



Decreasing morbidity and mortality

A comprehensive review of the Primary School Nutrition Programme (PSNP) was undertaken during the year, as part of the search for more effective implementation. In addition, there is joint work underway with the Department of Agriculture to develop a plan of action to address household food security within a broader poverty-alleviation framework.

The importance of collaboration with other role players within the Integrated Sustainable Rural Development Strategy is recognised.

Monitoring of child growth in community facilities is gaining ground — the Road to Health Chart was being used for 75% of children by 1998, as against 50% four years earlier. A new standard chart was printed and distributed during the year.

Despite operational problems in relation to the PSNP, school feeding programmes are in place in most provinces and there is a decrease in the rate of iron deficiency among school children.

The Department is discussing with food manufacturers the fortification of various staple foods with micronutrients. The Centre for Scientific and Industrial Research continued studies on the stability of specific micronutrients when introduced into mealie meal and wheat flour and whether this has any impact on acceptability to the consumer.

Women's health, including maternal health

Situation snapshot

- Health services are free to pregnant women
- 94% of pregnant women attend ante-natal clinics
- 80% deliver their babies supervised by a health worker
- A total of 51 145 legal abortions were performed in 2000

Interventions that have been targeted as critical to the improvement of women's health are: The reduction of maternal mortality, including deaths due to unsafe abortion; the expansion of awareness and screening programmes for cervical and breast cancer; and the reduction of rape and other violence against women.

For the past three years a mechanism for Confidential Enquiry into Maternal Deaths has been effective. Most public health institutions systematically file reports on all deaths during pregnancy, child birth and within six weeks of delivery. Reporting from the private sector is not yet satisfactory.

A report on trends in maternal deaths during the second year of reporting was released in 2000. It pointed to:

- Better management of obstetric complications.
- Inadequate referral systems, resulting in many deaths at primary care level.
- HIV/AIDS being the leading contributor to maternal deaths.





Most provinces have reproductive health committees that generate learning activities related to the problems revealed by reporting. The College for Obstetrics and Gynaecology has developed protocols for managing the leading causes of maternal deaths. The Department has developed guidelines for managing pregnant women at primary level.

A Safe Motherhood campaign was run in partnership with private sector organisations and a hospital- and clinic-based education campaign is also being rolled out on this basis.

In relation to maternal deaths arising from unsafe abortion, the major prevention strategy is access to safe, legal termination of pregnancy. However, despite enabling legislation being passed in early 1997, many rural areas are still effectively without such a service. Inequities in provision and major problems of access were highlighted in 2000 when the Portfolio Committee on Health in the National Assembly held public hearings on termination of pregnancy.

Limited though the existing service is, preliminary results of research conducted last year on incomplete abortions suggest that there is a drop in the proportion of seriously ill women seen after incomplete abortions.

Breast cancer and cancer of the cervix have been targeted for specific intervention. There is a policy to offer free screening for cervical cancer and this year the Department undertook its first assessment of implementation of this policy.

Reducing rape and other violence against women is a goal shared with the mental health section and is explored under that heading.



Mental health and substance abuse

Situation snapshot

- Globally, five out of the top 10 chronic disabilities are mental disabilities
- 1% to 3% of any population will need hospital admission for mental health problems
- 8 out of 10 countries devote less than 1% of their health budgets to mental health
- South Africa has 17 000 psychiatric hospital beds for public sector patients
- 80% of injury victims in SA survey had raised blood levels of alcohol or other drugs

Broad goals in this area of work are to integrate mental health into general health care wherever possible and treat as many people as possible in the community; to create programmes to prevent violence; and to reduce levels of substance abuse through youth-oriented prevention and treatment programmes.

Integrating mental health into general health depends partly on moving people from psychiatric institutions into the community. This in turn requires that health workers be trained in mental health, that general hospitals develop facilities to care for mental health patients and that community facilities — such as day care centres — be developed.



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A pilot deinstitutionalisation programme at Tower Hospital (Eastern Cape) and Madadeni Hospital (KwaZulu/Natal) proceeded through 2000/1. Patients were moved to the community under the care of non-government organisations. They are being carefully monitored and their progress compared with similar patients who have remained in hospital. A formal evaluation will be conducted later in 2001.

