Dentists	4 560	4 500
Medical interns	2 306	2 157
Medical practitioners	30 271	30 578

Source: Health Professions Council of South Africa

In operating theatres, the medical/physician assistant will assist the doctor in basic procedures like incisions and drainage.

The regulation of medical assistants will rest with the HPCSA.

The education and training of medical assistants will take place close to the location where the medical assistant will work. Most learning will take place at district hospitals. A clear link will be maintained with universities through internal training, telemedicine and block learning. The training period will be three years, followed by an internship at the district hospital.

There will be one training site per province with 12 students per site per year at the initial stage. More training sites will be developed within the next five years.

Developments will depend on how the universities and provincial departments of Health collaborate and what works best for each province and each university.

Oral health professionals

At the end of 2001, 11 dental and oral specialists, 849 oral hygienists and 347 dental therapists were registered with the HPCSA. There were 4 560 dentists at the end of 2003.

Dentists are subject to the CPD and community-service systems.

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

Pharmacists

Since 20 November 2000, all pharmacists 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 405 pharmacists commenced community service in 2004, compared with 49 in 2000.

A section of the Pharmacy Amendment Act, 2000 (Act 1 of 2000), which allows non-pharmacists to own pharmacies, came into effect during May 2003. It aims to improve access to medicines, make them more affordable, improve marketing

and dispensing practices, and promote consumer interests.

In 2004, 10 997 pharmacists were registered with the South African Pharmacy Council, of whom about 12% were employed in provincial and State hospitals.

Nurses

The SANC sets minimum standards for the education and training of nurses in South Africa. It accredits schools that meet the required standards and only grants professional registration to nurses who undergo nursing education and training at an accredited nursing school.

The key role of the Nursing Council is to protect and promote public interest, 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 2003, there were 177 721 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, 23 661 persons were registered as student and pupil nurses or pupil nursing auxiliaries on the registers and rolls of the Council.

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
- homoeopaths 652
- naturopaths 142
- osteopaths 60
- phytotherapists 23
- therapeutic aromatherapists 1 003
- therapeutic massage therapists 279
- therapeutic reflexologists 1 726

National Health Laboratory Service

The NHLS is a single national public entity that consists of the former South African Institute for Medical Research (SAIMR), National Institute for Virology (NIV), National Centre for Occupational Health (NCOH), university pathology departments and public-sector laboratories. It comprises about 250 laboratories.

The NIV and a section of the SAIMR have been combined to form the NICD, which 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.

The NCOH has been renamed the National Institute for Occupational Health. It investigates occupational diseases and has laboratories for occupational environment analyses.

On 10 May 2004, the Minister of Health, Dr Manto Tshabalala-Msimang, inaugurated the new Health Professions Council of South Africa (HPCSA) in Pretoria.

The HPCSA, which has a five-year term of office, comprises elected representatives of health professionals and individuals appointed by the Department of Health.

Its main objective is to protect the interest of the public by setting and maintaining standards for health professionals.

With effect from 2005, student doctors have to undergo a minimum five-year medical training programme followed by two years of internship.

Previous internships covered three or four domains – internal medicine, surgery, obstetrics and gynaecology. These have been increased to cover anaesthetics, psychiatry and other fields, thereby requiring an increase in the period of internship from one to two years.

In 2003, the one-year community service was also extended to cover clinical psychologists, radiographers, physiotherapists, dieticians, occupational and speech therapists, as well as environmental health officers.

They joined doctors, dentists and pharmacists who had been doing community service over the past few years.

In 2005, professional nurses – who constitute the largest group of health professionals – were expected to begin their community service.

Biovac Institute

The Biovac Institute, a public-private partnership for expanding local vaccine productions, was formally launched in 2004. The partnership will ensure the capital injection and expertise needed to revive production and will play a vital support role in local vaccine research.

Provincial Health departments

The function of 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.

Clinics

A network of clinics run by government forms the backbone of primary and preventive healthcare in South Africa. Clinics are being built or expanded throughout the country.

Hospitals

According to the Department of Health, there were 386 provincial public hospitals in 2003.

Ongoing programmes are in place to improve the quality of hospital services. The 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.

The National Tertiary Services Grant provides funding for tertiary health services, which deal with the various subspecialities such as cardiology or renal dialysis. This conditional grant to provinces, which significantly restructured national financing for tertiary services, was introduced in 2002/03. It funds services in 27 hospitals in all provinces, ensuring more equitable funding of higher-level services. By mid-2004, a long-term plan for funding and delivering tertiary care, the Modernisation of Tertiary Services Project, was being developed.

