Photograph: Shaun Harris/PictureNET Africa

Chapter 13

Health

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

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 Service Professions Council of South Africa and the Council for Social Service Professions.

Health authorities

National

The Department of Health is responsible for:

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

Government is committed to providing basic health care as a fundamental right. Services provided by primary health-care workers include immunisation; maternity care; screening of children for diseases; Integrated Management of Childhood Illnessses and child health-care; accident and emergency services; and oral health services.

Provincial

The provincial health departments are responsible for:

- providing and/or rendering health services
- formulating and implementing provincial health policy, standards and legislation
- the planning and management of 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 the inspection of 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 Health Care (PHC)

The Government is committed to providing basic health care as a fundamental right. Assessment of recent policy developments and progress on service delivery suggest that substantial progress continues to be made in providing PHC. These services are now far more accessible: they have been made free at the point of use, and some 495 new clinics have been constructed and 2 298 upgraded. A comprehensive package of PHC services has been developed and costed, and is being progressively implemented.

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 health care; 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 the conditions 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.

The Essential Drug List (EDL) for all levels consists of 693 medicines. Provincial governments determine which of the medicines applicable to each level of care are stocked in the different facilities. The Standard Treatment Guidelines and EDL for the different levels were developed using World Health Organisation (WHO) guidelines.

They will be revised regularly to include new developments in the medical and pharmaceutical fields.

Districts

The Department's health plan is based on the district model, which functions according to the PHC approach and implies the establishment of health districts in every part of the country. Forty-two health regions and 162 health districts have been demarcated nationally. The health districts have been realigned with the newly-demarcated municipalities.

Health policy

Some 40% of all South Africans live in poverty, and 75% of these stay in rural areas where health services are least developed. The core of government's health policy is to eventually provide health care that is affordable and accessible to all.

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

- reorganisation of support services
- improvements 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
- human resource development (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. It came into operation as a public entity in the middle of 2001.
- 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 Cabinet of a draft human

resource plan for the sector and the negotiated abolition of rank and leg promotions. Community service was extended to dentists and pharmacists.

Telemedicine

The objective of the telemedicine system is to deliver health care, tele-education and telecare services over a distance to South Africans in areas where the need is greatest.

Static or dynamic images can be sent from the referring site to the provincial receival site or centre of excellence. Medical consultations can be interactive with the use of video-conferencing equipment. The Free State, Mpumalanga and North West have teleradiology systems in place, while the Eastern Cape and KwaZulu-Natal have access to telepathology and tele-ophthalmology respectively. Tele-ultrasound and antenatal screening services have also been installed at health centres in the Northern Cape and KwaZulu-Natal.

The Free State was the site for the launch of the first Interactive Learning Communication and Management Centre in February 2002. Through the Centre, nurses, doctors and other health-care workers can receive skills training via satellite broadcasting.

The initiative was made possible by the Department of Health and SENTECH, the signal carrier for SABC1, 2 and 3.

The project will assist the Department in addressing the high level of staff turnover in rural areas. Its aim is to attract and retain health professionals in these areas by providing ongoing training and collaboration with other health professionals.

All medical schools in South Africa have offered to join hands with the Department of Health in providing the educational component of distance learning.

The project will ultimately establish additional networks between secondary and primary sites. Selection criteria of rural sites will be based on the need for access to medical expertise and technical support.

The Department of Health has established four technical working groups to investigate and report on the following aspects of telemedicine practice:

- clinical protocols
- tele-education in telemedicine
- network infrastructure and standards
- legal aspects, licensing and ethics.

The Department of Health and the Medical Research Council (MRC) have signed a memorandum of understanding and established the Research Centre for Telemedicine. The Centre is responsible for conducting the telemedicine research-based needs of the Department and clinics. The objectives of the Research Centre are to:

- evaluate the operations and systems of the national telemedicine projects to ensure improvement in the delivery of health-care services
- look into the future of telemedicine by establishing a telemedicine test-bed in a rural area to investigate and clinically test new telemedicine technologies for their affordability, cost-effectiveness and sustainability
- provide tools for the implementation of telehealth, such as training and teaching material and research into relevant protocols, standards and medico-legal aspects of telehealth.

By mid-2002, output of the Research Centre included the following:

Telemedicine evaluation research

The evaluation report, containing findings from all six provinces that participated in the first phase of the National Telemedicine System, was submitted to the national Department of Health. The report contributed to the development of strategies for further expansion of telemedicine in South Africa.

The findings of the report demonstrated the following benefits of the National Telemedicine System:

- access to specialist radiologist reporting within an hour compared to five to seven days' delay when X-rays are transported by ground

- increased competence of PHC providers in interpreting radiographic studies
- improved ability of community-service doctors to diagnose and manage various medical conditions particularly those related to trauma and chest diseases
- reduced professional isolation usually felt by the junior medical doctors performing community service in the rural health facilities of South Africa
- a reduction of unnecessary transfers from rural to urban tertiary centres.

The clinicians noted the opportunities for education and training at every level of health-care providers (doctors, nurses and medical students).

Telemedicine clinical technology research

To accomplish its deliverable of researching clinical effectiveness and cost-efficiency of new telemedicine technology that is affordable and sustainable, the Telemedicine Research Centre established the South African PHC Telemedicine Workstation Research Test-bed in the Nkomazi District of Mpumalanga. The Test-bed network is near the borders with Swaziland and Mozambique and comprises the Tonga Hospital and Naas and Mangweni clinics, with each site having a PHC Telemedicine Workstation designed and built by the MRC. These sites are linked to various institutions within South Africa. The Test-bed is being used for clinical testing of new telemedicine technologies that have a potential of providing technical support to PHC services in South Africa. The technologies being researched and clinically tested include hardware, software and telecommunication technologies that are clinically efficient and cost-effective for the rural areas of developing countries.

Telemedicine training and research capacity-building

One of the main challenges of the Research Centre is to promote the integration of telemedicine technology into the medical practices of South African health professionals. Although telemedicine equipment has been deployed to about 30 sites for the first phase of the South African Telemedicine System, some of the sites are still not utilising the technology effectively. The MRC Research Programme, in collaboration with the Department of Health, provincial departments and medical schools, has developed a comprehensive telemedicine training programme that was implemented during 2001/02. A description of the telemedicine training course was developed and a *Telemedicine Training Manual* compiled.

