



SA YEARBOOK 2009/10
HEALTH



In the current Medium Term Strategic Framework period, the Department of Health aims to transform the public health system to reduce inequalities in the health system, improve quality of care and public facilities, boost human resources (HR) and step up the fight against HIV and AIDS, tuberculosis (TB) and other communicable diseases as well as lifestyle and other causes of ill-health and mortality.

The Health Technical Task Team for the 2010 FIFA World Cup™, led by the Department of Health, is focusing on various areas such as emergency medical services (EMS), communicable diseases, environmental health, port health, stadiums, provision of primary healthcare (PHC) and the establishment of command and control points.

There is collaboration with the South African National Defence Force in providing the necessary back-up for emergency events. It also collaborates with the South African Red Cross Society in terms of support for aeromedical transportation in cases of need. The experience provided by the FIFA Confederations Cup in 2009 will contribute vastly to ensuring world-class health and medical services in 2010.

In 2009, the Department of Health also finalised and costed the Communicable Disease-Control Strategic Plan for the Soccer World Cup in 2010.

Statutory bodies

Statutory bodies for health-service professionals include the Health Professions Council of South Africa (HPCSA), the South African Dental Technicians' Council, the South African Nursing Council (SANC), the South African Pharmacy Council (SAPC) and the Allied Health Professions Council of South Africa (AHPCSA).

Regulations in the private health sector are effected through the Council for Medical Schemes. The Medicines Control Council is charged with ensuring the safety, quality and effectiveness of medicines.

Health authorities

National

The Department of Health has adopted the 10-Point Plan for the 2009 to 2012 period. The plan includes:

- providing strategic leadership and creating a social compact for better health outcomes
- implementing a National Health Insurance (NHI) system

- accelerated implementation of the HIV and AIDS plan and increased focus on TB and other communicable diseases
- overhauling the healthcare system and improving its management
- improved HR planning, development and management
- improving the quality of health services
- revitalising health infrastructure
- mass mobilisation for better health for the population
- reviewing the drug policy
- strengthening research and development.

Provincial health departments

Provincial health departments 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 developing health services in South Africa at provincial level has been the shift from curative hospital-based healthcare to that provided in an integrated community-based manner.

The provincial health departments are responsible for:

- providing and/or rendering health services
- formulating and implementing provincial health policy, standards and legislation
- planning and managing a provincial health information system
- researching health services to ensure efficiency and quality
- controlling quality of health services and facilities
- screening applications for licensing and inspecting private health facilities
- coordinating the funding and financial management of district health authorities
- consulting effectively on health matters at community level
- ensuring that delegated functions are performed.

The national department assists provincial health departments to develop service-transformation plans to reshape and resize the health services and develop appropriate, adequately resourced and sustainable health service-delivery platforms, which are responsive to needs.

Legislation

National Health Act, 2003 (Act 61 of 2003)

The National Health Act, 2003 provides a framework for a single health system for South Africa. It highlights the rights and responsibilities of health-providers and healthcare users, and ensures broader community participation in healthcare delivery from a health facility level up to national level. It establishes provincial health services and outlines the general functions of provincial health departments.

The Act provides for the right:

- to emergency medical treatment
- to have full knowledge of one's condition
- to exercise one's informed consent
- to participate in decisions regarding one's health
- to be informed when one is participating in research
- to confidentiality and access to health records
- to complain about service
- of health workers to be treated with respect.

Tobacco Products Control Amendment Act, 2008 (Act 63 of 2008)

The Tobacco Products Control Amendment Act, 2008 seeks to amend the Tobacco Control Act, 1993 (Act 83 of 1993), to provide anew for advertising, sponsorship, promotion, distribution and information required in respect of the packaging and labelling of tobacco products; to make the

standards that apply to manufacturers of tobacco products applicable to importers of tobacco products; to prohibit the sale of tobacco to and by persons under the age of 18 years; to extend the provisions in respect of free distribution of tobacco products; to provide anew for tobacco sales by means of vending machines; to extend the minister's power to make regulations; and to adjust the provisions in respect of offences and penalties.

Medicine and Related Substances Amendment Bill

The Bill aims to amend the Medicines and Related Substances Act, 1965 (Act 101 of 1965), to provide for the establishment of the South African Health Products Regulatory Authority (SAHPRA); to provide for the certification and registration of products, which include medicines, medical devices, certain foodstuffs and cosmetics; and for the control of scheduled substances.

Nursing Act, 2005 (Act 33 of 2005)

The Nursing Act, 2005 provides for the introduction of mandatory community service for nurses. This contributes significantly to efforts to ensure equitable distribution of nurses to meet the health needs of communities.

The Act seeks to ensure that nursing-education programmes are registered with the National Qualifications Framework so that nurses can gain recognised credits and retain them for future studies. The main objectives of the Act are to:

- serve and protect the public in matters involving health services provided by the nursing profession
- ensure that the SANC serves the best interests of the public and does so in accordance with national health policy
- promote the provision of acceptable nursing care
- regulate the nursing profession and the way in which nurses conduct themselves
- promote the operations and functions of the SANC and the registrar
- promote liaison regarding health, nursing education and training standards
- ensure that the SANC advises the Minister of Health on matters affecting the profession
- provide for the registration of nurses and the keeping of registers.

Mental Healthcare Act, 2002 (Act 17 of 2002)

The Mental Healthcare Act, 2002 introduced a

International World AIDS Day is celebrated on 1 December each year. In 2009, government commemorated this day by introducing the following new measures:

- all children under one year of age will get treatment if they test positive – treatment will not be determined by the level of CD cells
- patients with both tuberculosis (TB) and HIV will get treatment with antiretrovirals (ARVs) if their CD4 count is 350 or less
- TB and HIV/AIDS will now be treated under one roof
- all pregnant HIV-positive women with a CD4 count of 350 or with symptoms regardless of the CD4 count will have access to treatment
- all other pregnant women not falling into this category, but who are HIV-positive, will be put on treatment at 14 weeks of pregnancy to protect the baby
- government will ensure that all the health institutions in the country are ready to receive and assist patients and not just a few accredited ARV centres.

The changes would be implemented from April 2010



process to develop and redesign mental-health services in line with the rights of mental-health-care users, as guaranteed by the Constitution of the Republic of South Africa, 1996. This legislation grants basic rights to people with mental illnesses, and prohibits various forms of exploitation, abuse and discrimination.

The Act provides for:

- empowering the users themselves so that they can engage service-providers and society
- allocating adequate resources
- a commitment to the cause of mental health at all levels of society.

To achieve this, a series of innovative processes and procedures regarding the care, treatment and rehabilitation of mental-health users, as well as clear guidelines on good practice in relation to the role of mental-healthcare practitioners, will be introduced.

Although the Act reserves the right to involuntary hospitalisation, it also contains accompanying conditions for strict admission and reviewing processes and procedures before any decision on psychiatric referrals may be made.

All provinces have established independent mental-health review boards, charged in terms of the Mental Healthcare Act, 2002, to oversee the care, treatment and rehabilitation of patients who were admitted without their consent.

