

## **CHAPTER ONE: VISION, MISSION AND SITUATION ANALYSIS**

### **1. VISION**

The vision of the national Department of Health is to play a role in securing a caring and humane society in which all South Africans have access to affordable and good quality health care.

### **2. MISSION**

The mission of the Department is to build on our achievements attained between 1994 and 1999 in improving access to health care for all and to focus on reducing inequities in health care, improving the quality of care provided at all levels of the health care system with increases in the efficiency of service delivery.

### **3. SITUATION ANALYSIS**

A detailed situation analysis is outside the scope of this document. Selected areas will be reviewed briefly.

### 3.1 Demography

Census figures for 2001 reflect a shift in the demography of the country. The country's population grew from 40,58 million in 1996 to 44,82 million in 2001.

Table: Population by province, 1996 and 2001 (StatsSA, Census in Brief, 2001)

Province	1996	2001	% growth
EC	6 302 525	6 436 763	2.1
FS	2 633 504	2 706 775	2.8
GP	6 348 423	8 837 178	20.3
KZN	8 417 021	9 426 017	12.0
LP	4 929 368	5 273 642	7.0
MP	2 800 711	3 122 990	11.5
NC	840 321	822 727	-2.1
NW	3 354 825	3 669 349	9.4
WC	3 956 875	4 524 335	14.3
SA	40 583 573	44 819 778	10.4

The most populous provinces according to the 2001 Census are KwaZulu-Natal (9.4m), Gauteng (8.8m) and Eastern Cape Province (6.4m). The largest increase in population growth is seen in Gauteng (20.3%) followed by the Western Cape (14.3%). The more rural provinces of Eastern Cape and the Free State showed much lower growth rates of 2.1 and 2.8% respectively. The only province with a negative growth is the Northern Cape (-2.1%). These figures suggest significant internal migration from the more rural provinces to the more urban provinces.

Census 2001 also revealed that 4,4 million of the population was under the age of 5 years whilst 9,8 million were between 5 and 14 years and 9,4 million were aged between 15 and 24. This implies that more than 23 million people are below

25 years of age. In addition the total number of disabled numbered 2,26 million or 5% of the population.

Census 2001 data on disability may be useful for identifying areas of critical need in terms of disability and planning of services to address this need. According to Census 2001 a total of 5% of all South Africans were reported to have disabilities. The most commonly reported disabilities were sight (577 096), physical (557 512), hearing (313 585), emotional (268 713), multiple (257 170), intellectual (206 451) and communication (75 454).

A significant 4.57 million people aged 20 years and older have no formal schooling with an additional 4,1 million having some primary school education. In Limpopo province about a third of the population aged 20 years and older have not received any formal education. More than 8 million South Africans may not be able to benefit from health promotion material that is designed for the more educated population.

According to the Labour Force Survey (2001) 16,5% of the working age population was not employed whilst 43,9% of the population was considered to be economically inactive. The Survey estimated 39,6% of the population to be employed.

About 45% of households still rely on wood, paraffin and coal as the source of energy for cooking. However, about 7 out of 10 households use electricity for lighting.

National 84,5% of households have access to piped water, the lowest access being in the Eastern Cape where only 62,4% of households have access. More than 95% of households in the Free State, Northern Cape, Gauteng and the Western Cape have access to piped water.

One and a half million out of eleven million households (13,6%) had no toilet in 2001 according to the census. Provinces with the highest percentage of households with no toilets are the Eastern Cape, Limpopo and KwaZulu-Natal. These three provinces also have the most number of households with no refuse collection service.

Census 2001 provides a picture of population shifts and clearly indicates those provinces that are least development in terms of levels of education, unemployment rates and infrastructure. These factors, that is level of education of the population, poverty and access to housing and proper sanitation are key determinants of health. This implies the critical importance of an intersectoral approach to the delivery of services especially to the most vulnerable.

## **3.2 Epidemiology and health status**

### **3.2.1 Child Health**

According to recent (August 2003) data, the national immunisation coverage is at 74%. This is an improvement from the 63,4% coverage found in the South African Demographic Health Survey (SADHS) conducted in 1998.

Mpumalanga and Gauteng experienced measles outbreak between September and October 2003. Positive measles laboratory confirmation cases, received by mid October 2003 included 30 from Mpumalanga and 104 from Gauteng. Given good clinical management no deaths associated with measles were reported since 1999. A measles outbreak strategy has been developed and activated. All provinces have been alerted to step up their surveillance.

The last case of wild poliovirus was reported in 1989. The surveillance of Acute Flaccid Paralysis (AFP) has improved significantly. South Africa is expected to detect 156 cases of AFP per year and by November 2003 208 cases were detected for the year, without all provinces reaching the target of 1 case per 100 000 children younger than 15 years of age. The stool adequacy is 80% and by November 2003 South African achieved an adequacy of 86%.

South Africa was declared to have eliminated neonatal tetanus in 2002. Neonatal Tetanus (NNT) surveillance is maintained to ensure elimination status annually. During 2003 two NNT cases were reported.