Legislation

The National Health Bill was approved for submission to Parliament during a Cabinet meeting early in August 2002. The Bill was endorsed by a MinMec meeting in Johannesburg in July 2002.

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 health-care providers, health workers, establishments and users.

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

The most contentious provision of the Bill has been that any 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 care, but also in terms of the cost of care.

The Mental Health Care Bill, 2001 was approved by the National Assembly in January 2002. The Bill provides for the care, treatment, rehabilitation and administration of persons who are mentally ill. It also sets out the differ-

ent procedures to be followed in the admission of such persons.

The Traditional Healers Bill was drafted in 2002. 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 is expected to lead to amendments of the Health Professions Act, 1974 (Act 56 of 1974), and Nursing Act, 1978 (Act 50 of 1978), in 2002/03.

The process of revising the regulations of the Medicines and Related Substances Control Amendment Act, 1997 (Act 90 of 1997), is almost complete. The regulations were published for comment in the latter half of 2001.

The Medical Schemes Amendment Act, 2001 (Act 55 of 2001), amended the Medical Schemes Act, 1998 (Act 131 of 1998), to extend certain rights of members to their dependants. In addition, the Act, among other things:

- broadens the definition of a complainant
- 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
- regulates the marketing of entities doing the business of a medical scheme.

Total of supplementary health-care practitioners at end of December 2001

Basic ambulance assistants	10 031
Ambulance emergency assistants	3 596
Environmental health officers	2 284
Medical technologists	3 929
Occupational therapists	2 377
Optometrists	2 010
Physiotherapists	4 191
Psychologists	4 755
Radiographers	4 073

Source: HPCSA

Medicine administration

Since 1997, there have been new developments necessitating the need for the Medicine and Related Substances Amendment Bill, 2002. The Bill makes provision for, among other things:

- the definition of the search-and-seizure powers of the inspectorate of the Medicines Control Council in a way that is consistent with the Bill of Rights.
- the appointment of a Deputy Registrar or Registrars for the Council to assist the Registrar as the workload increases.
- the 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 the patient about generic drug options.

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

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

Health team

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

Physicians

Some 29 927 doctors were registered with the HPCSA at the end of 2001. 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, have to obtain a specified number of points to retain their registration. The system involves doctors attending workshops, conferences, refresher courses, seminars, departmental meetings and journal clubs.

Non-compliance with the requirements of the system could result in, among other things, the doctor being deregistered.

The use of foreign professionals has assisted in relieving the shortage of skilled medical practitioners in many parts of South Africa. In November 2000, a new registration system for medical practitioners and dentists was announced, which changed the conditions under which foreign-qualified professionals practise in South Africa. Under the new system, registration is done in the following categories:

- independent practice (general practitioner)
- public service (general practitioner)
- education, postgraduate study
- public service (community service)
- independent practice (specialist)
- military service
- voluntary service.

Applications are subjected 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 that particular category for which they applied and were assessed.

There are set guidelines under which registration takes place in each of the categories. Applicants must satisfy internship/community service requirements before they seek registration with the HPCSA.

There are 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 2002, the programme placed 1 742 young doctors, dentists and pharmacists in the field. It has been estimated that 26% of public sector dental posts and 31% of pharmacy posts were filled through community service in 2001.

In 2003, the Department will expand community service to cover physiotherapists, radiographers, occupational therapists, speech and hearing therapists, clinical psychologists, dietitians and environmental health officers.

The Department harvested the first crop of nine graduates in the Cuban medical training programme in September 2002. Candidates were recruited largely from rural provinces and are contracted to work in the province that sponsored them. By June 2002, the Department of Health had placed 252 students in Cuba and a further 71 were expected to depart later in 2002.

In 2002, the Department introduced a special development grant to rural provinces to expand registrar posts at regional hospitals, thereby increasing the pool of specialists outside the major cities.

Within the context of the Southern African Development Community (SADC) region, South African universities have created 100 places at medical schools – over and above the normal intake – for students from the region.

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

	2000	2001
Dentists	4 481	4 503
Medical interns	1 054	1 339
Medical practitioners	29 788	29 927
Nurses (students included)	187 440	190 449

Source: HPCSA and South African Nursing Council

Pharmacy registration statistics on 31 December 2001	
Bodies corporate	700
Close corporations	987
Pharmacists	10 383
Pharmacists' assistants (learner basic)	150
Pharmacists (learner post-basic)	721
Pharmacists' assistants (post basic)	1 028
Pharmacy students	1 333
Pharmacist interns	712
CSPs	399
Pharmacies	
Community	2 503
Private institutional	156
Public institutional	500
Manufacturing	98
Wholesale	411
Virtual care	59

Source: South African Pharmacy Council

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. The HPCSA decided to also register dental assistants in future. 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.

There are oral and dental teaching hospitals connected to the universities of the Witwatersrand (Wits), Pretoria, Stellenbosch, the Western Cape, Durban-Westville and Medunsa outside Pretoria.

Dentists receive their clinical training at five of these hospitals, while dental technicians are trained at the Natal, Peninsula, Pretoria and Witwatersrand technikons.

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

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 the Government's plan to provide health services to all communities. It 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 to 49 in 2000.

A number of sections of the Pharmacy Amendment Act, 1997 (Act 88 of 1997), came into effect on 20 November 2000. The only sections of this Act which have not yet come into effect are those which relate to changes to the ownership of pharmacies, as well as the section relating to the applicability of the legislation to the State.

Five sets of regulations to the Pharmacy Act, 1974 (Act 53 of 1974), as amended, also came into effect on this date. These regulations relate to the practice of pharmacy, pharmacy education and training, the registration of persons and the maintenance of registers, the performance of pharmaceutical community service, as well as the management of a person who is unfit to practise for reasons other than unprofessional conduct. The changes to the legislation made provision for:

- a new approach to the training of pharmacist assistants who are mid-level workers
- a new non-punitive approach to the management of persons who are unfit to practise for reasons other than unprofessional conduct
- numerous changes to the regulation of the practise of pharmacy.

The implementation of the new regulations continued during 2001. A further set of regulations, which deal with the disciplinary process of the Council, came into effect on 1 June 2001. The new approach introduced fines and cost orders, and procedures to expedite the disciplinary process of the Council.

In 2001, 10 782 pharmacists were regis-

tered with the South African Pharmacy Council, approximately 7% of whom were employed in provincial and State hospitals. Pharmacists are trained at the universities of Potchefstroom, Port Elizabeth, Wits, Rhodes (Grahamstown), Durban-Westville, the Western Cape, the North and Medunsa in collaboration with Technikon Pretoria.