Violence prevention programmes are coupled with the setting up of surveillance systems to better understand patterns of non-natural mortality and non-natural injury. The mortality surveillance system proved extremely useful for intersectoral planning. The prevention programmes were innovative and followed the route of pilot implementation. These included:

- The opening of three violence referral centres in Eastern Cape, KwaZulu/Natal and Mpumalanga.
- Running a programme for violence prevention in schools at nine schools in three provinces.
- Establishing parent-to-child bonding programmes at four sites. This involves identifying high risk families and supporting them in a manner designed to promote both the physical development of the child and general mental health.

Reducing substance abuse requires an intersectoral approach involving a number of government departments as well as non-profit and community-based organisations. The Central Drug Authority was formed in 2000 to co-ordinate all activities and plan jointly.

- A prevention programme for secondary schools was developed and will be incorporated into the HIV/AIDS Life Skills strategy.
- Research was completed on possible interventions in relation to advertising of alcohol, counter-advertising campaigns and control of alcohol-linked sponsorship of sports and other public events.
- Research and awareness campaigns to reduce Foetal Alcohol Syndrome continued.

Chronic diseases and disability

Key strategic objectives range from ensuring implementation of national guidelines on the control of hypertension, diabetes and obesity; managing asthma; strengthening the National Cancer Control Programme; increasing surgery for cataracts; and ensuring that there is access to assistive devices.

Training of health workers and the production of materials to inform and educate the public have been major deliverables in this area of work. New materials included pamphlets on the early signs of childhood cancers.

Cataract surgery, which contributes to a reduction in blindness, was boosted by the contribution of Tunisian surgeons who performed 247 operations during a five-week visit. In addition, provincial initiatives to reduce the backlog for cataract surgery are encouraged through an inter-provincial competition that was won in 2000 by Northern Cape. The Ophthalmological Society of South Africa crowned this activity with a pledge to perform 60 000 free cataract operations over the next five years.

A national policy document on assistive devices was completed. Criteria were established on accessibility of health facilities to people with disabilities. There is a huge backlog in the supply of assistive devices and the national Department relieved this slightly by supplementing provincial efforts with 324 wheelchairs, 140 hearing aids and 430 spectacles.

Situation snapshot

- 29% of adult women are overweight
- Hypertension affects 9% of men and 13% of women
- Heart and circulatory malfunction caused 20% of deaths in 1996
- Cataract blindness affects 160 000 South Africans
- 3,7% of women and 2,4% of men report having diabetes
- 11,4% of women and 9% of men have signs of asthma or chronic bronchitis

Malaria control

Situation snapshot

- Globally there are 300-million to 500-million malaria cases a year
- About 4-million South Africans live in malaria endemic areas
- In 2000 South Africa recorded 61 934 malaria cases
- The disease is on the increase and fatalities rose to 423 in 2000
- About R93-million was spent on malaria control in 2000

Key objectives in reversing the increase in both the incidence and case fatality rate are: Improved management of people infected with malaria by swift detection and appropriate medication; appropriate and effective mosquito control measures; improved cross-border co-operation; and creating awareness in communities so they can take precautionary measures.

Factors that have contributed to the increase are the re-emergence of a vector that is resistant to insecticide plus growing resistance to first line drug used to treat malaria. Environmental conditions — particularly devastating floods in 2000 — contributed significantly.

Health Ministers of Botswana, Mozambique, South Africa, Swaziland and Zimbabwe have set up a Malaria Control Working Group and commissioned a detailed study on the socio-economic impact of malaria on the region.

Each country has also pledged to strengthen malaria control programmes and in South Africa — where only KwaZulu-Natal, Mpumalanga and Northern Province are affected — the following initiatives took place:

- Disease management was enhanced through the introduction of a new drug (Co-Artem) in KwaZulu-Natal to counteract the growing problem of drug resistant malaria.
- In response to insecticide resistance among mosquitoes, the use of DDT was reintroduced for vector control purposes with the support of the WHO. DDT is currently the most effective insecticide for this purpose.
- Public awareness was strengthened through an awareness day on September 1.
- The Lubombo Spatial Development Initiative — a collaborative venture with Mozambique and Swaziland — received R5-million specifically for insecticide spraying and vector control research.
- KwaZulu-Natal began the distribution of 85 000 bed nets in high-risk malaria areas.

Provided the above approach is sustained, the prospects of a reduction in malaria cases and deaths are good.