It is estimated that 150 000 of children born annually are affected by a significant birth defect or genetic disorder by the age of five years. In order to detect a 15% decrease in the prevalence of neural tube defects (NTDs), 263 000 births have to be monitored before and after the introduction of food fortification. To date 173 000 births have been monitored and 229 cases of NTDs have been notified.

Intestinal and respiratory infections, perinatal conditions, unnatural causes, HIV and AIDS are the leading causes of death among children aged 0-14 years.. The Integrated Management of Childhood Illness (IMCI) is a key strategy to reduce infant and child mortality. All three components of IMCI (i.e, case management, improvement of the health system, and household/community care components) are being implemented in South Africa. Thus far, approximately 5000 nurses have been trained in IMCI and more than 1 200 primary health care facilities have at least 1 person trained in IMCI. Since the implementation of the IMCI strategy the frequency of counselling by nurses has increased from 20% to 50% and drug misuse has decreased by 85%. Whilst these are impressive results, expansion of IMCI is slow due to lack of resources (financial, human and material in the form of transport) and the lack of a dedicated budget for child health.

### **3.2.2 Youth and Adolescent Health**

Young people are particularly vulnerable to HIV/AIDS and STDs, sexual and physical abuse, alcohol and substance abuse, early sexual intercourse, unplanned pregnancies and unprotected sexual activities, intentional and unintentional injuries and other high-risk behaviours. Many youth experience difficulties in accessing health information and services.

Many young people have their first sexual experience during their teenage years. Amongst sexual active youth aged 15-24 years old the age of sexual debut is 16 (Nelson Mandela Household Survey Human Science Research Council Report 2002). In this survey about 54% of young women aged 15-19 reported never having sex. Rural women reported earlier first sexual experiences compared to urban women. Young persons who begin sexual activity at a very early age are more susceptible to sexually transmitted infections and unplanned pregnancy.

Reducing HIV prevalence among young people aged 15-24 years is critical in the fight to eradicate HIV infection. The prevalence of HIV among adolescents aged below 20 years increased from 1.79% in 1991 to 15.4% in 1998 (SADHS, 1998). However, prevalence rates declined to 16.5% in 1999, thereafter stabilising to 16.1% in 2000 and 14.8% in 2001.

Although teenage pregnancy is thought to have continued to escalate, recent information about adolescent fertility shows that the birth rate for teenagers of 15-19 years has decreased from 116 per 1000 in mid 1998 to 78 births per 1000 women by mid 1996 (SAHR 2000). However, these figures are still considered high and in need of intervention.

According to the Antenatal HIV Seroprevalence Survey conducted by the Department of Health 15,4% of those attending ANC clinics in 2001 were under 20 years of age whilst 28,4% were between 20 and 24, whilst the figures for 2002 were 14,8% and 29,1 respectively.

There are approximately 68 health facilities in the country where the adolescent friendly clinic initiative has been introduced and implemented. However, national targets have not been met because of staff shortages. Peer educators and groundbreakers are utilised to popularise the youth friendly health services. The Planned Parenthood Association of South Africa is running twenty-seven youth centres. At provincial level, staff turnover is a major problem. In addition, the lack of appropriate physical infrastructure is a barrier to the effective implementation of youth friendly services.

School health services are not functional in many parts of the country. A school health policy has been approved by MINMEC. School Health Policy and

Implementation Guidelines have been launched in July 2003 and have been disseminated in all provinces.

Intentional and non-intentional injury are also major causes of morbidity and mortality among young people. The Life Skills programme, which is implemented in collaboration with the Department of Education, addresses this aspect of young people's experiences.

### **3.2.3 HIV and Sexually Transmitted Infections**

According to the 2002 Antenatal HIV Seroprevalence Survey, 26.5% of pregnant women who attended public health services were HIV positive in 2002. Although this estimate of prevalence is higher than the 24.8% reported in 2001, this increase is not statistically significant.

In 2002 KwaZulu-Natal recorded the highest HIV prevalence rate (36.5%). This is higher than the 33.5% recorded in 2001. Gauteng (31.6%) had the second highest prevalence rate in 2002 followed by the Free State (28.8%), Mpumalanga (28.6%), North West (26.2%), Eastern Cape (23.6%), Limpopo (15.6%), Northern Cape (15.1%) and the Western Cape (12.4%).

The increases observed in KwaZulu-Natal, Gauteng, North West, Eastern Cape and Limpopo were not statistically significant as were the decreases in the three provinces that showed a decline in prevalence. The increase in the Western Cape, although real could be attributed to sampling variations and should be closely monitored in the coming years.

Women aged between 25 and 29 years continue to be the most affected age group with an estimated 34.5% being HIV positive. Women in the age group 30-34 years follow with a 29.5% prevalence rate and those aged between 20 and 24 with 29.1%).

The increases in HIV prevalence between 2001 and 2002 in the age groups 25-29 and 30 and 34 years were statistically significant as were the increases in the 40+ age group. The good news is that the lower prevalence rates found in 2001 in those aged 20 and younger was again found in the 2002 survey.