Nurses

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

It prescribes the 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 2001, there were 172 338 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, 18 111 persons were registered as student and pupil nurses or pupil nursing auxiliaries on the registers and rolls of the Council.

Basic training for registration as a nurse and midwife is offered at approved universities and at nursing colleges in association with universities.

The duration of the basic course for registration as a professional nurse and midwife is four academic years.

Postbasic courses for registered nurses are offered at universities, nursing colleges in association with universities, hospital nursing schools and technikons. The minimum duration of the postbasic courses for registration of an additional qualification is one academic year.

Basic training for enrolled nurses is offered at approved nursing schools which may be nursing colleges or hospital nursing schools. The duration of training for the course is two years.

Basic training for nursing auxiliaries is offered at approved hospitals, homes for the aged, and institutions for the disabled. The duration of training is one year.

Supplementary health services

Supplementary health professionals are trained at either a university or a technikon. South Africa has a dire shortage of health professionals such as physiotherapists, dietitians and radiographers. At the middle of May 2001, there were 89 793 supplementary health professionals registered with the HPCSA.

Chiropractors, homoeopaths and allied health service professionals

By October 2002, the following practitioners were registered with the Allied Health Service Professions Council of South Africa:

Ayurveda	112
Chinese medicine and acupuncture	636
Chiropractors	386
Homeopaths	628
Naturopaths	143
Osteopaths	59
Phytotherapists	23
Therapeutic aromatherapists	946
Therapeutic massage therapists	255
Therapeutic reflexologists	1 617

Provincial health administrations

The functions of the provincial health administrations are 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 health care to that provided in an integrated community-based manner.

Clinics

A network of mobile clinics run by government forms the backbone of primary and pre-

ventive health care in South Africa. Clinics are being built or expanded throughout the country. Between 1994 and 2002, health services were brought within easier reach of about six million people through the building of some 500 clinics.

Hospitals

Provincial hospitals play a vital role in the training of physicians, nurses and supplementary health personnel.

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 complaint and suggestion procedures. 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 new National Tertiary Services Grant, which will fund 27 hospitals in all the provinces in 2002/03. The National Planning Framework and provincial strategic position statements have progressed substantially, providing a sound basis for health service planning and a firmer base for the Health Facilities' Revitalisation Grant.

The Hospital Revitalisation Programme (with a budget of some R528 million) and the Hospital Management Grant (amounting to R129 million) deal with some substantial elements of quality of care. It also targets the management systems and the skills needed by managers to drive a process of quality improvement.

Information

Chris Hani Baragwanath Hospital in Soweto, Gauteng, the world's largest hospital, is undergoing an R82-million renovation. The upgrading includes, among other things, renovation of the surgical wards, a new psychiatric block and additional blocks for the medical and gynaecological sections. The Hospital, which has a capacity for 3 400 patients, also treats about 3 000 out-patients every day.

This comprehensive approach has kicked off at one hospital in every province in 2002. The selected institutions, all of which have submitted detailed business plans, are:

- Boitumelo Hospital in the Free State
- Colesburg Hospital in the Northern Cape
- Eben Donges Hospital in the Western Cape
- Ermelo Hospital in Mpumalanga
- Frontier Hospital in the Eastern Cape
- King George VI Hospital in KwaZulu-Natal
- Lebowakgomo Hospital in Limpopo
- Mamelodi Hospital in Gauteng
- Moses Kotane Hospital in North West.

Planning is already under way to include another three hospitals per province from next year. Eventually, the bulk of the Hospital Revitalisation Grant will be channelled into carefully planned initiatives to boost patient care from various angles – instead of being used only to replace or patch up buildings.

By February 2002, the Revitalisation Programme had funded 936 projects aimed at physical repairs and rebuilding. Four hundred and forty-four of these projects had been completed and 241 were on site. The Programme has R528,5 million to spend in 2002/03, which will bring the total expenditure since 1998 to R1,2 billion.

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 provide 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 services 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 times of emergencies or disasters.

National Health Laboratory Service

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

South African Vaccine Producers and State Vaccine Institute

The South African Vaccine Producers and State Vaccine Institute play a crucial role in the control and prevention of communicable diseases, by producing human vaccines and antiserum against diseases affecting the developing world. At present, the South African Vaccine Producers is not operational, owing to restructuring that aims for a strategic equity partnership with the private sector.

Information

Female condoms were first piloted in South Africa in 1998 at 29 public-sector sites. They are now available at an expanded 114 public-sector sites around the country, at no cost to the user. By the end of 2002, this number of public sector sites was expected to grow to 200.

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 health, 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.

Ancillary services

Various independent organisations, most of them voluntary, also provide vital health services.

The South African Red Cross renders emergency, health and community services and offers training in first aid and home-nursing. It also operates an ambulance service, medical supply points, old-age homes, an air ambulance and air-rescue service, and comprehensive youth programmes.

The St John's Ambulance Foundation operates in major centres around South Africa and offers training in first aid and home care to individuals, schoolchildren, and commerce and industry. It operates eye-care clinics around the country aimed at underprivileged communities.

Centres stock a range of first-aid kits for factory, office and home environments, as well as hiring out mobility aids. Various community service projects in the field of PHC are undertaken.

Medic Alert is a world-wide medical identification system. All members wear an identification emblem on which their medical condition and membership number are engraved.

Health personnel have 24-hour telephonic access to this register. Medic Alert also serves as a register for organ, tissue and body donors, as well as for people with pacemakers.

The South African First Aid League provides first aid at sports meetings, civil protection and training in first aid. It also provides first-aid kits.

Poison centres are staffed 24 hours a day. These centres also provide vital advice on antidotes and treatment for doctors, pharmacists, hospitals and the public.

Life Line provides a 24-hour telephone counselling service for those in distress. Similar confidential services are Child Line, Rape Crisis and Suicides Anonymous.

Alcoholics Anonymous is a non-profit organisation aimed at helping addicts deal with alcoholism.

Hospices improve the quality of life of the terminally ill through care, support and love. Nursing staff look after the physical, social, emotional and psychological needs of the patients and their relatives.

