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DEPARTMENT OF HEALTH

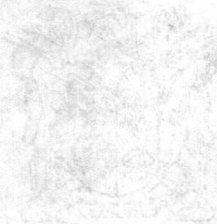
WHITE PAPER

FOR THE

TRANSFORMATION OF THE HEALTH SYSTEM IN SOUTH AFRICA

The White Paper for the **TRANSFORMATION OF THE HEALTH SYSTEM IN SOUTH AFRICA** is hereby published by the Ministry of Health. The object of the White Paper is to present to the people of South Africa a set of policy objectives and principles upon which the Unified National Health System of South Africa will be based. In addition to these objectives, this document presents various implementation strategies designed to meet the basic needs of all our people, given the limited resources available.

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TOWARDS A NATIONAL HEALTH SYSTEM

Published by the Department of Health

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PREFACE

We have set ourselves the task of developing a unified health system capable of delivering quality health care to all our citizens efficiently and in a caring environment. The strategic approach guiding us in this endeavour is that of Comprehensive Primary Health Care. We believe this accords with the health objectives spelt out in the Reconstruction and Development Programme, the vehicle for socio-economic transformation in our country.

We advance a wide range of policies that will fundamentally transform our health care delivery system. Some significant steps have already been taken in this direction but a lot still needs to be done. We intend to decentralise management of health services, with emphasis on the district health system; increase access to services by making primary health care available to all our citizens; ensure the availability of safe, good quality essential drugs in health facilities; and rationalise health financing through budget reprioritisation. Furthermore, the development of a National Health Information System will facilitate health planning and management, and strengthen disease prevention and health promotion in areas such as HIV/AIDS, STDs and maternal, child and women's health. The Integrated Nutrition Programme will focus more on sustainable food security for the needy.

As part of this process of health reform, I appointed various ministerial task teams and committees with wide representation. Their recommendations have been further consolidated by the Department of Health and inform the key policies articulated in this White Paper. A detailed policy document outlining our National Drug Policy was released in February 1995. It is a critical component of our review of our health services and should thus be read with this White Paper. A detailed policy on health insurance will be published and will thus complement the White Paper.

On behalf of our Government, I am very pleased to present to the people of South Africa a set of policy objectives and principles upon which the unified national health system of South Africa will be based. In addition to these objectives, this document presents various implementation strategies designed to meet the basic needs of all our people, given the limited resources available. These strategies are based on the belief that the task at hand requires the pooling of both our public and private resources.

I would like to acknowledge and thank all those who have participated in the consultation process undertaken, for dedicating their time and energy to this all-important task. Unfortunately, they are too numerous to be listed.

It is my sincere hope that this document will inspire all of us to work in unison towards the improvement of the health of our nation and ensure a brighter future for our children. May this effort inspire all of us, rich or poor, urban or rural to take individual and collective responsibility for our health.

Nkomo
DR NKOSAZANA C. DLAMINI ZUMA
MINISTER OF HEALTH

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Abbreviations used

AHSC	Academic Health Service Complex
AIDS	Acquired Immune Deficiency Syndrome
GDP	Gross Domestic Product
GNP	Gross National Product
RDP	Reconstruction and Development Programme
NGOs	Non-governmental Organisations
NHS	National Health System
DHS	District Health System
STDs	Sexual Transmitted Diseases
HIV	Human Immune Deficiency Virus
NHIS	National Health Information System
WHO	World Health Organisation
UNICEF	United Nations Childrens Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
PHC	Primary Health Care
MCWH	Maternal, Child and Women's Health
CHC	Community Health Centre
PHCN	Primary Health Care Nurse
NITER	National Increment for Teaching, Education and Research
PCTs	Primary Care Teams
EDL	Essential Drugs List
GNU	Government of National Unity
NDP	National Drug Policy
LBW	Low Birthweight Babies
PEM	Protein-energy Malnutrition
PSNP	Primary School Nutrition Programme
NNSDP	National Nutrition and Social Development Programme
FLAG	Food Legislation Advisory Group
GMP	Growth Monitoring and Promotion
PEP	Peri-natal Education Programme
DEPAM	Education Programme for Advanced Midwives
NACOSA	National AIDS Convention of South Africa
NAPWA	National Association of People Living with HIV/AIDS
CBOs	Community-based Organisations
EHOs	Environmental Health Officers
NAHSC	National Academic Health Service Council
NHLS	National Health Laboratory Services
ENHR	Essential National Health Research

