



Decreasing morbidity and mortality

This model integrated health and social care and was approved by Cabinet in February. The first stage of implementation will be funded in 2001. The model:

- Relies on strong district level co-ordination and integration into existing service networks.
- Provides for the employment of teams of lay workers led by a professional.
- Views the family of the HIV-positive member as the unit of care and includes support of children orphaned because of AIDS.

Priority Area 3: Research, monitoring and surveillance

HIV vaccine research

Government contributed R10-million to the South African AIDS Vaccine Initiative this year and half this amount came from the health budget. Government's ongoing investment in vaccine research springs from a concern that there should be a vaccine appropriate to the strains that prevail here and that it should ultimately be affordable for our people.

Regular surveillance

Annual national ante-natal surveys to establish the prevalence of HIV (and more recently syphilis) have been conducted for a decade and the Department's methodology has become sufficiently refined for it to be adopted as the WHO model for this kind of survey.

Government surveillance is now moving toward:

- Establishing incidence (new cases) as well as prevalence (total cases).
- Surveying "sentinel sites" outside of ante-natal clinics, to increase representativeness of samples.
- Establishing trends in HIV-relevant social and sexual behaviour.

Operational research among sex workers and their clients at four sites in Gauteng and the Free State revealed increased condom use and declining rates of STD infection.

Priority Area 4: Human and legal rights

This priority area focuses on advocacy campaigns to achieve an environment in which people with HIV can live openly, with acceptance and support. It also promotes the adoption of policies and laws that guard against possible discrimination against people living with HIV/AIDS.

During 2000/1, two campaigns were conducted under the Government AIDS Action Plan to promote acceptance and to popularise the theme that "Men make a difference" to the containment of HIV/AIDS. The latter is a response to the fact that the economic dependence of many women, their subservient position in relation to men and high rates of sexual violence are fuelling this epidemic.

Decreasing the incidence of tuberculosis

Given that tuberculosis is a curable infectious disease, the key to lowering the incidence is to identify and successfully treat as many "smear positive" — that is, infectious — cases as possible. The targets set by 2004 are an 85% cure rate in new smear positive cases and an 80% cure rate in cases of retreatment.

The revised National TB Control Programme, launched in 1996, adopted the World Health Organisation strategy of Directly Observed Treatment Short-course (DOTS) and began standardising procedures relating to diagnosis, treatment and reporting.

Situation snapshot

- 119 638 reported cases of pulmonary TB in 2000
- 75 652 of these considered infectious
- Successful treatment of 72% (course completed).
- Cure rate of just over 60% (course completed, sputum test done)
- Treatment interrupted in 17% of cases

This strategy focuses on community-based treatment and was implemented through an expanding number of Demonstration and Training Districts. This was slow initially as laboratory services had to be upgraded, drug supplies organised and monitoring systems established.

By March 2001, 134 Demonstration and Training Districts had been established. The cure rate has improved from 56% in 1996 to over 60% in 2000. During 2000/1 the number of districts meeting the target cure rate of 85% increased to 10 and a further 31 were reporting cure rates between 75% and 84%.

A four-drug combination pill was introduced for the intensive phase of treatment in all provinces, making South Africa the first country to adopt this form of treatment.

Despite the switch to a community-based TB control strategy, provincial health departments still spend substantial amounts purchasing hospital-based TB services from SANTA and Lifecare. In the second half of 2000 the Department commissioned a review of these services to establish whether they were appropriate and cost-effective. The review revealed serious deficiencies in the management of SANTA. Consequently, the Minister of Health and provincial MECs resolved that provinces would over a period of two to three years assume responsibility for the hospital services run by this organisation. In the interim, the services would be monitored and contracts tightly managed.

Child, adolescent and youth health

Situation snapshot

- Infant mortality rate — 45 per 1000 live births
 - Under five mortality rate — 59 per 1000 live births
 - 35% of females are pregnant or give birth by age 19
 - 18% of youth smoke at least two days out of three
 - 18% of youth try first cigarette before age of 10
- (Global Youth Tobacco Survey, MRC, 2000)

The Department's work in the area of child, adolescent and youth health is channelled into the intersectoral National Programme of Action for Children, launched in 1996 by the president at the time, President Nelson Mandela. The NPA is an international effort, spearheaded by Unicef and designed to move countries forward towards the realisation of provisions in the Convention on the Rights of the Child.

In relation to child health, a major aim is to reduce infant mortality — or death within the first year of life — and to decrease the rate of death in the first five years of life. In relation to adolescents and youth, objectives relate to the reduction of teenage pregnancies and substance abuse.

Immunisation

The Extended Programme of Immunisation is a major preventive means to this end, and specific objectives in this regard are:

- To eradicate polio by 2000.
- To eliminate indigenous measles by 2002.
- To achieve full immunisation of 90% of one-year-olds by December 2003.