Based on results of the 2002 antenatal survey it is estimated that 5.3 million South Africans were HIV positive by the end of 2002. This is higher than the 4.74 million estimated to be positive in 2001. It is also estimated that 91 271 babies became infected with HIV through mother-to-child transmission.

It is encouraging that HIV prevalence among teenagers has not increased for the fourth consecutive year. However, the increase in HIV prevalence in older

women (particularly those in their twenties) might be an indication that infection is simply delayed and not avoided. This calls for prevention to be sustained beyond the youth category that has largely been the target population of prevention programmes to date.

The survey also found that an estimated 3.2% of pregnant women attending antenatal care in the public sector had active syphilis. This is higher than the 2.8% found in 2001. The province with the highest rate was Gauteng (6.0%) followed by the Northern Cape (5.2%) and the Free State (5.0%). The remaining provinces recorded rates below 3.5% with KwaZulu-Natal with the lowest at 1.5%.

The highest syphilis prevalence rate in 2002 was recorded among women aged 24-29 years (3.7%). As with HIV prevalence among women aged below 20 years, syphilis rates showed a decline in this age group over the past four years.

There is good reason to believe that the STI control programme is working well despite the small increase in the rate between 2001 and 2002. It should be noted that the rate in 1998 was 9% as opposed to the 3.2% in 2002.

A process to roll out STI Surveillance to the 8 provinces has commenced. The current system in the 8 provinces provides limited data on STIs i.e. only data on male urethral discharge from the District Health Information System is currently

available on a monthly basis. Other data on STIs is provided by the annual Antenatal Survey, which gives an indication of syphilis prevalence among pregnant women.

Gauteng has implemented a surveillance system for STIs. Data from the STD reference centre have confirmed for other STIs the trend seen in syphilis in Gauteng. However, the challenge remains to see to what extent this is true in other provinces and for the private health sector, which provides services to most of the STI patients in the country. A second challenge is to improve the quality of STI care offered in the private health sector.

Since the start of this programme in late 2000, VCT services have been established in 2000 sites nationwide. This represents an increase of more than 1000 new sites since January 2003. The challenge remains, however, that in some of the facilities where this service is offered the uptake is still very low.

The research programme on the implementation of the prevention of mother-to-child HIV transmission has yielded information that is being fed into the expansion of the programme in all facilities. Provinces have been provided with guidelines for the implementation of the PMTCT package and additional funds

have been identified for this. KwaZulu-Natal, Gauteng, North West and Western Cape Provinces have extended coverage to a significant number of health institutions and other provinces are in the process of increasing coverage.

In 2002/3 the Department of Health purchased and distributed 2,5 million female condoms at a cost of R18,5 million. This is up from the 1,3 million purchased and distributed in the previous financial year. In addition, the number of sites at which female condoms are distributed have increased to 200 from 114 in the previous financial year. The male condom programme is much larger and the Department purchased and distributed 358 million male condoms at a cost of R104 million in 2002/2003. This is up from the 267 million condoms purchased and distributed in the 2001/02 financial year. In the 2003/04 provision was made to purchase 360 million male condoms and 900 000 female condoms.

### **3.2.4 Tuberculosis**

TB is the 3<sup>rd</sup> leading cause of death - accounting for 8% of deaths nationally. It was the 2<sup>nd</sup> and 5<sup>th</sup> leading cause of death among males and females respectively in the period 1997-2001.

According to the National TB Control Programme (NTCP), the reported incidence of all TB cases for 2002 was 494 per 100,000 population. In terms of cases

notified, this translates to more than 224,420 total TB cases. A total of 182,583 patients had pulmonary (lung) TB, of which 98,800 were new smear positives (infectious).

The Directly Observed Treatment, Short Course (DOTS) strategy is now implemented in 52 out of the 53 health districts (98% coverage) and the main challenge is to ensure the quality of DOTS. Some health districts, which initially performed well have decreased their performance because of insufficient human resources at health district and provincial levels to supervise and monitor implementation at district level. The national Department of Health has now identified 3 provinces as priority provinces for support to poorly performing health districts.

Provincial plans have been developed for the 2003/4 year and implementation is underway. All provinces have endorsed the TB Medium Term Development Plan 2002 – 2005 and are already implementing their plans.

Access to laboratory services remains a major challenge in the remote areas of the country with the most affected provinces being Eastern Cape, Limpopo and Mpumalanga. The turn around time in these areas varies from 2 – 14 days, which makes it unacceptable for a service that is a cornerstone of the programme. The bacteriological coverage is improving in most provinces, which shows that most patients are diagnosed using smear microscopy.

There has been no interruption of TB drug supplies reported nationally. The new adult TB drug regimen was introduced in January 2004, the increasing number of TB patients who are HIV positive or already have AIDS necessitated this change. Training programmes are being conducted for healthcare workers on the new TB drug regimen.