Transnet's health-care train, known as *Phelophepa* (good health), offers a unique service, bringing accessible and affordable health-care facilities to rural communities. Since its inception five years ago, Phelophepa's education programme has broadened existing services, which include eye, dental, health and psychological clinics, and an X-ray and a pharmacy service. The train is run by qualified permanent staff. The basic health education programme gives volunteers from local communities the opportunity to enhance their basic health-care knowledge. Topics such as baby care, how to keep one's environment and body clean, and the prevention of STIs and AIDS, have been included in a five-day course presented weekly in the educlinic.

It is estimated that more than 25% of South Africa's population is in need of some form of primary eye care. The primary eye-care programme, Sight Africa, is the brainchild of Lions Club International of South Africa and the South African Optometric Association. It aims to provide primary eye care to disadvantaged or indigent people who are visually impaired.

The Bureau for the Prevention of Blindness performs 4 000 cataract operations each year to restore eyesight.

Costs and medical schemes

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. A review of medical schemes was published in the Registrar's annual report. The complaints division of the Council for Medical Schemes dealt with 1 327 complaints in 2000/01.

The Act seeks to strengthen the Medical Schemes Act, 1998 in the following ways:

- improving protection for members. The Act addresses the problem area of insurance, by revisiting the provision on waiting periods, and specifically protecting against discrimination on grounds of age.
- reducing unnecessary red tape that imposes unduly heavy conditions on medical schemes.
- promoting efficient administration and good governance of medical schemes by, among other things, insisting on the independence of individuals in 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 health-care contracts
- impose penalties on medical schemes or administrators for the late payment of claims.

Community health

The optimal utilisation of resources for primary, secondary and tertiary health care is the responsibility of the Department of 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 and women of childbearing age. Immunisations against TB, whooping cough, tetanus, diphtheria, poliomyelitis, hepatitis B and measles are available free of charge to all children up to the age of five years. Tetanus vaccine is administered to women at risk during pregnancy to protect the newborn infant against neonatal tetanus. Other services include control of rabies and certain endemic diseases, such as malaria.

By February 2002, the percentage of children who were fully immunised stood at 73% after hovering for years around the 63% mark. To reach the target of 90% immunisation by 2004, the Government is going to concentrate its efforts on those districts that are not doing well particularly in the Eastern Cape and Limpopo (formerly the Northern Province).

Information

The week of 1 to 10 August 2002 was declared Immunisation Awareness Week, and kicked off with various district activities designed to inform the public about the success of the Expanded Programme on Immunisation and the benefits of the early childhood-vaccination programme in controlling vaccine preventable diseases.

The Awareness Week coincided with Child Health Week.

Integrated Management of Childhood Illnesses

Every year, some 12 million children in developing countries die before they reach their fifth birthday, many during the first year of life. Seven in 10 of these deaths are due to acute respiratory infections (mostly pneumonia), diarrhoea, measles, malaria or malnutrition, and often to a combination of these conditions.

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.

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 and not a country-specific problem. The risk areas are divided into high, intermediate and low-risk areas.

In South Africa, 61 934 malaria cases and 423 related deaths were reported by December 2000. The number of malaria cases for 2001 were 26 506, with 119 deaths. The dramatic reduction in cases and deaths is due to:

- a revision in the malaria drug-treatment policy
- change of insecticide
- increased cross-border malaria control initiatives
- climatic conditions not supporting malaria transmission.

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.

Using geographic information systems in a unique way, 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 (*http://www.mrc.ac.za*) containing, among other things, maps compiled by the Mapping Malaria Risk in Africa project. The initiative has seven regional centres throughout Africa.

The MRC is retailoring its Malaria Research Programme to increase collaboration and transdisciplinarity towards effectively meeting the country's present and medium-term needs. In this regard, intercountry collaborative control initiatives are being undertaken to build capacity within the southern African region. This includes community-based research on drug efficacy and insecticide varieties, and the potential of integrated control using bed nets.

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 plant have been identified and isolated. Anti-TB chemical entities have also been isolated from traditional medicines.

Through the Lubombo Spatial Development Initiative, government has been able to reduce malaria cases by 76% in KwaZulu-Natal, 64% in Swaziland, and 40% in the southern parts of Mozambique towards the border with KwaZulu-Natal. It was for this reason that the WHO honoured South Africa with an award for best malaria control in southern Africa. This initiative will be extended to benefit other countries in the SADC region.

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

Tuberculosis

TB has been a problem in South Africa for over 200 years. The spread of the disease has been exacerbated by the unique pattern of mining, industrialisation, urbanisation and politics. The epidemic is growing by about 20% per year. This is due to an increase in poverty and the population. Not enough patients are cured at the first attempt, and HIV/AIDS is complicating the disease.

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 country-wide.

Demonstration and training areas have been set up country-wide. 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. In June 2002, the number of DOTS districts increased to 150.

Government launched the National Medium-term Development Plan for the National TB Control Programme in January 2002. The Plan aims to achieve the following specific targets by 2005:

- a cure rate of between 80 – 85% among smear-positive TB cases
- decreasing the treatment interrruption rate to less than 10%
- detecting 70% of estimated new smear-positive TB cases.

It aims to achieve these objectives through a number of interventions including the implementation of sector or area-specific DOTS programmes, improving accessibility and efficiency of laboratory services and networks as well as ensuring an uninterrupted drug supply.

HIV/AIDS

On 9 October 2002, on the Fourth Anniversary of the Partnership Against AIDS, government reaffirmed its commitment to intensifying its comprehensive programme to fight HIV/AIDS in partnership with all sectors of society.

On that day, Cabinet received a report on what has been done since 17 April 2002 when government launched the Campaign of Hope, calling on all sectors of society to join hands in the campaign to prevent HIV-infection and to deal with its consequences.

Prevention

Since there is no known cure for AIDS, progress in prevention is critical.

A new phase of the awareness campaign, with R98 million of government funding, was launched in September 2002, with partners such as loveLife.

In 2002, 350 million condoms were supplied free including through such non-traditional outlets as clubs, shebeens and spaza shops.

The South African AIDS Vaccine Initiative is busy with laboratory testing of candidate vaccines and clinical trials could start in late 2003.

Prevention of Mother-to-Child Transmission (PMTCT)

The PTMCT programme continues. By June 2002, over 101 000 women had visited facilities attached to the 18 research sites – 63 000 accepted voluntary counselling and testing. Nevirapine was dispensed to 10 043 women and 6 947 babies.

Training in the Universal Roll-out Plan has started in all provinces. Health facilities for testing are being upgraded. Funds will be availed for the roll-out.