Steps are being taken to improve the quality of hospital services, with an increasing number of hospitals entering accreditation programmes. New quality-inspection authorities are to be established in terms of the National Health Act, 2003.

All maternal deaths are closely investigated as part of the maternal death surveillance and enquiry process.

Renewal of hospital stock focused initially on renovation and maintenance, but has progressed to major rebuilding under the Hospital Revitalisation Programme in the last two years. Capital budgets are currently at their highest since 1994. The Hospital Revitalisation Programme used R911 million in 2004 as part of a total budget of about R2 billion for improving health-service infrastructure. By September 2004, 30 hospitals were part of the Programme.

In 2004, the Nelson Mandela Hospital in Umtata in the Eastern Cape, one of three state-of-the-art tertiary-care hospitals, was commissioned. The others are Inkosi Albert Luthuli, which is already functioning in Durban, and the soon-to-be-completed Pretoria Academic Hospital.

The Hospital Association of South Africa represents all private hospital groups as well as independent hospitals. The Association has 183 member hospitals with about 25 000 beds, which represents more than 97% of hospitals in the private sector.

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 universities of technology also offer diploma

Registered and enrolled nurses, 2003

Registered nurses	96 715
Enrolled nurses	33 575
Nursing auxiliaries	47 431
Students in training	23 661

Source: South African Nursing Council

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

The role of local government

Local government is responsible for rendering 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.

The National Health Act, 2003 provides that formal service agreements between provinces and councils will be the basis for future development of PHC.

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.

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.

loveLife focuses more on teenage sexuality and relationships and the prevention of HIV-infection and related conditions. Apart from mass-media advertising campaigns backed by a helpline, loveLife focuses on providing services for young people. It has a programme to transform existing reproductive-health and communicable-infection services to make them more 'youth-friendly'. It has also 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 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 its implementation.

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 have pursued a high-profile campaign in support of expanded treatment.

Faith-based organisations (FBOs) are one of the mainstays of hospice 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 through 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.

Transnet Foundation's healthcare train, the *Phelophepa*, provides rural people in South Africa with essential healthcare services.

Phelophepa represents about a R15-million Transnet capital investment and is sponsored by local, national and international donors and funders.

The train utilises and supports existing primary healthcare services through referral to the nearest local clinic, social worker, hospital or doctor.

Since its inception in 1994, a total of 481 876 patients have been treated in the various clinics on board the train. Health education is also offered.

A further 676 719 individuals have been reached through the train's school screening, health education, counselling workshops and outreach programmes.

The Royal Society for the Promotion of Health in the United Kingdom awarded the founder of *Phelophepa*, Dr Lynette Coetzee, the inaugural Queen Elizabeth Medal for her contribution to public health within the Commonwealth.

Costs and medical schemes

About seven million South Africans are members or beneficiaries of medical aid schemes.

The Council for Medical Schemes regulates the private medical aid scheme industry in terms of the Medical Schemes Act, 1998 (Act 131 of 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 a small transfer from the Department of Health, increasing from R1,4 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. 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/her treatment is then partly or entirely financed by the particular provincial government or the health authorities of the administration concerned. Provincial hospitals offer treatment to patients with medical aid cover, charging a tariff designed to recover the full cost of treatment. This 'private' rate is generally lower than the rate charged by private hospitals.

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. The Act:

- Provides 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.
- Promotes efficient administration and good governance of medical schemes by insisting on the independence of individuals in certain key positions.
- Has introduced mechanisms to address problematic practices in the marketing of medical schemes and brokerage of services.

Minimum benefits are also prescribed. In 2004, a range of chronic conditions was added to the package of prescribed minimum benefits.

Community health

The most common communicable diseases in South Africa are HIV, AIDS, TB, malaria, measles and sexually transmitted infections (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.

South Africa's routine immunisation coverage target for fully immunised children under one year is 90%. According to 2003 statistics, the routine immunisation coverage was 82% while measles immunisation coverage was 78%.

Polio and measles

There have been no confirmed measles deaths since 2000, a direct result of the Measles Elimination Strategy. The last confirmed polio case in South Africa occurred in 1989, but it remains vital to maintain high levels of protection.

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 World Health Organisation (WHO), to become polio-free certified.