The interruption rate still remains high (12%) despite efforts to support patients throughout the treatment period. The NTCP has launched the Advocacy and Social Mobilisation Plan to increase community awareness and educate patients and families about the disease, increase the stakeholder base and get other partners involved in TB control activities. This Plan is currently implemented in five provinces – Eastern Cape, Limpopo, Free State, Western Cape and Gauteng.

Referral systems from the hospitals to clinics to communities are poor and therefore follow-up of patients is a challenge and in some areas made impossible by lack of means to trace defaulters i.e. telephones and transport. Each facility has been assisted to map out the flow of patients in their areas and the community structures available to support patients as well as their location. The DOT supporters, many of whom are volunteers, leave the programme for other programmes that pay stipends and this has resulted in the decision to train community health workers and home-based care workers so that they can take care of patients with a range of health problems. NGOs involved in the TB control

programme have for the first time accessed funding from the NTCP to broaden their activities in the communities they are working in.

To improve case detection in the facilities the TB suspect register has been implemented in all districts. All HIV positive patients are screened and tested for TB and all TB patients offered VCT in health districts that are implementing TB/HIV collaborative activities. All co-infected patients are offered a package of care comprising preventive therapy, early diagnosis and treatment of other opportunistic infections and ongoing psycho-social support. There are currently 40 districts implementing collaborative TB/HIV activities and these activities need to be rolled out.

Care of TB patients in public and NGO hospitals has been reviewed and admission and discharge criteria developed. The service level agreements for the SANTA and Lifecare hospitals have been developed but to date only one province (Eastern Cape) has signed an agreement with the SANTA hospitals. The forensic audit of the SANTA hospitals has been completed in Eastern Cape and KwaZulu-Natal and have been initiated in Mpumalanga and Gauteng.

The critical findings of the review referred to above (provincial district and NGO run TB hospitals) included:

- Patients continue to be diagnosed on X-ray findings – sputum not done

- Management of patients not optimal – no proper follow up in NGO hospitals by medical officers who are sessional in most cases.
- Poor referral systems between facilities therefore patients lost.
- There were no admission and discharge criteria for most hospitals
- Pulmonary TB patients admitted in general medical wards mixed with other patients who might be HIV positive.
- Lack of infection control measures in most hospitals
- High number of deaths from TB in the hospitals
- No TB registers in most district hospitals therefore patients who are diagnosed or die in the hospitals are not recorded in the TB register.

Recommendations were compiled for each hospital that was reviewed and provided to district and provincial personnel. The national Department undertakes 6 monthly support visits to provinces to monitor progress.

The reporting and recording system has been strengthened through the introduction of the electronic TB register. The register has been implemented in 7 of the 9 provinces and is used as a programme management tool at health district/sub-district level.

A training plan has to be developed for healthcare workers, supervisors and district managers. In order to deal with the high turn over rate of staff a train-the-trainer programme will be implemented in 2004/5.

The MDR-TB guidelines have been updated and the DOTS PLUS programme has been implemented in all provinces. This programme will also monitor the treatment outcomes of MDR-TB patients.

### 3.2.5 Cholera

The last case from KwaZulu-Natal was reported on 5 November 2003. The Eastern Cape, which was worst affected this year, reported its last case on 19 June 2003. Mpumalanga also had an outbreak with 148 cases and 7 deaths reported. The total number of cases reported from January to 5 December 2003 was 3 855 with 44 deaths. The nation-wide case fatality rate was 1.14%. Of concern is the high case fatality rate in Mpumalanga (4.73%). There are many reasons for the high fatality rate in Mpumalanga among which are: (a) late presentation to a health facility; and (b) immunosuppression.

**Table: Cholera in South Africa for 2003 [as on 05.12.2003]**

<b>Province</b>	<b>Cumulative Cases</b>	<b>Cumulative Deaths</b>	<b>Case Fatality Rate [%]</b>
<b>Eastern Cape</b>	3 142	37	1.18%
<b>Free State</b>	0	0	0.00%
<b>Gauteng</b>	4	0	0.00%

<b>KwaZulu-Natal</b>	560	0	0.00%
<b>Limpopo</b>	0	0	0.00%
<b>Mpumalanga</b>	148	7	4.73%
<b>Northern Cape</b>	0	0	0.00%
<b>North West</b>	0	0	0.00%
<b>Western Cape</b>	1	0	0.00%
<b>TOTAL</b>	3 855	44	1.14%

### **3.2.6. Malaria**

The total number of malaria cases and case fatality for the period 2002-2003 is shown in the table below. As can be seen three provinces bear the burden of cases and deaths from malaria, viz., KwaZulu-Natal, Limpopo and Mpumalanga. For all three provinces total number of cases have been decreasing over the three-year period and the case fatality rate has been consistently under 1%.