After the Constitutional Court judgment, all provinces received guidelines for implementation of the PMTCT package and will expand services according to their differing capacities. Already KwaZulu-Natal, Gauteng, North West and the Western Cape have extended cover-

age to a significant number of their health institutions and other provinces are following suit.

Support for survivors of sexual assault

Government decided in April 2002 to provide a comprehensive package of support for survivors of sexual assault.

Protocols were distributed to provinces by May and implementation has started. Health institutions, police, social workers and NGOs are working together. Additional funding is being provided.

Treatment for opportunistic infections

The quality of life of those infected with HIV is a major concern for government.

Treatment for opportunistic infections is available at public health-care facilities irrespective of HIV status. As part of the Diflucan Partnership Programme about one million tablets of Diflucan were processed by July 2002. Diflucan is provided free in over 300 public facilities. Some 7 800 health workers have been trained as part of the Programme. Treatment for TB is free and available in the public health sector.

Protecting and strengthening the immune system helps ward off infections. Government's poverty-alleviation programme and nutritional interventions help fight HIV/AIDS. Government also encourages investigations into complementary treatments for boosting the immune system. A protocol for research into such treatments has been drafted for submission to the Medicines Control Council.

Information

The late AIDS activist, Nkosi Johnson, who died at the age of 12 on 1 June 2001 (International Children's Day) as a result of AIDS, shared the World's Children's Prize for 2002 with Maiti Nepal.

More than 125 000 children from 20 countries took part in the Global Vote, which also posthumously awarded Nkosi with the Global Friends Award for 2002.

Nkosi was nominated for both awards for his role in fighting for the rights of children living with HIV/AIDS.

Anti-retroviral treatment

Anti-retroviral treatment can help improve the condition of people living with AIDS if administered at certain stages in the progression of the condition, and in accordance with international standards.

Government is actively engaged in addressing the challenges that must be overcome to create the conditions that would make it feasible and effective to use anti-retrovirals in the public health sector. It is therefore working to lower the cost of these drugs, which at present is too costly for universal access, and to strengthen the health system and intensify patient education to ensure that the drugs are not used in incorrect ways that can cause harm.

Practical measures

A technical task team of the National Treasury and the Department of Health is working on these and other cost implications of an expanded response to the impact of HIV/AIDS on all sectors of society.

In collaboration with academic institutions and others, government is running programmes to train for better HIV/AIDS care.

Work will start soon to establish public-sector Centres of Excellence for HIV/AIDS care in all provinces to ensure development of curricula on HIV/AIDS and TB care; dissemination of guidelines; and adequate skills in health workers to provide care and support.

To get better information on anti-retroviral treatment, government is to urgently investigate experience of HIV/AIDS treatment in the private health sector. Consideration is being given to some submissions from provinces to the Global Fund through the South African National AIDS Council (SANAC) for operational research within the public sector in the medium term on the practical impact of anti-retroviral treatment.

As part of the work for more affordable drugs, regulations to facilitate import and manufacture of cheap and generic drugs, drawn up in consultation with pharmaceutical companies, are to be introduced after some

technical amendments to the law. There is a New Partnership for Africa's Development programme for a number of African countries to work urgently with pharmaceutical companies towards manufacturing affordable drugs for diseases including TB and HIV/AIDS.

Strengthening the Partnership Against AIDS

New sectors are constantly being drawn into the Partnership.

SANAC decided in October 2002 to enhance its capacity to lead the fight against HIV/AIDS by streamlining its operations, strengthening its secretariat and broadening non-governmental representation on the Council.

Care and support

The departments of Health, Social Development and Education are working together to enhance support for families affected by the epidemic. From November, provincial co-ordinators in the programme received care kits to be used by nurses and lay counsellors.

Fighting discrimination

A National Policy on Testing for HIV is to be incorporated into the National Health Bill to be tabled in Parliament.

Work is being done on a plan for national education on legal and human rights of people living with HIV/AIDS.

Reproductive health

The third interim report on maternal deaths was released in August 2001. The report summarises the changing pattern of maternal deaths in South Africa. It covers the maternal deaths that were reported to the National Committee on Confidential Enquiries into Maternal Deaths Secretariat by 15 March 2001, and that occurred between 1998 and 2000.

In 2000, there were 940 maternal deaths reported (150 more than in 1999 and 264 more than in 1998) and in 710 (73%) cases the Maternal Death Notification Form and Assessors' Report were received and entered on the database. There were 402 direct maternal deaths, 264 indirect maternal deaths, 22 unknown causes of maternal deaths and 22 fortuitous deaths. There was a significant reduction in the proportion of direct causes of maternal deaths. This is largely due to the increased proportion of deaths due to non-pregnancy-related sepsis, mainly AIDS.

The five major causes of maternal death in 2000 were non-pregnancy-related sepsis (29,7%, mainly deaths due to AIDS), complications of hypertension in pregnancy (22,7%), obstetric haemorrhage (13,5%), pregnancy-related sepsis (12,4%, including septic abortions and puerperal sepsis) and pre-existing maternal disease (8,9%, mainly cardiac disease). These five account for 87,2% of maternal deaths. There has been a significant decline in the number of women dying as a result of complications of an abortion (1998: 32 cases, 5,7% of all maternal deaths, 1999: 37 cases, 5,2% and 2000: 26 cases, 3,9%).

The most common cause of maternal deaths in all levels of care was non-pregnancy-related sepsis, (level 1: 27,5%, level 2: 30,8% and level 3: 31,2%). Complications of hypertension remain the most common cause of direct maternal deaths in level 2 and 3 hospitals (44,6% and 46,5% respectively) with obstetric haemorrhage being the most common direct cause in level 1 institutions (29,7%). Deaths due to complications of anaesthesia are the third most common cause of death at this level. The proportion of deaths occurring in the level 1 institutions has remained constant at between 27,1% and 28,3% of all maternal deaths. Unfortunately, the rate of deaths per 100 000 births cannot be calculated as the number of births per level of care is not known.

The Department of Health has developed a card for women's reproductive health to improve continued care and to promote healthy lifestyles for men and women. 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 it effectively. The Department is convinced that a lack of information could be a contributing factor. Therefore, the Department is set on 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 the Week, talks and workshops are held in rural and urban areas to educate women on their reproductive rights and related issues.