National School Health Policy

The aim of the National School Health Policy and guidelines is to ensure that all children, irrespective of race, colour and location, have equal access to school-health services.

The policy is in line with the UN Convention on the Rights of the Child, which affirms the State's obligation to ensure that all segments of society, in particular parents and children, are informed and have access to knowledge of child health and nutrition, hygiene, environmental sanitation and the prevention of accidents.

Department of Health officials will be visiting all provinces, especially those with a school-health programme, to embark on a major training campaign of PHC nurses.

The nurses will be trained to:

- provide children with health education
- impart life skills
- screen children, especially those in Grade R and Grade One, for specific health problems, and at puberty stage when children undergo physiological changes
- detect disabilities at an early age

- identify missed opportunities for immunisation and other interventions.

National Health Insurance

The Department of Health seeks to establish an NHI system, which will introduce the necessary funding and service-delivery mechanisms to enable the creation of an efficient, equitable and sustainable health system in South Africa.

The key policy proposal is that the NHI be funded from two sources of revenue, namely, general tax revenue and an earmarked mandatory contribution. All employed individuals would make an appropriately determined mandatory contribution to an intermediary health fund.

The Government aims to make a universal subsidy contribution on behalf of the indigent and poor to this fund to provide for their services. To effectively realise the objective of universal healthcare for all, a number of reforms have to be undertaken, which should include regulatory, financing, health-service delivery and complementary reforms.

Steps in the development of the NHI system require reaching consensus on matters relating to the Basic Benefits Package (Essential Healthcare Package), the structure of the National Health Fund (NHF) and the role of private funders and providers.

With regard to the Basic Benefits Package, one of the key components of adopting an NHI system is defining the set of healthcare services that individuals and households would be covered for and how much it would cost the State to provide these services to the national population.

In terms of the structure of the NHF, there is a need for public and stakeholder engagement on the exact form that the proposed fund would take.

The role of private funders and providers is also important. The private health sector in South Africa holds a huge share of the country's national health resources, human and financial. There is a need to engage with stakeholders on the best way the NHI system would draw on the resources in the private sector for the benefit of the national population – not just those with private health insurance. There is also a need to resolve the role of private funders, as well as medical schemes in an NHI environment.

During the Medium Term Expenditure Framework (MTEF) period 2009 to 2012, the department aims to continue working towards the design of a NHI system for South Africa that promotes health-

system integration and ensures universal access for all South Africans.

In November 2009, the Minister of Health, Dr Aaron Motsoaledi, announced the appointment of a 25-member committee to advise him on an implementation plan for the NHI system.

2010 FIFA World Cup™

By September 2009, the Department of Health's 2010 Health Technical Coordinating Committee, comprising provincial and local government, military, private-sector and other stakeholders, was preparing for the 2010 World Cup.

EMS is the cornerstone of the Department of Health's service provision for the event. About 700 new ambulances had been purchased, and five modern state-of-the-art communications systems were in the process of being completed. This will enhance the ability to track the department's mobile resources at all times.

By September 2009, a software-based in-field diagnostic tool had been piloted in the Western Cape and would soon be rolled out across the country. Aeromedical services had been improved and five out of the eight hosting provinces had modern dedicated aeromedical helicopter services. The remaining three provinces were expected to implement similar services shortly after.

As part of the initiative to improve EMS, the training of emergency-care practitioners was enhanced with the provision of additional funding to provincial colleges of emergency care.

Services at major tourist destinations will be improved. Strategies were expected to be in place to ensure speedy responses to rural areas, and hospitals that serve those areas would be adequately prepared and supported.

Environmental health plans were reviewed in conjunction with host cities and the FIFA Organising Committee. The plans incorporate all the activities required to ensure that venues meet international standards in relation to food safety, water integrity, and sanitation and waste management. South Africans will benefit from these activities beyond 2010.

Free PHC will be provided for all spectators at official venues, including a script or referral to a health facility, if necessary. However, any investigations, procedures or admissions will be paid for by the patient.

Dispensing machines will be situated throughout the stadiums for basic drug purchases. Twenty-four-hour pharmacies will be in place for the duration of the event.

Health professionals Physicians

There are more than 34 500 doctors registered with the HPCSA. These include doctors working for the State, those in private practice and specialists. The majority of doctors practise in the private sector. In selected communities, medical students supervised by medical practitioners provide health services at clinics.

In terms of the Continuing Professional Development (CPD) system, all doctors, irrespective of earlier qualifications, must obtain a specified number of points to retain their registration.

The system requires that doctors attend workshops, conferences, refresher courses, seminars, departmental meetings and journal clubs. Non-compliance with the requirements of the system could result in a doctor being deregistered.

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

Oral health professionals

By December 2008, there were 948 oral hygienists, 477 dental therapists and 4 799 dentists registered with the HPCSA.

Dentists are subject to the CPD and community-service systems. Oral health workers render services in the private and public sectors.

Pharmacists

All pharmacists are obliged to perform one year of remunerated pharmaceutical community service in a public-health facility. Those who have not completed this year of service may not practise independently as pharmacists.

The primary object of the SAPC is to assist in the promotion of the health of South Africans. This is achieved in the fields of registration, education, practice and professional discipline.

The SAPC assists in the promotion of the health of the population on a national basis by establishing, developing, maintaining and controlling standards of education and practice of persons required to be registered in terms of the Pharmacy Act, 1974 (Act 53 of 1974).

The council is responsible for promoting the provision of pharmaceutical care, and for upholding and safeguarding the rights of the general public to universally acceptable standards of pharmacy practice in both the public and the private sectors. The council also advises the min-

The International Organisation for Migration and the United States Agency for International Development launched a R50-million programme to reduce HIV-vulnerability among South African farm workers in 2009.

The three-year programme, known as Ripfumelo (which means "believe" in Xitsonga), aims to target 20 000 farm workers, including migrant labourers, in Limpopo and Mpumalanga. Ripfumelo focuses on prevention and care services as well as the external factors that contribute to HIV-vulnerability.



ister or any other person on any matter relating to pharmacy.

The SAPC is a statutory council, which receives no grants or subsidies from government or any other source. The council is funded wholly by the profession who registers with the SAPC. The main consumer of its services, namely the public, does not and is not expected to contribute financially to the functioning of the council.

An important characteristic of the profession is that it is self-regulatory, and that non-professional authorities such as governments or governmental agencies do not dictate to the profession on matters of professional responsibility and training.

The council is a statutory body and the country's official "keeper of pharmacy registers". To safeguard the public, registration with the council is a legal prerequisite for practising pharmacy.

The council is vested with statutory powers of peer review and is responsible for funding itself.

It is the vision of the council to ensure that pharmaceutical services in the country are the best to meet the healthcare needs of the people.

Categories

In terms of the Act, the following categories of natural and juristic persons are registered with the council: pharmacy students, pharmacist interns, pharmacists performing community service, pharmacists, specialist pharmacists, pharmacist assistants, responsible pharmacists and providers and assessors.