National immunisation campaigns were conducted in 1995, 1996, 1997 and 2000.

On 1 July 2004, Dr Tshabalala-Msimang launched the Department of Health's Expanded Programme on Immunisation in Lenyenye, Limpopo.

The Programme had two rounds of mass immunisation taking place at all public clinics or immunisation posts. All children under five years of age received an oral polio vaccine during the first round and a repeat dose of polio vaccine during the second. Children from nine months to under five years of age received a measles vaccine during the first round.

This Programme is part of the continued global implementation of the WHO strategy to eradicate polio and eliminate measles in the world by 2005.

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 established an Intercountry Certification Committee to ensure that polio-free certification in the region occurs before December 2005.

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 NHS 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.

Existing 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. About 10% of the population lives in a malaria risk area.

During 2000, a serious malaria epidemic was experienced in South Africa and in neighbouring countries. To effectively address the issue, the Department of Health, in collaboration with research organisations and academia, implemented policies to change the insecticide and drugs used in malaria-control programmes.

This resulted in a dramatic decrease in the number of cases from 51 535 in 1999 to 13 295 in 2003. Although policies are determined by the Department, the provincial malaria control programmes are responsible for implementing the content of policies which includes changing the insecticide and drugs used as well as increasing awareness of the disease.

It has been recognised that malaria cannot be viewed as a country-specific problem but rather as a regional problem.

Through the innovative multinational Lubombo Spatial Development Initiative involving Mozambique, South Africa and Swaziland, malaria prevalence in Mozambique has been reduced by 82% and in KwaZulu-Natal by 96% compared with 2002. A Trans-Limpopo initiative is also being explored between South Africa and Zimbabwe.

In keeping with international trends, the Department of Health is implementing the Rollback Malaria strategic plan. The goal is to reinforce existing malaria-control initiatives and to place greater emphasis on controlling malaria in pregnant women and young children.

South Africa is a signatory to the Abuja Declaration, which undertakes to reduce malaria morbidity and mortality by 50% by 2010.

There is active co-operation with Zimbabwe on cross-border malaria control. Malaria-control experts are being sent to other Southern African Development Community countries to provide technical assistance and strengthen control programmes in the subregion.

South Africa participated in a major regional malaria awareness campaign, *Racing Against Malaria*, which involved rally teams travelling in the southern African region and converging in Dar es Salaam, Tanzania, for African malaria-prevention celebrations in 2003.

To monitor the disease effectively, the MRC together with the national and provincial departments of Health, developed a malaria-information system to obtain data with regard to the disease and operational aspects pertaining to control programmes. Through these public-private partnerships, malaria is effectively being controlled in South Africa. However, to ensure that the incidence of malaria remains on a downward trend, increased intercountry collaborations are essential.

Malaria-control teams of the provincial departments of Health are responsible for measures such as education, patient treatment, 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 Dichloro-Diphenyl-Dichloromethans because of the growing resistance to pyrethroid insecticides.

The MRC's South African Traditional Medicines Research Group is investigating plants used by traditional healers for the treatment of malaria. Two plants that are effective against malaria parasites *in*

vitro 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 been isolated.

Insecticide-treated nets are another intervention that has had an impact in reducing the number of malaria deaths, particularly among children under the age of five years.

Tuberculosis

Improvements in TB care are confronted by increasing numbers of cases, as HIV and AIDS become progressively more visible (from 109 328 TB cases reported in 1996 to 255 422 TB cases reported in 2003).

Despite various improvements in the TB control programme – such as an electronic register, decreased waiting time for test results, and high coverage with Directly Observed Treatment Short Course (DOTS) – both cure and completion rates are suboptimal, at 53,9% (cured) and 67,8% (successful treatment completion rate). This may reflect pressures on services owing to HIV-infection, which increases susceptibility to TB. A national surveillance study showed resistant strains in 1,7% of new cases and 6,6% of previous cases returning for treatment.

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 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 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 across the country.

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 5%
- detecting 70% of estimated new smear-positive TB cases.

HIV and 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.

South Africa celebrated the sixth anniversary of the Partnership Against AIDS in Randfontein, Gauteng on 9 October 2004.

Government's commitment to intensifying implementation of the Plan is backed by large budgets for the HIV and AIDS programme.

Dedicated funding for HIV and 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.

On 19 November 2003, Cabinet, in principle, approved the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.