A range of activities with SADC member states were engaged in during 2003. These included: the Rally Against Malaria across Southern Africa which culminated in a rally in Tanzania in April 2003; established links/collaboration with SADC Military Health Services to assist in emergency response in the region; a joint Plan of Action for the smooth transition of malaria control from SADC Health from Pretoria-SA to Gabarone-Botswana has been prepared; strengthened collaboration with World Health Organisation Southern African Malaria Control (WHO-SAMC); development and submission of SADC regional

malaria proposal to the Global Fund; secured \$22,5m from the Global fund for the Lebombo Spatial Development Initiative malaria project; SADC Malaria Day celebrated in RSA in the Limpopo province in Musina; and organized a successful malaria conference, with the following key outputs; malaria policy issues discussed and information shared; malaria surveillance issues strengthened through a workshop and participation of local, SADC countries and WHO.

Within the country the Department drafted an Insecticide Treated Net policy. In addition, workshops were conducted to train provincial and local health workers on a range of issues including: malaria case management; laboratory diagnosis, malaria advocacy and IEC, and malaria information systems. The overall aim was to strengthen capacity the provincial and District levels.

In 1996, South Africa discontinued use of DDT and alternatives like pyrethroids were used for indoor residual house spraying. However, during 2000 South Africa experienced a malaria outbreak with malaria cases peaking at 64 622 and malaria deaths at 458. Insecticide resistance to pyrethroids was detected and a change in malaria policy resulted in the re-introduction of the use of DDT in KwaZulu-Natal during the 2000/2001 malaria season and later in Limpopo and Mpumalanga. The Department of Health is committed to the responsible handling of DDT which is only applied to the inside walls of dwellings with no DDT being released in the environment. The reintroduction of the use of DDT

together with other measures resulted in a 79% decrease in the number of malaria cases and a 75% decrease in the number of malaria deaths have been reported since the 2000 outbreak.

**Table: Malaria cases and case fatality, 2000 - 2003**

	2000		2001		2002		2003	
	Cases	Deaths (CF%)	Cases	Deaths (CF%)	Cases	Deaths (CF%)	Cases	Deaths (CF%)
KZN	41786	340 (0.8)	9473	47 (0.5)	2345	16 (0.7)	1981	1 (0.05)
LP	9487	68 (0.7)	7197	61 (0.8)	4836	44 (0.9)	5822	75 (1.30)
MP	12390	45 (0.4)	9061	6 (0.1)	7965	29 (0.4)	3838	15 (0.40)
REST OF SA	959	5 (0.5)	775	5 (0.6)	473	7 (1.5)	35	0 (0.00)
TOTAL	64622	458 (0.7)	26506	119 (0.4)	15619	96 (0.6)	11676	91 (0.8)

### 3.2.7 Nutrition

Food fortification is a major national priority and regulations to legislate mandatory fortification of bread flour and maize flour with specific minerals (zinc and iron) and

vitamins (vitamin A, riboflavin, thiamin, vitamin B<sub>6</sub>, niacin and folic acid) to improve the micronutrient status of the population came into effect on 7 October 2003. Educational and promotional aspects have begun in February 2003 with full implementation by the end of 2003. The programme was formally launched by the Minister on April 1, 2003.

Vitamin A supplementation for children 6-60 months and women 6 weeks post-partum is ongoing and coverage will be monitored through the SADHS in 2003. Through the social sector cluster, partnerships have been developed with the Department of Agriculture and the CSIR for the development of vitamin A rich indigenous foods.

The Baby-Friendly Hospital Initiative has resulted in 94 out of 480 maternity units being declared as baby friendly by September 2003. The rate at which the programme is being implemented differs in provinces. Gauteng and North West have slowly caught up, while KwaZulu-Natal and Limpopo are leading in the number of BFHI maternity facilities. Provinces which are largely urban such as Western Cape and Gauteng have greater challenges with promoting and protecting breastfeeding than the mainly rural provinces. Breastfeeding rates are known to be low in urban areas. In addition to that, some facilities use session doctors and specialists on a part-time basis, which make training and re-orientation very difficult.

The training of health workers on HIV and infant feeding is ongoing. The biggest problem is the challenge posed by the provision of free infant formula to mothers on the PMTCT programme. A draft infant feeding guideline is being developed jointly by the Nutrition and Child Health Directorates and will be available by the end of the 2003/04 financial year.

The draft Regulations relating to Foodstuffs for Infants and Young Children were published on 26 September 2003 for public comment. Once promulgated it will go a long way to promote, protect and support breastfeeding.

In May 2003 the Food-based Dietary Guidelines for Healthy South Africans Seven Years and Older was approved. These guidelines will form the basis of all future nutrition education material to promote healthy eating.

The Primary School Nutrition Programme (PSNP) will be transferred to the Department of Education in the 2004/05 financial year. The Department of Health is working closely with the Department of Education to ensure a smooth transition during 2003/04. Every effort will be made to ensure that the targets set, in terms of number of beneficiaries and number of feeding days will be maintained during and post the transition. However, it should be noted that the Integrated Nutrition Programme will still be co-ordinated by the Department of Health.