Pharmacy training

Pharmacy training is provided by eight pharmacy schools that have been approved by the SAPC.

This training consists of four years of full-time study, which leads to the awarding of a BPharm Degree, followed by a 12-month pre-registration practical training period. The practical training year is of extreme importance for the pharmacy graduate. It is an opportunity for the pharmacist

intern to gain practical experience and knowledge in the practice setting.

This practical training period may be carried out in a community pharmacy, institutional pharmacy, manufacturing pharmacy or at a provider of a qualification in pharmacy approved by the council for such training.

After successful completion of the year of practical training, as well as a pre-registration evaluation, the intern is registered as a pharmacist, and must do one year of pharmaceutical community service in a public-sector facility before he/she can practise independently as a pharmacist.

A list of institutions that offer pharmacy education are available from the SACP (www.sapc.za.org), and all enquiries regarding undergraduate and postgraduate studies should be addressed directly to these institutions.

Provincial departments of health also offer bursaries.

During academic training, a candidate registers as a pharmacy student after successful completion of the first year of study. This registration enables students to work in a pharmacy under the supervision of a pharmacist. Such registration is cancelled when a candidate discontinues his or her studies.

Nurses

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

Nurses are required to complete a mandatory 12-month period community service programme and once they have completed it, they may be registered as a nurse (general, psychiatric or community) and midwife.

The key roles of the nursing council are to protect and promote public interest, and to ensure the delivery of quality healthcare by prescribing minimum requirements for the education and training of nurses and midwives, approving training schools, and registering or enrolling those who qualify in one or more of the basic or post-basic categories.

The implementation of the OSD for nurses continued in 2009.

National Health Laboratory Service (NHLS)

The NHLS is the single largest diagnostic pathology service in South Africa with over 265

laboratories serving 80% of the country's population. All laboratories provide diagnostic services to the national and provincial departments of health, provincial hospitals, local authorities and medical practitioners.

The NHLS conducts health-related research, appropriate to the needs of the broader population into, among other things, HIV and AIDS, TB, malaria, pneumococcal infections, occupational health, cancer and malnutrition.

The NHLS trains pathologists, medical scientists, occupational health practitioners, technologists and technicians in pathology disciplines.

Its specialised divisions comprise the:

- National Institute for Communicable Diseases, whose research expertise and sophisticated laboratories make it a testing centre and resource for the African continent, particularly in relation to several of the rarer communicable diseases
- National Institute for Occupational Health, which investigates occupational disease and has laboratories for occupational environment analyses
- National Cancer Registry, which provides epidemiological information for cancer surveillance.

Medical Research Council (MRC)

The MRC was established in accordance with the MRC Act, 1991 (Act 58 of 1991), and is the largest health research body in South Africa.

The aims of the MRC are to promote the improvement of the health and quality of life of South Africans.

Health research is the core business of the MRC and must be validated and of high quality if it is to impact on the health of South Africans.

The MRC's peer review and audit systems ensure that such high standards are met. MRC research, development and technology transfer encompass all spheres of knowledge-generation that impact on health and quality of life – from basic to applied research.

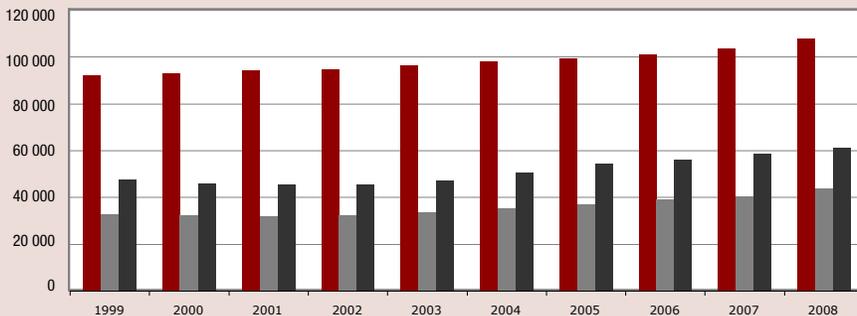
Following international best practice, all the broad disciplines of human-health research are within the ambit of the MRC; from laboratory to clinical, public health, policy and implementation. This work is often done in an integrated, multidisciplinary fashion.

Frequently, a participatory approach is used in setting the research agenda, performing and analysing the research and disseminating the research results.

Health research is the primary instrument by which the MRC seeks to gain a better understanding of people's bodies and minds and their interaction with the environment, as well as discovering methods by which the department can preserve and promote physical, mental and spiritual health.

The portfolio of MRC research must also address the health and development priorities of South Africa as defined by the National Health Research Committee, set up under the National

South African Nursing Council – growth in registers



Between 1999 and 2008, there was an overall increase in the total number of nurses on the registers from 172 893 to 212 806 (more than 23.1% growth).

- Nursing figures as at 31 December each year.
- Excludes persons staying outside South Africa
- ■ RW/RM = registered nurses and registered midwives
- ■ EN/EM = enrolled nurses and enrolled midwives
- ■ ENA = enrolled nursing auxiliaries.

Source: South African Nursing Council

Health Act, 2003, to advise the Minister of Health on health-research priorities for South Africa.

The MRC research priorities are agreed upon annually in consultation with the Minister of Health.

Furthermore, the MRC's vision of "building a healthy nation through research" can only be achieved if research results are translated into policy, practice, health promotion and products.

The principal stakeholder of the MRC is the national Department of Health.

The role of local government

Local government is responsible for rendering the following:

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

Many local authorities provide additional PHC services. In some instances, these are funded by provincial health authorities, but in major metropolitan areas the councils carry some of the costs.

Non-governmental organisations

Many NGOs at various levels continue to play a crucial role in healthcare and cooperate with government's priority programmes.

They make an essential contribution in relation to HIV, AIDS and TB, and also participate significantly in the fields of mental health, cancer, disability and the development of PHC systems.

Through the Partnership for the Delivery of PHC Programme (PDPHCP), including the HIV and AIDS Programme, the department has strengthened its collaboration with NGOs. The PDPHCP has empowered communities and NGOs working in the health sector by focusing on three key areas:

- providing skills to NGOs in the rural nodes by using accredited service-providers
- reducing unemployment by ensuring that NGO workers are provided with stipends
- ensuring accountability by requiring NGOs to include community members in their administration structures.

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

Medical schemes

The private medical-aid scheme industry is regulated by the Council for Medical Schemes (in terms of the Medical Schemes Act, 1998 [Act 131 of 1998]). The council is funded mainly through levies on the industry in terms of the Council for Medical Schemes Levies Act, 2000 (Act 58 of 2000).

In September 2009, there were 112 medical schemes. The total number of principal members of registered medical schemes increased by 6% from 3 178 127 at 31 December 2007 to 3 366 383 at September 2008.

The number of beneficiaries increased by 4,6% from 7 478 040 in 2007 to 7 823 137 in 2008. The total gross contribution income for all medical schemes amounted to R55,5 billion for the period ended 30 September 2008, 1,2% lower than the budget of R56,2 billion for the same period.