The Minister of Health, Dr Manto Tshabalala Msimang, launched the Contraception and the Youth and Adolescent Health Policy Guidelines on 26 March 2002. This is to promote access to health services for the vulnerable groups by improving capacity of health and other workers in caring for women and children.

The guidelines are aimed at the provision of quality care and preventing and responding to the needs of the youth and promoting healthy lifestyles among all youth. Promotion of a healthy lifestyle includes programmes or activities 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 Department of Health launched maternity-care guidelines and national guidelines for the cervical cancer screening programme in 2000.

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. 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 in Asian (8,9%) and fourth most common 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 smears with a 10-year interval between each smear. 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 had been a significant decrease in the maternal mortality rate from unsafe abortions – from over 64% in 1994 to 9,5% in March 2002.

The Department of Health continues to support training in abortion care and in contraception provision. There had been an increase from 239 trained providers in March 2001 to 366 trained providers in March 2002. There was an increase in the number of functioning designated facilities from 33% 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. The Subdirectorate is also developing a policy on the Management of Survivors of Sexual Offences.

Tobacco control

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

Regulations of the Tobacco Products Control Amendment Act, 1999 (Act 12 of 1999), which were gazetted in 2000 include:

- a ban on all advertising from 23 April 2001
- all public places to be smoke-free, but employers and restauranteurs can set aside 25% of their space for smokers, and this space has to 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 world-wide recognition with the awarding of the Luther L Terry Award in August 2000. The Minister of Health, received the award at the 11th World Conference on Tobacco for outstanding leadership in tobacco control.

The Department of Health has set up a tobacco hotline for the general public to lodge smoking-related complaints. The response has shown that the South African public is aware of the dangers of smoking. 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 multi-pronged. 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.

Other components of the current Act will also come into effect soon. 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 mgs to 12 mgs while nicotine will decrease from 1,5 mgs to 1,2 mgs on all cigarettes sold in South Africa.

South Africa is currently the vice chair of the Intergovernmental Negotiations on the Framework Convention on Tobacco Control. This Framework Convention will serve as a global public health treaty to reduce tobacco-related deaths. Government is also an active member of the bureau which guides the process of developing this Framework to ensure that it is tabled before the World Health Assembly in May 2003.

Alcohol and substance abuse

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 g/100 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 up to 45% (in Cape Town) of persons injured as a result of transport accidents were tested positive for alcohol.

Use of cannabis (dagga) and mandrax (methaqualone) alone or in combination (white pipes) continues to be high. The increases in treatment demand for cocaine over time reported earlier for Cape Town, Durban and Gauteng have not continued and there has been a levelling off in treatment demand. In Gauteng increases were, however, noted in the proportion of females reporting cocaine/crack as their primary drug of abuse. Nine percent of trauma patients in Cape Town tested positive for cocaine in 2001 (up from 3% in 1999/00). Increases 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 SAPS' Forensic Science Laboratory in the Western Cape (166 kg).

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

The year 2002 has seen increases in excise taxes on most alcohol products above the level of inflation and new legislation is expected in the areas of alcohol marketing and retail sales of alcohol. Progress continues to be made to reduce the supply of illicit drugs (e.g. detection at airports and seizures of assets of drug kingpins), but progress on the demand side has been limited.

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 will report to Parliament annually. (See chapter: *Social Development*).

Violence against women

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

The Department is raising awareness and promoting intersectoral and interregional cooperation in this area. On 25 November 2002, government launched the 16 Days of Activism on No Violence Against Women and Children campaign.

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. Advanced training of health-care 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 the UNISA Institute for Social and Health Sciences, was designed to improve the population's health status, safety and quality of life through public health-oriented research aimed at preventing death, disability and suffering arising from crime, violence and unintentional incidents of injury. The Lead Programme's overall strategic orientation and 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 by the age of five.

The Department of Health's four priority conditions are albinism, Down's syndrome, Fetal Alcohol Syndrome 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 due to genetic disorders and birth defects. This will involve decentralisation of training, expansion of the sentinel sites for birth-defect monitoring and collaboration with non-governmental organisations (NGOs) in creating awareness.

Policy

The policy guidelines for the management and prevention of genetic disorders, birth defects and disabilities were launched by the Minister of Health in August 2001. Initial training on the priority conditions outlined in these guidelines took place in July and August 2001. Seventy health-care workers were trained and the long-term target is to have one health-care worker in each PHC facility who is able to recognise certain genetic disorders and birth defects, and to manage and refer appropriately. A tool to evaluate genetic services has been developed and will be used to measure progress on the implementation of the policy guidelines.

A second document, *Guidelines for the Management, Treatment, Counselling and Prevention of the Most Common Genetic Disorders, Birth Defects and Disabilities*, which deals with 10 common conditions that the PHC worker may come across in the clinic setting, will be submitted to provincial departments for adoption.

The Department of Health is part of an interdepartmental steering committee that oversees the implementation of the National Biotechnology Strategy chaired by the Department of Science and Technology. The health issues include vaccine development and the development of low-cost diagnostics and drugs against local conditions such as hypertension, cancer, malaria, and TB.

Training

The Subdirectorate: Training continues to support provinces in genetic training. Funds earmarked for assisting provinces with training and outreach clinics were transferred to the Southern African Inherited Disorders' Association in 2000. During 2001, these funds were used to assist with training courses in the Eastern Cape, Western Cape and Mpumalanga.

There is a great shortage of health-care workers skilled in genetics. To create a cadre of genetic nurse councellors, a curriculum for a postbasic one-year genetics diploma course has been developed and will be submitted to the Nursing Council for approval.

Surveillance

South Africa, through the Birth Defects

Surveillance System, is a member of the International Clearinghouse for Birth Defects Monitoring Systems. In the long term, this should result in diagnoses being accurate and the data collected on birth defects 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.

A study on the awareness and prescribing practices of health-care workers on the beneficial effects of folic acid during pregnancy showed that while 33% of health-care workers were not aware of the role of folic acid, 75% of them said they advised patients on folic acid.

Awareness

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

- Albinism Awareness Month (September)
- National Inherited Disorders Day (October 1)
- Down's Syndrome Day (October 20)
- World Haemophilia Day (April 17).

Regular meetings have been held with NGOs to discuss collaborative issues. One of the outcomes of this collaboration is the Minister of Health's recognition of the Haemophilia Comprehensive Care Programme. This recognition follows 30 years' of attempts by the Haemophilia Foundation to obtain government recognition for its Programme, and this was celebrated in five provinces in October/ November 2001.