While retaining a strong focus on HIV-prevention and expanding support for positive living in the early stages of HIV-infection, the Plan also provides for ARV treatment in the public health sector as part of government's comprehensive strategy to combat HIV and AIDS.

The Plan envisaged that there would be at least one service point in every health district across the country and, within five years, one service point in every local municipality.

These service points will give citizens access to a continuum of care and treatment, integrated with the prevention and awareness campaign which remains the cornerstone of the strategy to defeat HIV and AIDS.

This will mean:

- stepping up the prevention campaign so that the estimated 40 million South Africans not infected stay that way
- a sustained education and community mobilisation programme to strengthen partnerships in the fight against the epidemic
- expanding programmes aimed at boosting the immune system and slowing down the effects of HIV-infection, including the option of traditional health treatments for those who use these services
- improved efforts in treating opportunistic infections for those who are infected but have not reached the stage at which they require ARVs
- intensified support for families affected by HIV and AIDS
- introduction of ARV treatment for those who need it, as certified by doctors.

Accreditation of public health facilities where ARV treatment will be provided commenced in January 2004. All nine provinces have begun implementation and by the end of September 2004, 50 of the 53 health districts had at least one service point, ahead of the original target of March 2005. A total of 102 of the 113 facilities identified by provinces to provide comprehensive HIV and AIDS services had been accredited.

By the end of September 2004, 11 253 people were receiving ARVs. Communication to promote awareness through the *Khomanani* Campaign has been intensified. A 24-hour telephone helpline, which provides information relating to HIV and AIDS to patients, community members and healthcare-providers, receives 5 000 calls daily. The number of home and community-based care programmes as well as hospices is expanding.

Significant progress has been achieved in the prevention and treatment of sexually transmitted infections:

- High-quality South African Bureau of Standards-approved condoms are available from clinics and other non-clinic outlets. Public-sector male condom distribution increased dramatically from 150 million in 1997 to 270 million in 2003. This represents an 80% improvement.
- Distribution of male condoms through non-traditional outlets has been strengthened and monitored. Condoms have been distributed to at least 3 000 diverse outlets such as spazas, taverns and hair salons, with an average of over one million public-sector condoms distributed each month.
- The Department of Health increased the number of designated clinical sites where women can access female condoms from the initial 28 pilot sites in 2000 to over 200 in 2003. This represents a six-fold increase in sites in just four years. In 2003 alone, 1,4 million female condoms were distributed.

Awareness and life skills campaigns

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

Nationwide, the STI partner notification rate increased steadily from 39% in 2000 to 71% in 2002. This trend continued in the first three months of 2003 (77%).

During 2002/03, awareness advanced mainly through the *Khomanani* Campaign and the life skills and HIV and 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 HIV, AIDS and TB.

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 Operational 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 September 2004, there were 3 072 VCT service points.

Preventing mother-to-child transmission (PMTCT) of HIV

The PMTCT programme is expanding. The original research sites continue to provide a full package of care, and help 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 June 2004, there were more than 2 000 facilities offering PMTCT services.

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.

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.

HIV and AIDS vaccine research and development

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

Clinical trials of two test vaccines commenced at two trial sites (Soweto and Durban) in November 2003. These are Phase One trials involving only a small group of volunteers and largely looking at the safety of products in humans. The two test vaccines represent substantial international collaborative ventures and have or are also being tested in other countries. One of the two (the Venezuelan equine encephalitis-based product) is the first test vaccine specifically developed for the C strain of HIV – the strain responsible for most infections in sub-Saharan Africa. The commencement of these two trials pushed South Africa to the forefront of vaccine research and development in the world, making it the first African country to run multiple trials. An additional product is pending approval by the MCC.

A number of wholly South African-developed products have been sent for manufacture for trials and have entered registration procedures with the appropriate regulatory bodies. These trials could start in 2005.

SAAVI has also established a multidisciplinary research agenda involving about 200 people.

SAAVI works closely with many international organisations including the African AIDS Vaccine Programme and the International AIDS Vaccine Initiative, and receives funding from some of these organisations – including the HIV Vaccine Trials Network of the United States National Institute of Health, and the European Union.

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. By mid-2004, the number had increased to an estimated 892 groups in all provinces, consisting of more than 24 000 care givers.

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 death rate among pregnant women.

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 women 35 years and older.

The Department of Health and the University of South Africa collaborated to develop the *Braille HIV and AIDS Directory*, which was launched on 10 August 2004.