The gross contributions per average beneficiary per month of R800 was for the period ended 30 September 2008, an increase of 9% compared to the previous year. Gross relevant healthcare per average beneficiary per month was about R722 for the period ended 30 September 2008.

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

Provincial hospitals offer treatment to patients with medical-aid cover, charging a

In July 2009, Anglo Coal South Africa was recognised by the Global Business Coalition on HIV and AIDS, Tuberculosis and Malaria for its pioneering workplace programme focused on tackling HIV and AIDS in South Africa.

The Business Excellence Award for Best Workplace Programme was presented to Mr Ben Magara, CEO of Anglo Coal South Africa, at an awards dinner held in Washington DC. The event was attended by global health leaders.

The awards recognise companies which have demonstrated extraordinary commitment, action and results, and have achieved exceptional success in putting their assets to work in the fight against the greatest health threats of our time.



tariff designed to recover the full cost of treatment. This private rate is generally lower than the rate charged by private hospitals. The Medical Schemes Amendment Act, 2001 (Act 55 of 2001), improves the regulatory capacity of the Registrar for Medical Schemes and regulates reinsurance. The Act:

- provides improved protection for members by addressing the problem area of medical insurance, revisiting the provision on waiting periods, and specifically protecting patients against discrimination on grounds of age
- promotes efficient administration and good governance of medical schemes by insisting on the independence of individuals in certain key positions
- introduced mechanisms to address problematic practices in the marketing of medical schemes and brokerage of services.

Minimum benefits are also prescribed.

Primary healthcare, hospital services and emergency medical care

Access to PHC services, as measured by headcounts, reflects a consistent upward trend. Headcounts increased from 67 021 961 in 1998/99 to 99 365 898 in 2004/05, to 101 758 377 in 2005/06, stabilised at 101 644 080 in 2006/07 and increased to 101 748 188 in 2007/08.

By December 2008, a total of 83 111 282 people had used PHC services in the public sector, which marked an increase from the figure of 73 747 763 recorded in December 2007.

The national PHC utilisation rate was 2,5 visits per person in September 2008. Although this figure was lower than the set target of 2,7 visits per person, it was higher than the 2,2 visits per person achieved in 2007/08, and the 2,1 visits per person recorded in 2006/07.

The national PHC supervisory rate reflected an improvement from 56% in December 2007 to 69,4% in December 2008, against a national target of 100%. The Department of Health aims to achieve a PHC supervisory rate of 100% in 2009/10, and for the two outer years of the MTEF period.

In April 2008, the department convened a National PHC Conference in Gauteng to commemorate 30 years since the PHC Conference that adopted the Alma Ata Declaration. The Birchwood Declaration was adopted, which recommitted the health sector in its entirety to the ideals of the PHC approach.

In 2008, two external reviews of the health sector's performance over the last 14 years observed

that the development of the District Health System (DHS) as a vehicle for the delivery of PHC services appeared to have stagnated in the country, and that some gains made in the first few years of the democratic Government appeared to have been reversed.

The external reviews accentuated the need to revitalise PHC in South Africa, to improve the functioning of the DHS, to ensure support from provinces and the national department to district management teams (DMTs) and to hold DMTs accountable for performance. These issues are encompassed in the Birchwood Declaration. It was therefore essential that the implementation of key provisions of the declaration was vigilantly monitored and consistently reported on during the 2009/10 MTEF period, with interventions made to unblock areas of slow progress.

During 2008/09, the Department of Health produced the Draft Disaster Management Policy. Over the 2009/10 MTEF period, the department aims to produce an Integrated Disaster Management Plan in terms of the Disaster Management Act, 2002 (Act 57 of 2002), and the Disaster Management Framework of 2005. This plan is expected to be implemented in phases.

The first phase, expected to take place in 2009/10, includes implementation by the national Department of Health and all nine provincial health departments. Phase Two aims to involve 45 pre-identified hospitals for 2010. By the end of the MTEF period, an additional 200 hospitals are expected to be implementing the Integrated Disaster Management Plan. By the end of December 2008, the emergency centre regulations were 70% completed.

Finalisation of these regulations was to be accelerated in 2009/10.

The EMS Business Plan, completed in 2008, envisaged the development of a fully functional EMS Information System. A selection of EMS performance indicators has been included in the District Health Information System (DHIS).

Hospital Revitalisation Project

During 2008/09, 33 hospitals were under construction as part of the Hospital Revitalisation Project and 11 more hospitals were in the planning phase. Five hospitals were nearing completion, namely Dilokong and Nkhensani in Limpopo, St Lucy's and St Patrick's in the Eastern Cape and Barkley West in the Northern Cape.

The Eastern Cape also completed the specialised eye clinic in the Frontier Hospital. Mamelodi Hospital outside Pretoria was expected to be opened in 2009.

In 2009/10, the Department of Health was planning to complete the evaluation of five tertiary hospitals, namely New Nelspruit; New Limpopo Academic; King Edward VIII KwaZulu-Natal; and Kimberley; and Rustenburg hospitals. It is intended that these five hospitals, when completely revitalised, would render tertiary services and serve as provincial referral hospitals. Subject to the outcome of the review and the availability of resources, construction of these hospitals will start by the end of this MTEF period.

Hospital management was also strengthened in various ways during 2008/09. A total of 122 out of 400 hospital managers were enrolled for a hospital-management training programme offered by institutions of higher learning, and approved by the national department. This was in keeping with the 2008/09 target of training 120 managers. By the end of 2011/12, a total of 240 of the targeted 400 hospital managers will have undergone the hospital-management training.

In 2008/09, 286 of the more than 380 hospitals nationally had appointed health-information officers. About 12 of the targeted 17 hospitals implemented standardised electronic cost centres.

A total of 25 hospitals developed their health-facility improvement plans, as part of the process of improving quality of care. About 57 hospitals were expected to produce and implement these facility-improvement plans by March 2010. By the end of the MTEF period, 190 of the 381 public hospitals will have implemented these plans.

Health status

Child health

The South African demographic and health surveys, conducted by the Department of Health in 2003, reflected that the infant mortality rate had decreased marginally from 45 per 1 000 in 1998 to 43 per 1 000 in 2003. The three mortality audit reports namely *Saving Mothers*, *Saving Babies* and *Saving Children*, reported an under-five mortality rate of 69 deaths per 1 000 live births.

During 2008/09, the health sector implemented a combination of interventions to decrease infant and child mortality. Key among this was the Expanded Programme on Immunisation, which has over the last decade and a half made a significant contribution towards protecting South African children against vaccine-preventable diseases such as measles, diphtheria and pertussis.

Immunisation coverage figures indicate a progressive increase in the number and percentage of children fully immunised, from 78% in 2002 to 82% in 2006/07, to 84% in 2007/08, and to

84,6% in December 2008. There were, however, districts that did not attain the expected 90% coverage in 2008/09, and targeted support was provided to them.