**Table: Number of learners reached, 1994/5 - 2003/04**

FINANCIAL YEAR	NUMBER OF SCHOOLS			NUMBER OF LEARNERS		
	TARGETED	REACHED	% COVERAGE	TARGETED	REACHED	% COVERAGE
1994/95	15 911	13 167	83	6 293 626	5 628 320	89
1995/96	20 110	15 894	79	6 877 175	5 567 644	81
1996/97	17 025	13 061	77	6 075 356	4 880 266	80
1997/98	17 945	14 549	81	6 024 773	5 021 575	83
1998/99	17 500	15 776	90	5 574 305	4 830 098	87
1999/00	16 087	15 428	96	5 422 204	4 719 489	87
2000/01	16 087	15 428	96	5 422 204	4 719 489	87
2001/02	16 000	14 667	91	5 400 000	4 700 000	87
2002/03	16 441	15 653	95	4 830 600	4 595 452	95

The Department has initiated a programme to provide nutrition supplementation for people with TB, HIV and AIDS, and other chronic debilitating diseases. The objectives of this programme include to: increase macro-nutrients and micro-nutrient intake and maintain body weight and strength; reduce micro-nutrient depletion; improve functioning of the immune system and the body's ability to fight infection; extend the period from infection to the development of AIDS; and improve response to treatment. The nutrition supplementation strategy is therefore a major component of the Comprehensive HIV and AIDS Care, Management and Treatment plan and is linked to initiatives of other government departments that are aimed at addressing household food insecurity and poverty.

### **3.3 Human Resources, Management, Equipment and Infrastructure**

A recently completed audit of health facilities in the 8 urban renewal nodes (Mitchells Plain, Khayaleshisa, Mdansane, Motherwell, Alexandra, Inanda, Kwa-

Mashu, Galeshewe) commissioned by the national Department of Health found that whilst on average facilities were in relatively good condition there were a number of gaps in supervision, availability of doctors, equipment and infrastructure. The gaps included: about half the facilities surveyed did not get written feedback from supervisors in the last three months; four of the eight facilities did not have copies of major policy documents and protocols; there was limited IEC material in locally spoken languages in most facilities; lack of full time doctors in the 2 urban nodes in the Eastern Cape province; uniform lack of pharmacists though pharmacy assistants were found in some facilities; lack of essential equipment like examination lights and diagnostics sets in many facilities; lack of a functional stock card system for management of drugs and supplies in 5 of the 8 nodes; and lack of adequately trained staff in maternal and child health in some facilities.

Provinces have been provided with feedback and have undertaken to ensure that these gaps are filled. Planning to fill gaps will become part of the district health planning and reporting system which is being institutionalised in all provinces.

The national Department with assistance from the Health Systems Trust is in the process of completing a national survey of all PHC facilities. Unfortunately the results of the survey are not available at the time of drafting of this plan. The results will be used to improve services at facility level once it becomes available.

A National Human Resource Plan (also known as the Pick Report) has been drafted and key aspects implemented. In addition, community service has been extended to almost all categories of health workers since it was initiated for doctors. The next category to be included would be nurses in 2005. In an effort to increase the pool of professionals and in line with the recommendations of the Pick Report is the development of a mid-level health worker cadre. Pharmacy assistants have been trained and deployed to counter the shortage of pharmacists in the public health sector. Other categories including medicine and nursing are also considering the development of mid-level workers.

Another strategy to extend the work of health professionals is the decision to extend and strengthen the community health worker cadre. They are the community members trained to be the link between families and communities with the public health system.

In an effort to recruit and retain scarce skills and health professionals in rural areas, a scarce skills and rural allowance has been agreed with organised labour and will be implemented in 2004 (backdated to July 2003). It is hoped that this incentive to work in rural areas and in the public sector will assist in increasing the number of health workers providing services in the public health sector.

### **3.4 Pharmaceuticals**

The overall goal of the National Drug Policy (NDP) is to ensure access to safe, cost-effective and affordable quality medicines for all citizens. The appropriate management of medicines has been identified as a critical component of health service delivery. The Essential Drugs Programme (EDP) has been identified as one of the vehicles to implement the NDP.

A series of strategies have been implemented in 2002/03 to strengthen the EDP. The Medicines and related Substances Control Amendment Act, 1997 (act 90 of 1997) was proclaimed on 2 May 2003. This Act provides for the establishment of a Pricing Committee which was established in July 2003. The role of the Pricing Committee is to monitor the price of medicines and to advise the Minister on how to ensure access to quality medicines at an affordable price.