The Directory provides information about the support and care services available to people living with HIV and AIDs, where these services can be accessed, and who to contact to find out more.

The Department of Health has done much to educate people with disabilities about HIV and AIDS. Among other things, it has:

- developed audio cassettes for the blind with key HIV and AIDS messages
- printed the Five-Year Sexually Transmitted Diseases, HIV and AIDS Strategic Plan in Braille
- afforded people with disabilities the opportunity to be represented on the South African National AIDS Council.

High-blood-pressure complications are responsible for 20% of maternal deaths during pregnancy; uncontrolled bleeding (obstetric haemorrhage) for 13,9%; pregnancy-related sepsis for 12,4%; while 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. 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 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 young people, and promoting a healthy lifestyle among the youth. 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 micronutrient supplements to help ensure the well-being of mothers.

The Guidelines for the Cervical Cancer-Screening Programme aim 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 aims to screen at least 70% of women in their early 30s within 10 years of initiating the Programme. The Programme allows for three free pap-smear 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 to promote the participation of men in reproductive health and in the prevention of domestic violence and HIV and 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. Access to termination services remains inadequate. To improve access and alleviate the pressure on existing services, the Act is to be amended. The system of designating services will be changed to ensure that more public health facilities offer termination procedures.

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 still occur and this is cause for concern.

The Department of Health continues to support training in abortion care and contraception provision.

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.

Environmental health

Government has taken measures to reduce environmental health risks.

In terms of the Health Act, 2003, environmental health services are vested with local government. This shifted the responsibility for rendering environmental health services to metropolitan and district councils from 1 July 2004.

Traditional medicine

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

The launch of the Centre 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.

To protect the intellectual property rights of traditional peoples, the MRC will conduct biomedical research on medicinal plants and traditional claims will be channelled through this Centre.

The WHO estimates that up to 80% of Africa's people use traditional medicine. In sub-Saharan Africa, the ratio of traditional health practitioners to the population is about 1:500, while the ratio of medical doctors is 1:40 000.

Traditional health practitioners have an important role to play in the lives of African people and have the potential to serve as a critical component of a comprehensive healthcare strategy.

In South Africa alone, threre are an estimated 200 000 traditional health practitioners. They are the first healthcare-providers to be consulted in up to 80% of cases, especially in rural areas, and are deeply interwoven into the fabric of cultural and spiritual life.

Research also indicates that in many developing countries, a large proportion of the population relies heavily on traditional practitioners and medicinal plants to meet PHC needs. Although modern medicine may be available in these countries, traditional medicines remain popular for historical and cultural reasons.

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.

In February 2004, the Minister of Health launched the Reference Centre for African Traditional Medicines in the Western Cape and in KwaZulu-Natal.

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, which must be separated by a solid partition
- a fine of R10 000 for those who are caught selling or giving cigarettes to children.

In October 2003, the Minister of Health released details of new provisions designed to protect public health by strengthening South Africa's tobacco control laws. A Bill to amend the Tobacco Products Control Act, 1993 (Act 83 of 1993), was published for comment.

The Bill brings the existing Act in line with the provisions of the WHO's International Framework Convention on Tobacco Control (FCTC) and makes it more effective by closing loopholes and increasing fines.

South Africa is a co-signatory with 74 other countries of the FCTC that commits governments worldwide to take measures to reduce tobacco use.

The main provisions of the proposed Amendment Bill are to:

- require larger health messages on cigarette packs, including picture messages
- increase fines for those who break the law, particularly with regard to allowing smoking in public places
- ban false descriptions of tobacco products, like 'low-tar', 'light' and 'mild'
- prohibit the presence of any person under 18 years in a designated smoking area in a public place
- increase the minimum age for the sale of tobacco products to 18 years
- ban the duty-free sale of cigarettes.

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.

The Department of Health has set up a tobacco hotline ([012] 312 0180) for the general public to lodge smoking-related complaints.

People who want to quit smoking can contact the National Council Against Smoking's Quit Line on (011) 720 3145.

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.

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 FAS, and in the Western Cape, one in 20.

According to a report by the MRC's Alcohol and Drug Abuse Research Group, released in October 2003, alcohol remains the dominant substance abused in South Africa. Across the five sites in the South African Community Epidemiology Network on Drug Use, between 44% (Cape Town) and 69% (Mpumalanga) of patients in specialist substance-abuse treatment centres list alcohol as their primary substance of abuse.

The 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.