The department submitted the country's Polio-Free Certification document to the Africa Regional Certificate Committee (ARCC) of the World Health Organisation (WHO) in August 2008. A wild poliovirus outbreak and importation preparedness plan was also updated, submitted and accepted by the ARCC. This was in keeping with the set target for 2008.

During the MTEF period 2009/10 to 2011/12, the Department of Health aims to implement a package of key interventions to steer the health sector towards Millennium Development Goal (MDG) Four, which aims to reduce childhood mortality by two thirds by 2015. Two new vaccines will be introduced to help prevent deaths from pneumonia and diarrhoea, namely Prevenar and Rotatrix, respectively.

Provincial departments were expected to introduce these two vaccines in a phased manner in 2009/10.

The anticipated reduction in morbidity and mortality might take longer to manifest itself than was originally anticipated. Other key interventions during the next planning cycle will include increasing the proportion of PHC facilities saturated with health workers trained in the Integrated Management of Childhood Illnesses (IMCI) to 80% by 2011/12, strengthening the implementation of the Household and Community Component of the IMCI, as well as the Perinatal Problem Identification Programme in the 18 priority districts.

The 18 districts are located across the nine provinces. The Department of Health expanded the Reach Every District Strategy to 44 of the 52 districts. A total of 238 of the 545 health facilities with maternity beds were accredited as providing baby-friendly services, against a target of 245 facilities. There are strict criteria that these facilities had to comply with to achieve this accreditation.

Maternal and women's health

One of the key challenges that had confronted the health sector's efforts to improve maternal and women's health over the last few years had been the increase in the Maternal Mortality Ratio (MMR).

In 1998, the *South African Demographic and Health Survey* (SADHS) reported an MMR of 150 per 100 000 live births, while in 2002, Statistics South Africa estimated MMR to be at 124 per

100 000. However an MMR of 124 per 100 000 is still considered high for a middle-income country such as South Africa.

The MDG Five requires countries to improve maternal health and reduce their MMR by 75% by 2015.

During 2008/09, the department continued to implement diverse interventions to reduce maternal mortality. Key among these were the 10 recommendations from the *Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002 – 2004*, which were as follows:

- Protocols on the management of important conditions causing maternal deaths must be available and utilised appropriately. All midwives and doctors must be trained in the use of these protocols.
- All pregnant women should be offered information on screening for and appropriate management of communicable and non-communicable diseases.
- Criteria for referral and referral routes must be established and used appropriately in all provinces.
- Emergency-transport facilities must be available for all pregnant and post-partum women and their babies with complications (at any site).
- Staffing and equipment norms must be established for each level of care and for every health institution concerned with the care of pregnant women.
- Blood for transfusions must be available at every institution where caesarean sections are performed.
- The use of contraceptives must be promoted through education and service provision and the number of mortalities from unsafe abortion must be reduced.
- Correct use of partograms should become the norm in each institution conducting births. A quality-assurance programme should be implemented, using an appropriate tool.
- Skills in anesthesia should be improved at all levels of care, particularly at level one hospitals.
- Women, families and communities at large must be empowered, and should participate actively in projects and programmes aimed at improving maternal and neonatal health as well as reproductive health in general.

By the end of December 2008, 87% of institutions were implementing recommendations from the *Saving Mothers* and *Saving Babies* reports,

against a 2008/09 target of 90%. However, the Department of Health encountered challenges in monitoring this objective, because of the complexity of measuring which of the 10 recommendations were being implemented.

To address this, the department initiated discussions with the National Committee for Confidential Enquiries into Maternal Deaths about a new approach to tracking the proportion of health facilities implementing these recommendations.

In 2008, 50% of community health centres (CHCs) provided Choice on Termination of Pregnancy (C-TOP) services, which was consistent with the target for 2008/09 of cascading C-TOP to PHC facilities.

A cervical cancer screening coverage of 22% was attained by 2008, against a 2008/09 target of 40%.

In the 2009/10 planning cycle, key priorities for strengthening maternal health included ensuring that 95% of pregnant women are tested for HIV by 2011/12, that 95% of eligible pregnant women are placed on antiretroviral prophylaxis, using dual therapy, and that at least 50% of post-partum women are reviewed within three days.

Communicable disease control HIV and AIDS

Key milestones were achieved in combating communicable diseases such as HIV and AIDS, TB and malaria. The public health sector continued to implement the Comprehensive Programme for HIV and AIDS Care, Management and Treatment (CCMT).

Prevention remained the cornerstone of the CCMT, with voluntary counselling and testing (VCT) and prevention of mother-to-child transmission services being provided in more than 95% of public health facilities in 2008/09.

By the end of December 2008, more than 206 million male condoms had been distributed, building towards the 2008/09 target of 450 million male condoms. About 2 894 000 female condoms were distributed.

About 95% of districts had a turnaround time of six days or less for CD4 tests. By the end of January 2009, a total of 695 293 patients had been initiated on antiretroviral therapy (ART) of which 625 062 were adults and 70 231 were children.

The *Antenatal Care Survey* for 2007 reflected a 1% reduction in HIV prevalence between 2006 and 2007, and a 2% reduction between 2005 and 2007.

In 2009/10, the Department of Health aimed to accelerate the implementation of the National

Strategic Plan for HIV and AIDS and Sexually Transmitted Infections (STIs), in keeping with the 10-Point Plan for 2009 to 2014.

With regard to prevention, the department aims to maintain the availability of VCT services in 100% of its PHC facilities, and strives to ensure that by March 2010, 50% of South African men will have undertaken an HIV test. Distribution of both male and female condoms will be expanded.

Care and support will also be fortified through community-based services. About 27 000 community care-givers are expected to be receiving a stipend by March 2010. With regard to treatment, by September 2009, 700 000 people were receiving ART. Efforts are to be made to ensure that 85% of these patients remain on ART after completing one year of treatment.

Tuberculosis

One of government's priorities is to increase the national TB cure rate from 60% in 2008 to 70% in 2010 by improving interventions for TB control and management. The TB cure rate of 60% in 2008 decreased from 63% in 2007.

TB-tracer teams are being appointed and placed in districts across South Africa to help reduce the defaulter rate, resulting in a decrease in the rate from 10% in 2005 to 7,9% in 2008.

A national prevalence survey of TB was expected to be conducted in 2009/10.

The management and control of TB also reflected positive outcomes during 2008/09.

More than 80% of TB patients who presented to the health facilities in 2008 were tested for HIV.

Provinces are being trained on an ongoing basis in the TB Control Programme. Key challenges in 2008/09 included the lack of reliable data on the magnitude of multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB).

A study was initiated to generate this data. In keeping with the departmental policy, all patients with MDR-TB and XDR-TB are admitted to hospital for the intensive phase of treatment; for the evaluation of treatment; for the purpose of evaluation, initiation and monitoring of side effects; education and counselling; and discharge planning.

The criteria for discharge include the patient's stability, culture conversion to negative and a good support system for patients to ensure treatment compliance.