Emergency Services

Emergency care is the only health right directly guaranteed in Bill of Rights. Deficiencies in the existing system of emergency medical services are recognised and a strategy for the period 2000 to 2010 attempts to address these shortcomings. Every province has begun to develop business plans deriving from this central strategy.





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Cholera resurgent

South Africa's worst recorded cholera outbreak began in August 2000. By the end of March, 81 265 cases had been recorded and hundreds of new cases were still occurring daily.

The country had seen few cholera cases since major outbreaks in four consecutive years in the early 1980s. The scale on which cholera re-emerged this year underscored the extent to which poverty and underdevelopment still blight our society.

The outbreak centred overwhelmingly on KwaZulu-Natal, although quite a number of cases were reported from Gauteng, Mpumalanga and Northern Province and a scattering from four other provinces.

The case fatality rate of 0,22% was extraordinarily low and indicated a particularly effective response by the

KwaZulu-Natal health authorities. In all areas, the front-line response – in terms of prevention and management – was mounted by district and provincial outbreak control teams. However, the Department played a significant support role by:

- Reviewing and re-issuing cholera guidelines.
- Running workshops on outbreak response in KwaZulu-Natal and the Eastern Cape.
- Co-ordinating training for laboratory personnel to ensure effective surveillance and diagnosis.
- Supplementing information materials for health workers and the general public.
- Securing expert advice from the World Health Organisation.

Importantly, the Minister of Health and Cabinet colleagues – notably the Ministers of Waters Affairs and Forestry and Provincial and Local Government – secured an inter-sectoral approach at the highest level.

During the past Year:

- Provinces, with the exception of Gauteng, began to reassume direct responsibility for emergency medical services instead of contracting local authorities to deliver on their behalf. Some completed the process within the 2000/1 year and all (except Gauteng) are scheduled to have done so by July 2001.
- Regulations for pre-hospital emergency medical services were drafted and will be discussed with various role-players before publication for general comment. The regulations will provide clear parameters for both private and public sector services.
- Training for emergency service personnel is provided in all provinces, except Mpumalanga and North West. These provinces are presently establishing training colleges.



Health is in the air, the water and the food we eat . . .

Public health is often a case of intervening in environments rather than curing individuals. The Cluster for Non-Personal Health Services, comprising Environmental Health, Occupational Health and Health Promotion, specializes in such work. So does the Directorate for Food Control. And some would be surprised to find Oral Health in this league.

The Cluster for Non-personal Health Services sets frameworks for health action in the work place, in schools and in communities. Typically, this cluster works in partnership with other government departments, community groups, trade unions and business organizations to pursue its goals.

In 2000/1, the goal of transforming schools into centres for the promotion of health was pursued with the Department of Education. Under this strategy, provincial departments have recorded achievements

in promoting children's awareness of communicable diseases, developing life skills, building toilets in schools and improving hygiene.

Safe pesticide use and good water quality have been major concerns in environmental health. The Department supported nearly 50 rural water and sanitation projects. The National Centre for Occupational Health (NCOH) continued to generate significant research, with some 40 projects active during the year. It also fulfils a statutory role by providing a large volume of autopsy reports.

In the area of preventive oral health, progress was made towards fluoridation of water supplies with regulations promulgated in September. Water providers have 12 months to register with the Department. At a national level, food control and safety are promoted largely through setting standards and creating frameworks for monitoring. This Directorate's brief includes control of genetically modified foods and important groundwork towards regulating such foods was done in 2000/1.

Strategic Goal

Improving quality of care

Situation snapshot

From the public's point of view:

- 58% rated health care as excellent or good; 17% as poor
- 29% said health care got better after 1994; 34% said it got worse
- 47% of African respondents could access care when needed (Kaiser Foundation/Independent Newspapers Survey April 1999)

Studies in SA health facilities show:

- Drug stocks at clinics often fall short
- Diagnosis and treatment are often inadequate
- Records are commonly poorly kept

A central objective in relation to improved quality of care is the development and implementation of a National Policy on Quality. Further objectives form a number of clusters:

- Strengthening the Batho Pele principles among health workers; promoting service users' awareness of their rights and responsibilities through the Patients' Charter and related activities.
- Fostering accountability through standard complaints mechanisms; processes to regularly measure consumers' views and expectations; and establishing boards and committees at all hospitals and clinics so that communities can impact on the planning and management of services.