Over time, there has been a dramatic increase in treatment demand for heroin as the primary drug of abuse in Cape Town and Gauteng, but this has also levelled off. Demand for long-term treatment appears to be increasing. The abuse of over-the-counter and prescription medicines such as slimming tablets, analgesics and benzodiazepines (e.g. diazepam and flunitrazipam) continues to be an issue, but treatment-demand indicators are stable.

Inhalant/solvent use among young persons continues to be an issue of concern. Poly-substance abuse remains high, with 34% of patients in specialist treatment centres in Gauteng and 47% in Cape Town reported to be abusing more than one substance. All sites for which age data are available have shown an increase over the past few years 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 and children

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

The *16 Days of Activism on No Violence Against Women and Children* Campaign is held at the end of every year.

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. The MRC, through the South African Gender-Based Violence and Health Initiative (SAGBVHI) assisted the national Department of Health with the writing of the Sexual Assault Policy and Clinical Management Guidelines for the management of sexual-assault cases. These have been adopted and 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.

The training done by SAGBVHI members has raised the awareness of healthcare workers, particularly nurses, about the health impact of violence against women.

Violence prevention

The Department of Health is playing an important role in the prevention of violence. 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.

The Crime, Violence and Injury Lead Programme, co-directed by the MRC and the 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 these conditions. This will involve the decentralisation of training, the 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 more accurate diagnoses. 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 regular meetings 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 include people with permanent, moderate or severe disabilities, as well as those 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 outpatient 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.

The backlog in wheelchairs and hearing aids was expected to be eliminated by the end of 2004/05.

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 access 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 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.

The Compensation Commissioner for Occupational Diseases is responsible for the payment of benefits to miners and ex-miners who have been certified to be suffering from lung-related diseases as a result of working conditions. The Mines and Works Compensation Fund derives funding from levies 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, 1973.

Mental health

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

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 a health issue like any other. The purpose is to bring community services closer to

Hundreds of South Africans regained their sight during the *Fight-4-Sight* Campaign held at Pretoria East Hospital in October 2004.

The Campaign, a joint initiative of the Primary Eyecare Clinic, Ophthalmicare and private healthcare-provider, Netcare, aimed to make a difference by screening indigent people for cataracts and operating on them, if surgically viable.

A 24-hour surgical marathon was held, involving 10 ophthalmologists, who operated in six-hourly shifts.

More than half of South Africans aged 65 and older develop cataracts.

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 the family will be able to appeal to the board, and all certified cases will be reviewed at least once a year.

The Mental Health Information Centre (MHIC) is situated at the Health Sciences Faculty of the University of Stellenbosch and has been in operation since 1995. It forms part of the MRC's Unit on Anxiety and Stress Disorders and aims to promote mental health in South Africa.

The MHIC is also actively involved in research, and conducts academic and clinical research trials for conditions such as obsessive-compulsive, panic, posttraumatic stress and generalised anxiety disorders. Work is also done on mood, psychotic and dementia disorders, as well as other major psychiatric diagnoses. A key focus area is mental health literacy. The MHIC regularly conducts mental health attitude and stigma surveys among various population and professional groups.

Quarantinable diseases

The Port Health Service is responsible for the prevention of quarantinable diseases in 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.

Consumer goods

Another function of the Department of Health, 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.

Integrated Nutrition Programme and food security

The 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, 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 breastfeeding
- contribution to household-food security.

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

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 are responsible for compliance monitoring and law enforcement. Fines of up to R125 000 can be imposed upon millers who fail to comply.

The National School Nutrition Programme is based on community participation and mobilises communities to develop food gardens. The primary goal of the Programme is school feeding, while also utilising resources invested by government to create sustainable livelihoods for local communities.

The Programme has been transferred from the Department of Health to the Department of Education. The immediate goal for the Department of Education is to ensure continuity of the Programme. By mid-2004, the feeding scheme had reached 85% of the estimated 15 000 schools that the Programme was supposed to cover.

The Programme also focuses on creating employment opportunities for women. The focus is on the 21 Presidential nodes where women are encouraged to form small businesses to administer the school-feeding programme for a group of schools in the area.

By August 2004, a plan with concrete proposals for the nodes had been developed for presentation to the Cabinet.

Acknowledgements

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Estimates of National Expenditure 2004, published by National Treasury
Health Professions Council of South Africa
Medical Research Council
National Health Laboratory Service
South African Nursing Council
South African Pharmacy Council
www.gov.za
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