In 2008/09, the Department of Health encountered several challenges in the implementation of this policy. These included patient-based factors such as resistance to hospital admission by some patients with XDR-TB and MDR-TB; poor

response to treatment, resulting in late conversion of patients; and treatment failures, such as patients not responding positively to treatment after one year.

Health-system factors included poor infection-control in some health facilities due to dated health infrastructure, and inadequate clinical skills among some health workers to manage patients with MDR-TB and XDR-TB.

The department implemented a diversity of interventions to overcome these constraints. Funding was provided to provinces to improve hospital infrastructure and enable the implementation of appropriate infection-control measures.

More than 6 000 health professionals were trained on the clinical management of TB, including XDR-TB and MDR-TB, as well as on infection-control measures.

New culture facilities (laboratories) were established by the NHLS in Limpopo and Mpumalanga and three additional facilities to conduct second-line drug-sensitivity tests for XDR-TB were created.

Community care and defaulter tracing were also improved. About 72 tracer teams were appointed to track TB defaulters, which contributed to discharge planning, and follow-up visits were conducted by health workers.

The key issue going forward is monitoring compliance with infection-control measures, particularly in cases where isolation at home would not be possible.

The department identified the reduction of mortality due to TB and associated diseases as a key priority, which is also consistent with MDG Six. The department aims to enhance the screening of TB patients with HIV. In 2009/10, 80% of TB patients were expected to be counselled and tested.

The quality of counselling will facilitate acceptance of testing. About 2 000 health professionals and 2 500 non-health professionals will be trained in TB management annually from 2009 to 2012. All patients presenting with MDR-TB and XDR-TB will be started on treatment.

Malaria

A 48% increase in the number of malaria cases was observed in 2008, compared to 2007. In 2007, 5 210 malaria cases were reported compared to 7 727 in 2008. About 44 malaria deaths were reported in 2008, compared to 48 in 2007, reflecting an 8% decrease.

However, the 10% target in the reduction of malaria cases was not met. South Africa contin-

ues to collaborate with neighbouring countries on malaria control.

A Trans-Limpopo Malaria Initiative meeting was held in Zimbabwe in August 2008.

An implementation plan for collaboration with the Democratic Republic of Congo around malaria control was also developed. Technical skills were also shared with Mozambique and Swaziland through the Lubombo Spatial Development Initiative.

The current malaria-control targets were expected to be sustained in 2009/10. These include maintaining a malaria case fatality rate of not more than 0,5%; sharing technical skills in malaria control with four countries, namely Botswana, Mozambique, Swaziland and Zimbabwe; conducting a formal review of the malaria-control programme; and assessing national epidemic preparation and response in line with international health regulations.

Measles

No measles outbreaks occurred in the country in 2008. However, there was a measles outbreak in 2009, particularly in Gauteng.

Cholera

A source of concern nationally was the increase in the number of confirmed cholera cases across the country, with the highest number of cases and deaths reported in Mpumalanga, Limpopo and Gauteng respectively.

By February 2009, about 8 100 cases had been confirmed countrywide, with about 51 deaths.

The national case fatality rate was 0,63%. Joint intervention between the national and provincial departments of health, as well as other departments such as home affairs, defence and water affairs, assisted in curbing the impact of cholera.

About 22% of health workers responsible for environmental health and communicable diseases were trained to prevent and respond to food-borne diseases in 2008.

H1N1 Influenza

In 2009, the H1N1 Influenza pandemic hit South Africa. The pandemic started in Mexico and the United States of America in April 2009 and rapidly spread to 166 countries globally with a cumulative number of 174 913 laboratory-confirmed cases and 1 411 confirmed deaths by August 2009.

By September 2009, the number of confirmed cases in South Africa had risen to 5 841, with 27 deaths reported.

On 6 July, the WHO described the spread of the pandemic within affected countries and to new countries as inevitable and largely unstoppable. Fortunately though, they noted that the virus was largely mild and not virulent at all. The WHO recommended that countries should take steps to mitigate the impact on communities.

The Department of Health took the following measures:

- Letters co-signed by the ministers of health, basic education and higher education and training were sent to all school principals, and rectors/principals of institutions of higher learning. These letters described the challenges and advised school principals on what action they needed to take.
- The Minister of Health also sent letters to leaders of all major faith groups, calling on religious leaders to share information on the virus with their congregations.
- Similar letters were also sent to organised labour and business, traditional healers, community development workers and social workers.
- The department also embarked on TV and radio campaigns to get the message across South Africa.
- Pamphlets and posters were distributed in local communities in local languages to create awareness.

Non-communicable diseases (NCDs)

A report on the National Burden of Disease (BoD), commissioned by the Department of Health, was completed in 2008/09.

The objectives of this report were to describe the pattern and distribution of diseases, disabilities and injuries seen in the public and private health facilities using the ICD10 classification system, and to describe the pattern and distribution of risk factors recorded for diseases, disabilities and deaths.

The report provided further evidence of the increasing contribution of NCDs to the BoD in South Africa. The report classified patients attending public health-sector facilities into broad groups of diagnosis.

Of the 1 486 089 sampled records of patients who attended PHC clinics in the public sector between 2002 and 2006, about 32,1% were found to have presented with NCDs. This was higher than the proportion of patients presenting with communicable diseases (24,2%) and those afflicted by injuries and trauma (11,4%).

The picture was slightly reversed when the records of hospital patients were reviewed, as 37,4% of patients were found to have presented with communicable diseases; 29,3% with NCDs; and 16,7% were affected by injuries and trauma. In summary, for both PHC clinic- and hospital-based patients, NCDs accounted for about 30% of broad patient diagnosis.

During 2008/09, the department implemented various measures to improve the management of NCDs. The department collaborated with five provinces, the Eastern Cape, Free State, Limpopo, North West and the Western Cape, to ensure that PHC facilities in these provinces adhered to national NCD-management guidelines.

Guidelines for the implementation of free healthcare for people with disabilities were also disseminated in all provinces.

The Department of Health continued implementing interventions to curb the impact of NCDs in 2009/10. Primary focus will be on diabetes and hypertension as proxy conditions, but effort will also be devoted to other chronic conditions.

The Diabetes Strategy is expected to be implemented jointly with other departments in the Government's Social Cluster.

The goals of the strategy include preventing diabetes and related NCDs, ensuring early diagnosis, improving quality of life of people living with diabetes, reducing morbidity and premature mortality and promoting research into NCDs.

The department will also implement the Long-Term Care Service Model to improve the management of NCDs in 35 districts in 2010/11.

To improve cancer reporting and provision of services, cancer-registration regulations were expected to be promulgated in 2009/10.

Mental healthcare services will also be improved, with a particular emphasis on the reduction of harmful use of alcohol. The national strategy to reduce the harmful use of alcohol will be implemented incrementally, starting with three provinces in 2009/10, and covering all nine provinces by March 2011/12.

Government introduced free health services for people with disabilities. Beneficiaries include people with permanent, moderate or severe disabilities and those who have been diagnosed with chronic irreversible psychiatric disabilities.