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- To establish school vaccination programmes to maintain booster doses for hepatitis B, measles and diphtheria.

During this year a mass immunisation campaign protecting against measles and polio was conducted nation-wide among pre-schoolers. Campaigns of this nature reach out into the community and are designed to benefit children who are either not covered by routine clinic-based immunisation or have not been effectively protected by the routine immunisation.

The coverage achieved in this national campaign was 92% for measles and 94% for the first round of polio, falling to 70% in the second round.

Overall, full immunisation of one year-olds is about 64%.

While South Africa has not had a confirmed case of polio for 12 years, we still do not meet the World Health Organisation's criteria to be certified polio free. This is mainly because we are not sufficiently rigorous in detecting cases that show the polio-like symptoms of acute flaccid paralysis (AFP), reporting them and ruling out the possibility of polio by laboratory tests. In an effort to meet this standard, WHO funding has been provided to employ AFP surveillance officers in several provinces.

The goal of eliminating measles by the target date of 2002 is no longer a dream but a real possibility. There has been a dramatic reduction in the number of suspected and confirmed cases in recent years. In 1996, the number of reported measles cases was 10 567 with 24 deaths. In 2000 the number of suspected cases had dropped to 1 593. Of these, only 39 were confirmed by laboratory tests and there were no deaths.

The achievement of high immunisation rates requires the co-operation of parents and caregivers. Unfortunately, a few highly publicised adverse reactions after immunisation — even if they are unconfirmed — can undermine public confidence. The Department is establishing a National Adverse Events Committee to investigate possible instances of adverse reaction to immunisation and to communicate to the public.

Other developments in relation to immunisation in the last year included:

- Switching to the more accurate intradermal method of administering BCG vaccine, which partially protects against tuberculosis. The transition is virtually complete in the public sector but additional work is required in the private sector.
- Completing the introductory process for the HiB vaccine, that protects against a range of childhood infections including pneumonias and meningitis. HiB vaccination is now integrated into the normal immunisation programme at primary care level and the cost will in future be carried by the provinces.

Integrated Management of Childhood Illnesses

Turning from prevention to the management of illnesses in young children, the Department has adopted as policy an approach pioneered by Unicef and the WHO, known as the Integrated Management of Childhood Illnesses (IMCI).

It emphasises the ability of health professionals:

- To empower mothers and caregivers to participate in the health care of children.
- To use medication appropriately.
- To rapidly identify severely ill children and manage them prior to referral.



The objective is to have all health districts implementing IMCI at primary care facilities by the end of 2003. The following progress has been recorded towards this goal:

- A total of 1 800 health professionals have been trained in IMCI and an intensive five-day case management course has been prepared for doctors, to improve the alignment of their approach with that of nurses who have undergone IMCI training.
- All provinces are utilising IMCI to a greater or lesser degree. The first four provinces to embark on the programme — KwaZulu-Natal, Mpumalanga, Northern Cape and Northern Province — have had two years of hands on experience and the others at least a year. A review of IMCI was performed during the course of the year and the report was expected early in 2001/2.

Management of genetic conditions

About 150 000 children born each year will develop some genetically determined condition by the age of five. Awareness of such conditions among health workers and the public at large is low and the Department has engaged in a variety of activities to enhance awareness. This year policy for the management and prevention of genetic conditions was adopted and a workshop was held with service providers from all provinces to improve the gathering of data on these conditions.

Adolescent and youth health

In relation to adolescents and youth, specific objectives are the reduction of teenage pregnancy and the reduction of substance abuse, including the smoking of tobacco products.

Initiatives to prevent young people becoming infected with HIV are clearly also relevant to the prevention of pregnancy in teenagers. Information programmes, the introduction of life skills education in schools and the distribution of free condoms — all part of the HIV/AIDS strategy — have an impact in this area.

Youth friendly services are being developed in collaboration with the NGO loveLife.

During the year under review the Tobacco Products Control Act of 1999 came into effect. Details of the Act are dealt with under Legislative Reform (Page 51). Various provisions were drafted with the intention of reducing smoking among young people. These include the ban on advertising of cigarettes, much of which is aimed particularly at a young market, and increasing penalties on the sale of tobacco products to anyone under 16 years.

Poverty alleviation and food security

Situation snapshot

- 22% of children aged 1 - 9 years are stunted
- This rate rises to 31 % among 1 - 3- year-olds
- Only 25% of households nationwide are food secure
- 18% of children aged 1 -3 years on commercial farms are underweight
- Breastfeeding rates improved from 33% (1995) to 68% (1999)

Among the objectives in this area of work are effective implementation of the Integrated Nutrition Programme (which includes the primary school nutrition programme); promoting community-based monitoring of children's growth; promoting food fortification initiatives; and providing resources to educate communities.