To support the work required to implement the Act a new unit for pharmaceutical economical evaluations was established in April 2003. Staff for the unit is being hired to ensure that the unit is fully functional. The directorate will be responsible for:

- The establishment and management and continuous update of a database with all the relevant pharmaceutical information to be utilised for the technical activities related to transparent pricing, single exit price,

wholesale and distribution fee, dispensing fee for medicines and related matters;

- Establishment of a functional pharmaco-economics evaluation unit;
- Supervision and conduct of operational research on relevant topics pertaining to drug pricing;
- Provision of advice and information to the National Essential Drugs List Committee and the Provincial Therapeutic Committees on pharmaco-economics related issues; and
- To serve as a secretariat for the Pricing Committee

To evaluate the supply, distribution and use of pharmaceuticals a survey was conducted early in 2003. The positive findings included: (a) the EDP was widely implemented with 86% of EDL drugs found in facilities and 90% of medicines prescribed from the EDL and 97% of facilities having copies of the EDL/STG booklets compared to 59% in previous surveys; (b) 75% of facilities recorded vaccine fridge temperatures twice daily, a considerable improvement from the 25% found in the baseline surveys of 1996 and 1998; (c) 83% of facilities have a dedicated dispensary compared to 56% in the baseline surveys; (d) injections were prescribed to 5% of patients compared to 11% in the baseline; (e) 88% of patients knew how to take their medication; and (f) 81% of patients asked reported to be satisfied with the care that they received.

However the 2003 survey also found challenges that remained to be addressed.

These included:

- Financial management and accountability needed improvement;
- 20% of facilities had no stock control system in place;
- 50% of stock records were inaccurate;
- 53% of facilities had no secure delivery area and many facilities did not adequately secure schedule 5 drugs;
- 11% of facilities did not have an intact cold chain; and
- 21% of patients reported that they experienced transport problems in reaching health facilities.

### **3.5 Health Financing**

The average provincial health expenditure per uninsured person at the start of the constant (2002) price time series reflected in the table below in 1997/98 was R967. Most provinces beginning the series with below average *per capita* health expenditures experienced positive overall rates of *per capita* growth, while those starting the series with above average expenditures all exhibited contraction in *per capita* spending. Thus by the end of this time series, Northern Cape is expected to have had an average annual real increase in *per capita* health expenditure of 3.7%, Mpumalanga 2.4%, Limpopo 1.4%, Eastern Cape 1.0% and

North West 0.7%, while Gauteng, Western Cape and Free State will have experienced negative average annual growth of 2.9, 2.7 and 1.3% respectively. KwaZulu-Natal, that started the series with health expenditure slightly less than the provincial average, is also expected to have experienced a contraction in real health spending by the end of the MTEF period at an average rate of 0.4% per year. What the data suggests is that those provinces which started with low per capita expenditure have gained the most whilst those provinces starting with most have actually contracted in *per capita* terms. Whilst this indicates a move towards inter-provincial equity this trend does not necessarily imply that health services are being adequately funded in general as will be shown later.

**Table: Provincial public health expenditure per uninsured person (2002 prices)**

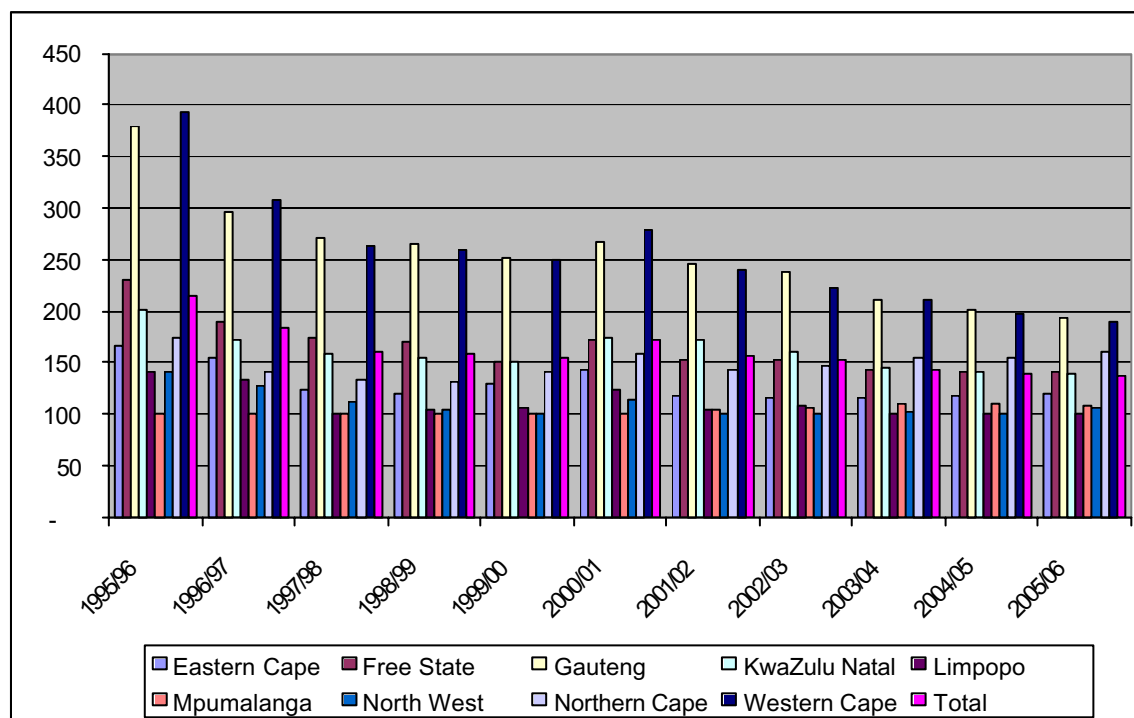
<i>Province</i>	1997/98 (actual)	1998/99 (actual)	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate )	2003/04 (MTEF)	2004/05 (MTEF)	2005/06 (MTEF)	Average annual % growth
EC	745	687	729	722	686	696	753	782	804	1.0
FS	1 048	981	849	867	879	908	926	945	947	-1.3
GP	1 629	1 526	1 417	1 353	1 417	1 413	1 363	1 336	1 287	-2.9
KZN	954	887	856	882	990	955	942	941	926	-0.4
LP	600	606	601	621	603	647	649	667	669	1.4
MP	604	575	571	505	604	636	718	730	729	2.4
NW	668	598	564	578	578	594	661	674	709	0.7
NC	802	760	795	796	823	878	1 004	1 038	1 073	3.7
WC	1 579	1 488	1 404	1 407	1 386	1 327	1 363	1 321	1 269	-2.7
<b>Average</b>	<b>967</b>	<b>909</b>	<b>876</b>	<b>873</b>	<b>905</b>	<b>907</b>	<b>926</b>	<b>930</b>	<b>924</b>	<b>0.6</b>