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

People with temporary disabilities or a chronic illness that do not cause a substantial loss of functional ability, and people with disabilities who

are employed and/or covered by relevant health insurance, are not entitled to these free services.

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

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

By the end of December 2008, the waiting period for a wheelchair in all nine provinces was eight weeks or more. During 2009/10, the department aimed to continue working with provinces to further reduce this waiting period.

Public-sector hospitals have been made more accessible to people with disabilities. Guidelines on the implementation of the National Rehabilitation Policy have been finalised, and the revision of the price list for orthotic prosthetic devices completed.

In supporting the health needs of the elderly, the department's policy is to keep the elderly in the community with their families as long as possible.

The department continues to develop national policy guidelines on the management and control of priority diseases or conditions of older persons, to improve their quality of life and access to healthcare services.

These include developing exercise posters and pamphlets, and guidelines that focus specifically on older persons, for example, national guidelines on falls in older persons, guidelines on active ageing, guidelines on stroke and transient ischemic attacks and national guidelines on osteoporosis.

Healthy lifestyles

During 2008/09, the department focused on three key areas of promoting healthy lifestyles, namely health-promoting schools, healthy nutrition and tobacco control, working in unison with other government departments such as the Department of Basic Education.

Health-promoting school guidelines were finalised and disseminated, and workshops on the implementation of the guidelines were conducted in the provinces.

This is consistent with the 2008/09 target. By the end of 2008/09, 4 100 schools were expected to become health-promoting schools. Food gardens were also established in 1 266 clinics.

National legislation to reduce tobacco use was implemented.

All health facilities, including private-sector health institutions (100%) are smoke-free areas. Tobacco-control policies were also implemented in schools, targeting the youth.

The department also used local media to communicate with the public on a diversity of health issues. Health messages focusing on breast, cervical and prostate cancer, mental health, World No Tobacco Day, World Health Day and the launch of two new child vaccines were covered in the print media.

Nutrition

During 2008/09, joint efforts of government departments to eradicate malnutrition among South African children, especially those under five years of age, continued to yield significant milestones.

The *Development Indicators, 2009*, published by The Presidency, indicated that severe malnutrition among children under five years of age decreased from 29 176 in 2006 to 26 373 in 2008.

About 78% of children aged 12 to 59 months were reached during the *Vitamin A Campaign* in September 2008. The 2008/09 targets were to provide Vitamin A supplementation to 100% of children aged six to 11 months; 35,7% of children aged 12 to 59 months; and 75% of post-partum mothers.

A total of 610 000 eligible people living with HIV, AIDS and TB received nutritional supplements, which exceeded the set target of 500 000.

During 2009/10, the Department of Health continued to improve the micronutrient status of children, women and the general population.

In 2009/10, 50% of children aged 12 to 60 months will be receiving two doses of Vitamin A. This figure is expected to increase to 80% by 2011/12.

The department aims to support all hospitals in the 18 priority districts (169 hospitals) to implement the WHO's 10 Steps to the Management of Severe Malnutrition.

The Department of Health plans to develop and implement the Integrated Food Production Strategy in collaboration with the departments of agriculture, forestry and fisheries; and of basic

education. This will be implemented in 18 priority districts in 2009/10, and will cover 25 districts by the end of the MTEF period.

Improving access to safe and affordable medicines

In 2009, the Department of Health continued with its efforts to improve access to safe and affordable medicines. The PHC Essential Drug List (EDL) and Standard Treatment Guidelines 2003 were reviewed to ensure their continued utility in PHC service delivery. The *EDL Book for Quaternary Services* was also reviewed.

A few challenges were experienced with drug supply in the first few months of 2008/09, but these were successfully resolved. With regard to TB drugs, the two contracted suppliers for Streptomycin, which are the sole suppliers of the registered product in South Africa, were unable to supply. However, the product was sourced internationally and successfully brought into the country through a Section 21 permit.

Moving into the 2009/10 MTEF period, the department aims to maintain a 0% stock-out rate of ARV medicines on tender (45 items) in all nine provinces. The department aims to ensure a 0% stock-out rate of TB drugs on tender (35 items) in all nine provinces. The Department of Health also aims to implement the Drug-Supply Management Information System to improve the monitoring of drug availability.

The process is expected to start with four provinces participating, with at least seven provinces using the system by the end of 2011/12.

Progress was also made with the licensing of pharmacies and dispensers that met the requirements.

A policy on African traditional medicine was published in the *Government Gazette* for public comments before 31 October 2008. The Research Colloquium on African Traditional Medicine was convened in September 2008.

During 2008/09, the Department of Health completed a benchmarking exercise that compared the prices of medicines and pharmaceutical products in South Africa against countries such as Australia, Canada, New Zealand and Spain, which have a similar regulatory framework for medicines. The principle of the benchmarking exercise was that South Africans should not pay more for medicines than citizens of countries with similar features. Based on the benchmarking results, the Medicine Pricing Committee finalised and submitted its recommendations on medicine prices to the minister in 2008.

The recommendations were published in the *Government Gazette* in August 2008, with a time frame of 30 days provided for stakeholders to respond. Implementation of these recommendations would potentially reduce medicine prices by 30%, resulting in a net saving of about R3 billion.

However, this process has several challenges, including resistance from the pharmaceutical industry. A process of resolving this was underway and was expected to be completed in 2009/10.

The efforts to reduce the prices of medicines are consistent with MDG Eight, which urges nations of the world to develop a global partnership for development. Target 17 of this goal implores countries to work in cooperation with pharmaceutical companies to provide access to affordable drugs in developing countries.

In 2009, the department was in the process of establishing the SAHPRA. The purpose of the SAHPRA is to improve the efficiency of medicines' regulatory processes and reduce the long time-lines for the registration of medicines. Under the SAHPRA, the department will regulate, among other things, complementary medicines, which are not well regulated and pose a serious public health risk.

It is the department's intention to regulate medical devices, in vitro medical diagnostic products, food with medical claims as well as African traditional medicines under the SAHPRA.

Toxicological aspects related to animal medicine residues will also be strengthened.

Health information, epidemiology, evaluation and research

Data comprehensiveness and reliability have improved steadily over recent years. Health information is being used across all provinces for management, developing various health plans and monitoring their implementation.

However, the use of information varies across the 52 districts. In the 2009/10 MTEF period, the department was expected to migrate from the existing system of manual submission of data from the DHIS by health facilities, to an electronic submission system. About 80% of facilities will be using this system by March 2012. Phase One of the Electronic Health Record for South Africa will also be implemented.

A national mid-term review of the Comprehensive Plan for HIV and AIDS was produced and disseminated. Monitoring of the Comprehensive Plan for HIV and AIDS was strengthened, with all nine provincial datasets being available. Continuous

capacity-building sessions continued to improve data quality and reporting.

In 2009/10, the department was expected to commence with the development of the country's 2008/09 report to the United Nations (UN) Assembly Session on AIDS. Consultation, data collation and production of the report will be completed.