The first International Conference on Birth Defects and Disabilities in the Developing World was held in Johannesburg in August 2001. More than 19 countries from six continents were represented.

Information

South Africa has met many of the criteria for polio-free certification and had its last polio case due to the wild polio virus 12 years ago.

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.

Issues raised included the:

- need for locally relevant studies to determine the extent of the problem of birth defects
- need to develop generic training material and for country-specific adaptation
- involvement of other government sectors as well as community leaders in health promotion efforts.

Polio and measles

Polio remains a major problem in Africa, although the last confirmed case in South Africa occurred in 1989. 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.

The year 2000 was the final year for global polio eradication. South Africa implemented three years of mass immunisation campaigns against polio (1995 to 1997), when all children under the age of five years received two extra doses of oral polio vaccine four weeks apart, irrespective of their previous vaccination history.

Since 1996, active case-based surveillance for acute flaccid paralysis (a polio-like disease) has been implemented in all public hospitals country-wide. Although the surveillance indicators are not yet optimal, intensive training and information sessions have been conducted. A toll-free line is available for the reporting of any suspected polio cases: 0800 111 408.

The Expanded Programme on Immunisation has been introduced and has succeeded in reducing both polio and measles to close on elimination.

Chronic diseases, disabilities and geriatrics

The Department continues to focus on the development of guidelines for the clinical management of priority chronic diseases, dis-

eases of lifestyle, eye care, cancers and cataract surgery. Patient education and in- formation, including their rights and responsibilities are also emphasised. Booklets, posters, audiotapes and videotapes with appropriate informative health messages have been developed for distribution to clinics.

The Department promotes the rights of patients as well as their 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.

Health-care 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 enhance patient compliance.

The Department aims to reduce avoidable blindness by increasing the cataract surgery rate. To this end, South Africa entered into an agreement with Tunisia whereby Tunisian doctors came to South Africa to perform cataract surgery. In 2001, the Tunisian doctors performed 260 cataract operations in six weeks. These surgeons are accredited by the Bureau for the Prevention of Blindness.

A floating trophy has been instituted and is awarded to the province with the best cataract surgery rate. In 2001, the trophy was won by the Free State.

The backlog in the supply of assistive devices to people with disabilities has been reduced by the additional purchase of 324 wheelchairs, 430 pairs of spectacles and 140 hearing aids. An additional 400 wheelchairs and hearing aids were purchased in 2001.

Wheelchair repair centres have been established in most parts of the country, including rural areas. The establishment of these centres was made possible by a donation from the Flemish Government. The absence of this repair service often resulted in damaged wheelchairs having to be written off, at great cost to the State. Disabled people have been trained to repair wheelchairs, and in some instances, to manage this service as a business enterprise.

A project that was started in 1998 to train health workers in Sign Language is continuing. By May 2002, 93 health workers had been trained.

About 20 000 audiotapes had been produced, carrying HIV/AIDS messages. These tapes will go some way in raising awareness of HIV/AIDS among blind and visually-impaired people.

The population of older persons (60 years and older) was estimated to be close to three million in 1999. 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 health-care 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 and inclusive of older persons, e.g. 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 the provinces and will raise awareness of abuse in all its subtle forms.

Disabilities

Policy and guidelines

The National Rehabilitation Policy was launched at Mbekweni Health Centre in Umtata in August 2001. The Assistive Devices Policy has been adopted

The Department developed criteria to assist facilities to assess their accessibility status. The document contains a checklist of things to consider during assessment.

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 corner-stones 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, and 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 the family 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 country-wide. Where possible, consultations are undertaken by these authorities by means of multidisciplinary teams comprising psychiatrists, psychiatric nurse practitioners, psychologists, pharmacists, social workers and occupational therapists.

According to the Mental Health Care Bill, 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 only placing them in institutions.

The Department of Health has embarked on pilot projects in the Eastern Cape and KwaZulu-Natal to compare the condition of patients who are discharged to those still in hospital.

The new Bill 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 Bill recognises that there are not enough psychiatrists, especially in rural areas. According to the Bill, a mental health-care practitioner can make such a decision. It also introduces a review board, comprising a mental health-care 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.

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) 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 valid yellow fever vaccination certificates. 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, 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, or from the abuse of hazardous substances, and 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 National Food Consumption Survey (NFCS) of 1999 showed that at least 21,6% of children between the ages of one and nine years-old are stunted, indicating chronic past undernutrition. Younger children (one to three years of age) are most severely affected as well as those living on commercial farms (30,6%) and in tribal and rural areas. Underweight affects 10,3% of children in this age group (18% on commercial farms). Wasting, an indicator of acute current undernutrition, is not common in South Africa with a prevalence rate of 3,7% of children between one and nine years-old.

Micronutrient deficiencies are prevalent in the country and are affecting especially vulnerable groups such as children and women. The NFCS showed that most children appear to consume a diet low in energy and poor in protein quality and micronutrient density. It also found that one out of two children aged one to nine years have an intake of approximately less than half the recommended level for vitamin A, vitamin C, riboflavin, niacin, vitamin B6, folate, calcium, iron and zinc. Iron deficiency and anaemia are common problems among children in rural communities. Although anaemia could be a result of malaria and parasite infestations, dietary deficiency in iron is also a major concern.

The NFCS findings support the results from the 1994 SAVACG survey among children six to 71 months which found that 33,3% of all South African children are vitamin A-deficient, a prevalence which indicates that vitamin A deficiency is a serious health problem in the country. The SAVACG survey also found a 21,4% prevalence of anaemia, 10% prevalence of iron deficiency and 5% prevalence of iron deficiency anaemia.

The National Iodine Deficency Disorder (IDD) Survey, which was conducted in 1998 among primary school children, has shown that learners in 89,4% of primary schools surveyed have a normal iodine status, following the mandatory iodation of food-grade salt in 1995. However, learners in 10,6% of the schools, mostly in rural areas, were iodine-deficient. According to the MRC, 62,4% of households consume iodised salt.

Infectious diseases constitute one of the major factors contributing to child malnutrition. Conversely, malnutrition makes a child more susceptible to these infectious diseases. The most common infectious diseases in South Africa affecting the growth of children and which may lead to malnutrition and death are HIV/AIDS, measles, diarrhoea and acute respiratory infections. While the malnutrition-infection complex most commonly affects children, it is also significant where adult morbidity is concerned. Infections and diseases play a major role in loss of productivity through their impact on adult physical performance and work capacity.