For the ratios of health expenditure by the different provinces, we can go back to the start of the time series in 1995/96. In that year the ratio of health expenditure

per uninsured person in the highest spending province to that of the lowest spending province was 3.9. This ratio fell dramatically in 1996/97 to 3.1, an effect of the work of the health function committee in allocating proportionately more finance to least funded provinces. The ratio then declined gradually (with a blip in 2000/01) to reach 2.4 in 2002/03 and is projected to fall further to 1.9 by the end of the current MTEF period. This indicator thus also shows a narrowing of inter provincial inequality in health financial allocations. However, it should be said that we have not as yet achieved equity in financial allocations amongst the nine provinces as is shown in the table below.

The ratio of the highest to the lowest provincial spenders, however, tells us only about the outliers, not about the seven provinces lying in between. A broader picture of financial inequality is portrayed by the ratios of health expenditure per uninsured person of eight of the provinces to that of the lowest spending province in a given year. The table and figure below show trends in these ratios with the lowest spending province set at 100 and here the picture is more mixed. A general narrowing of provincial health financial inequalities can still be seen over the 11 year time series, but it is also clear that progress towards equity is uneven, unsystematic and far from complete.

**Figure and table below: Ratios of health expenditure per uninsured person of provinces to that of lowest spending province (set at 100) in a given year**



Province	1995/96 (actual)	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	1999/0 0 (actual)	2000/0 1 (actual)	2001/0 2 (actual)	2002/03 (estimate )	2003/04 (MTEF)
EC	166	154	124	120	129	143	119	117	116
FS	230	190	175	171	151	172	152	153	143
GP	380	297	272	265	251	268	245	238	210
KZN	201	172	159	154	152	175	171	161	145
LP	142	134	100	105	107	123	104	109	100
MP	100	100	101	100	101	100	105	107	111
NW	141	128	111	104	100	115	100	100	102
NC	175	142	134	132	141	158	142	148	155
WC	393	308	263	259	249	279	240	223	210
Average	216	183	161	158	155	173	157	153	143
Ratio highest to lowest	3.9	3.1	2.7	2.7	2.5	2.8	2.5	2.4	2.1

Research recently conducted by the Health Economics Unit of the University of Cape Town and the Centre for Health Policy at the University of Witwatersrand shows the levels of expenditure by health district (coterminous with A and C municipalities) on primary health care in clinics and health centres financed from all sources in 2001/02 and relates the level of spending to the district deprivation index score (DIS), a measure of socioeconomic disadvantage. Expenditure varied enormously across districts, ranging from some R300 per person per year at the top end to less than R50 per person per year at the bottom. We do not yet know exactly how much the current essential package of primary health care services costs to deliver, in part because the package has expanded since an initial costing was made three years ago. Research on this issue is continuing, but indicatively we can say that primary health care spending should now be in the order R200 or more per person per year. The majority of districts thus appear to be well below this provisional benchmark figure.

What is even more serious is that, although the level of primary health care spending was not related in a simple way to district deprivation, in general the more deprived districts spent less and the better off districts spent more. This is an unfortunate example of the infamous health 'inverse care law': those who need health care most get it least, while those who need health care least get it most.

The widespread under-spending on primary health care, especially in the most deprived districts, arises from a number of factors including:

- deficiencies in infrastructure and management capacity in underprivileged areas;
- difficulties of recruiting and retaining health personnel in deprived areas;
- multiple financial flows for primary health care (provincial health department direct spending, provincial transfers to local government and local government funding from own revenue) and lack of coordinated (and possibly ring fenced) financing of this key health care level;
- imperfectly coordinated provision of primary health care by provincial health departments and local governments; and
- pressure to spend on hospitals.