A preliminary report on the BoD survey, commissioned by the department, was completed and shared with provincial departments of health. Furthermore, to harness the efforts of all provinces conducting BoD studies, a national BoD workshop was held in July 2008. The final report on the BoD survey will be presented to the Technical Committee of the National Health Council.

In 2008/09, Statistics South Africa (Stats SA) agreed on a joint process of improving the quality of health information. Health-sector officials participated in data-quality assessment workshops conducted by Stats SA.

A link to the DHIS dataset was also created for Stats SA. Furthermore, officials from Stats SA participated in capacity-building sessions for monitoring and evaluation officers responsible for tracking progress of the Comprehensive Plan for HIV and AIDS. This collaboration will continue over the next MTEF period, and will assist to generate reliable data for health-service planning and monitoring.

Improving quality of care

During 2008/09, the Department of Health began to develop and implement a quality-assurance programme, focusing on the functioning of individual health facilities.

A policy framework for establishing national core standards for health facilities and a system for ensuring compliance were developed.

The department published the National Core Standards in April 2008, which covered seven domains, namely patient safety, clinical care, governance and management, patient experience of care, access to care, infrastructure and environment, and public health.

Appraisals of 27 priority hospitals were conducted by national teams between June and August 2008, and the results informed the development of the health-facility improvement plans of each hospital. By the end of September 2008, facility-improvement plans had been developed for 25 hospitals.

Supportive facilitation was provided to these facilities by the national and provincial departments of health as well as health districts.

The nature of the support provided aimed at assisting facilities to focus on achieving results to turn around specific problems in the short term, thus building their capacity to improve quality in the long term.

Many public health-sector institutions assessed during this process were found to be performing well. However, communication of their best practices was limited and needed expansion.

Key constraints identified included patient waiting times, referral pathways and management, maintenance of facilities and utilities, communication of best practices, medical-waste management, implementation of infection prevention and control policies and lack of formal systems to measure and prevent adverse events.

These are expected to be addressed over the 2009/10 MTEF period. The provincial departments of health continue to provide support and increase the number of facilities involved in this quality-assurance initiative. The national department continues to improve leadership, planning, standard-setting and monitoring.

The National Colloquium on Quality was held in November 2008 with stakeholders from all sectors of the health services, both private and public sectors as well as regulatory bodies, professional associations, organised labour, academics and non-governmental organisations (NGOs).

As an outcome of this colloquium, a concerted move towards the National Quality-Improvement Programme and the institutional arrangements aimed at underpinning its implementation was expected to be realised in 2009/10.

Initial concrete steps are expected to be achieving consensus across the health system on standards and indicators for quality and building the contributions of all partners into short- and medium-term action plans to improve quality through quality-improvement projects.

Over the next planning cycle, the Department of Health aims to produce national organisational standards, norms and clinical guidelines. By the end of March 2010, the department would have benchmarked the performance of 54 facilities (out of 4 029) in the public and private sectors against the set of national standards. By the end of the MTEF period, 1 610 facilities would have been benchmarked.

About 100 public-sector facilities are expected to be supported to implement quality-improvement projects, including infection-prevention and -control plans by March 2010.

By the end of the MTEF period, 1 500 public-sector facilities would have produced these plans.

The Department of Health aims to establish a system of call centres to ensure that patients and users of healthcare services have access and are able to raise their concerns. This will also enhance capacity for independent review by means of an ombudsperson.

Human resources

Steady progress was made with the introduction of various categories of mid-level workers in 2008/09. A total of 23 students were enrolled at the Walter Sisulu University in the Eastern Cape in January 2008 for the Clinical Associates Programme.

Key milestones were also achieved in the planning process for the implementation of the Clinical Associate Programme at the University of Pretoria and the University of the Witwatersrand in 2009. The target was to enrol 36 students nationwide as part of the first pilot programme.

Three provincial colleges for EMS and the South African Military Health Services implemented the Emergency Medical Technician Programme. A draft scope of practice for these technicians was produced.

The scope of practice and qualifications for radiography technicians were reviewed in 2008/09. The Pharmacist Technician Scope of Practice was also completed. The department also initiated negotiations with the HPCSA regarding the approval of forensic-pathology officer qualifications.

The department reviewed the implementation of the Community Caregiver (CCG) Policy by provinces through visits and national workshops. By the end of 2008/09, the existing CCG Framework was expected to have been revised.

The allocation of newly qualified health professionals for community service was also completed for doctors, pharmacists, dentists and allied health professionals.

An impact assessment of the South Africa-Cuban Medical Training Programme was also completed and a report produced.

To strengthen oversight of health professionals, the South African Dental Technicians Council and the SANC were inaugurated by the Minister of Health on 27 June 2008 and 10 July 2008, respectively.

During 2008/09, the department continued with the implementation of the Occupation Specific Dispensation (OSD). Discrepancies in the implementation of this policy were identified in collaboration with the provincial departments of health, which in many instances consisted of



The Port Health Service is responsible for the prevention of quarantinable diseases in the country as determined by the International Health Regulations Act, 1974 (Act 28 of 1974). These services are rendered at sanitary airports (OR Tambo, Cape Town and Durban international airports) and approved ports. An aircraft entering South Africa from an epidemic yellow-fever area must make its first landing at a sanitary airport. 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.

overpayment of nurses. The Office of the Auditor-General assisted in this process by conducting audits of the implementation of the OSD. In 2009/10, the department aimed to continue working with provinces to monitor the outcome of the OSD.

Regular reports will be submitted to the technical and policy committees of the National Health Council on outcomes of audits to inform decision-making regarding the recovery of over-remuneration.

Another key priority for the 2009 to 2012 planning cycle is the implementation of the OSD for doctors, dentists, pharmacists and EMS personnel.

International relations

During 2008/09, the Department of Health strengthened its bilateral, trilateral and multilateral relations with numerous African countries, including Namibia, Cameroon, Guinea Bissau, Mali, Malawi and Zambia.

In June 2008, a surgical team from South Africa visited Namibia and conducted nine open-heart surgical procedures at Windhoek Central Hospital, which were the first of their kind. South Africa signed the Agreement on Health Matters with Namibia in August 2008 in Windhoek. With the support of medical specialists from South Africa, the Namibian Cardiac Unit at Windhoek Central Hospital was officially opened in August 2008.

A team of Namibian experts also participated in an MDR-TB and XDR-TB workshop in South Africa in September 2008.

South Africa also signed the Agreement on Health Matters with Cameroon in September 2008 during a WHO-Regional Office for Africa meeting in that country.

The Department of Health provided support to countries involved in post-conflict reconstruction. The Agreement on Health Matters between South Africa and Burundi was signed in September 2008 in Bujumbura, Burundi. A draft programme of action for the implementation of this agreement was also developed. An agreement with Sudan on health matters was finalised. The Department of Health, together with the SANC, visited the DRC in August 2008 to assist in establishing the Congo Nursing Council.

In September 2008, health officials from the DRC participated in workshops in South Africa, focusing on diverse health issues, including maternal; women; child's health and nutrition; management of MDR-TB and XDR-TB; the establishment of national core standards for health facilities; and malaria control.

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