Malnutrition in South Africa is not just manifested in undernutrition, but also in overnutrition. Many predisposing causes of chronic diseases are associated with lifestyle. The

NFCS found that 7,7% of children in the one to nine year age group are overweight in the formal urban areas with a higher prevalence among children of well-educated mothers (12,5%).

The South Africa Demographic and Health Survey (SADHS) of 1998 found that 29% of adult men and 55% of adult women are overweight while 9% of adult men and 29% of adult women are obese. Obesity is regarded as a major risk factor for diabetes mellitus, hypertension and other chronic diseases of lifestyle. The same survey found that 16% of adult women and 13% of adult men were hypertensive in 1998. It is estimated that 8% of the adult population have type 2 diabetes.

The low prevalence of exclusive breast-feeding is a cause of concern. The SADHS found that in the first three months of life, only 10% of infants were exclusively breast-fed, while the rate of bottle-feeding was 48,3% nationally.

Growth monitoring and promotion is one of the most useful tools available in infant and young child health, because it provides quick and easy information to detect disease early and to monitor the nutritional status of the child. Unfortunately, care-givers of infants and young children often show a lack of correct knowledge and incorrect practices around growth monitoring and promotion. The result is the late detection of disease and malnutrition, thus impacting negatively on the health and well-being of the infant and young child. In 1998, only 74,6% (SADHS) of mothers with children younger than 13 months had Road to Health Charts (RtHCs).

The nutrition situation is exacerbated by a lack of nutritional information and knowledge. Added to this are undesirable dietary habits and nutrition-related practices, attitudes, perceptions and socio-cultural influences that could adversely affect nutritional status. To attain good health and nutritional status, people need sufficient knowledge and skills to grow, purchase, process, prepare, eat and feed their families a variety of foods in the right quantities and combinations.

In addition, the 1994 Project for Statistics on Living Standards and Development estimated that 39% of the population is vulnerable to food insecurity. According to the NFCS, only 25% of households appeared food secure at a national level. It is estimated that almost 57% of the South African population were living in poverty in 1996.

Undernutrition, as well as the range of micronutrient deficiencies of public health significance, require complementing strategies and an integrated approach to ensure optimal nutrition for all South Africans. The situation is further complicated by the many causes of malnutrition, which could be direct factors such as inadequate food intake, or underlying factors such as household food insecurity or even basic factors such as a lack of resources.

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 people. Priority target groups for nutrition interventions are:

- children under 60 months, especially children under 24 months of age
- at-risk pregnant and lactating women
- persons suffering from lifestyle-related diseases and communicable diseases
- at-risk elderly persons
- at-risk poor households/members of poor

households, including primary school learners from poor households living on farms, in rural areas and in informal settlements.

Achievements include:

- National Nutrition Guidelines for People living with TB, HIV/AIDS and other chronic debilitating Conditions.
- *Manual for Growth Monitoring and Promotion.*
- Printing and distribution of standardised RtCHs with a coverage of 75%.
- Booklet and pamphlet on the INP.
- Provisioning of high-dose vitamin-A supplementation to post partum women and children six to 60 months of age.
- Pamphlet on *How to Prevent Iodine-deficiency Disorders.*
- Booklet on *Iodine-deficiency Disorders* .
- *Vitamin A-deficiency* booklet.
- Food fortification.
- Regulations have been drafted for the mandatory fortification of all maize meal and wheaten flour with vitamin A, thiamin, riboflavin, niacin, vitamin B6, folic acid, iron and zinc. The regulations will be published as part of the Act on Foodstuffs, Cosmetics and Disinfectants, 1972 (Act 54 of 1972). The draft regulations were expected to be published in May 2002 for a period of three months to allow for public comments whereafter the final regulations will be published. The regulations will come into effect six months after the date of publication.
- Assessment of Food Service Management Services in health, care and correctional service facilities in 2000.
- Participation in PMTCT Pilot Sites.
- Baby-friendly hospital initiative with 39 hospitals declared baby-friendly.
- South African Breast-feeding Guidelines for Health Workers.
- Annual celebration of Breast-feeding week during August.
- Pamphlet on exclusive breast-feeding.
- Draft regulations on the marketing of designated products (breast-milk substitutes) are being formulated based on the Code of Ethics for the marketing of breast-milk substitutes. The regulations will be published as part of the Act on Foodstuffs, Cosmetics and Disinfectants, 1972.
- School-feeding in 15 400 primary schools reaching 4,7 million learners (87% of target and 47% of total number of learners) on 116 (56%) to 197 (100%) school days.
- External evaluation of certain aspects of school-feeding.
- Poverty-relief projects in all nine provinces.
- Training of health workers on:
  - growth monitoring and promotion
  - vitamin A supplementation
  - lactation management
  - South African Code of Ethics on the marketing of designated products (breast-milk substitutes)
  - infant feeding and HIV/AIDS
- Assessment of Financial and Administrative Procedures of the INP in 2000.

Acknowledgements

Allied Health Service Professions Council of South Africa
Department of Health
Estimates of National Expenditure 2002, published by the National Treasury
Health Professions Council of South Africa
Medical Research Council
South African Nursing Council
South African Pharmacy Council

Suggested reading

Arden, N. *African Spirits Speak: A White Woman's Journey into the Healing Tradition of the Sangoma.* Rochester, Vermont (USA): 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.
Bayer, R and Oppenheimer G.M. *AIDS Doctors: Voices from the Epidemic.* Cape Town: Oxford University Press, 2002.
Campbell, S. *Called to Heal: Traditional Healing Meets Modern Medicine in Southern Africa.* Halfway House: Zebra Press, 1998.
Kibel, M. and Wagstaff, L. eds. Child Health for All: A Manual for 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.
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.
Booysens S.W. ed. *Introduction to Health Services Management.* Kenwyn: Juta, 1996.
Kok, P. and Pietersen, J. *Health. Pretoria: Human Sciences Research Council, 2000.* (National Research and Technology Project).
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 Human Sciences Research Council, 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.
Felhaber, T. ed.*South African Traditional Healers' Primary Health Care Handbook*. Traditional aspects compiled by I. Mayeng. Cape Town: Kagiso, 1997.
Couvadia, H. M. and Benatar, S. eds. *Tuberculosis With Special Reference to Southern Africa.* Cape Town: Oxford University Press, 1992.
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.