Abbreviations used

Academic Health Service Complex	AHSC
Acquired Immune Deficiency Syndrome	AIDS
Gross Domestic Product	GDP
Gross National Product	GNP
Reconstruction and Development Programme	RDP
Non-governmental Organisations	NGOs
National Health System	NHS
District Health System	DHS
Sexually Transmitted Diseases	STDs
Human Immunodeficiency Virus	HIV
National Health Information System	NHIS
World Health Organisation	WHO
United Nations Children's Fund	UNICEF
United Nations Development Programme	UNDP
United Nations Fund for Population Activities	UNFPA
Primary Health Care	PHC
Maternal, Child and Women's Health	MCHW
Community Health Centre	CHC
Primary Health Care Nurse	PHCN
National Institute for Teaching, Education and Research	NITER
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Essential Drugs List	EDL
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National Academic Health Service Council	NAHSC
National Health Laboratory Services	NHLS
Essential National Health Research	ENHR

Chapter 1

Mission, Goals and Objectives of the Health Sector

South Africa has a population of over 40 million, 73% of whom are women and children. Although classified as a middle-income country and spending 8,5% of GDP on health care. South Africa exhibits major disparities and inequalities. This is the result of former apartheid policies which ensured racial, gender and provincial disparities.

The majority of the population of South Africa has inadequate access to basic services including health, clean water and basic sanitation. Statistics for 1994 suggest that between 35% and 55% of the population live in poverty. Fifty three percent of the population live in rural areas the vast majority of whom are poor (seventy-five per cent of the poor live in rural areas).

Women and children are amongst the most vulnerable groups in South Africa. Sixty-one per cent of children in South Africa live in poverty, and women are also disproportionately represented among the poor.

It is estimated that the Infant Mortality Rate (IMR), Under-five Mortality Rate (U5MR) and Maternal Mortality Rate (MMR) are much higher than expected of a country with South Africa's level of income. Existing disparities amongst the various race groups are well documented.

The Government has developed a framework for socio-economic development in its Reconstruction and Development Programme (RDP), in which it has set out broad principles and strategies for development in all key areas and sectors in order to effectively address the various problems facing the majority of the people of South Africa.

The task of improving the health of South Africa's population is not that of the health sector alone. The RDP sets the framework whereby the health of all South Africans must reflect the wealth of the country and lays the foundation for a process of democratising the State and society that will foster the empowerment of all citizens and promote gender equality.

The second major thrust of the RDP concerns building the economy. Poverty is widely recognised as a major determinant of the health status of individuals, households and communities, and gains in health will only be possible if the RDP's attack on poverty through economic development succeeds.

The third component of the RDP is the development of human resources. Equipping individuals with the necessary knowledge to care for themselves will be a major step towards improving their health. No factor can be shown to be more important for a family's health than the educational status of women. Therefore the RDP's specific emphasis on women in the planning and implementation of human resource development is critical to the improvement of health.

Finally, within the RDP's focus on meeting basic needs, the development and improvement of housing and services like water and sanitation, the environment, nutrition and health care represents its most direct attack on ill health. It follows that trends in health status during and following the implementation of the RDP will be amongst the most important indicators of the success of the entire programme. The Department of Health aims to ensure that the health sector succeeds in fulfilling this vital role in ensuring progress.

Details of the proposed health sector strategies are set out below. They are based on a common vision which reflects the principles of the RDP:

- (a) The health sector must play its part in promoting equity by developing a single, unified health system.
- (b) The health system will focus on districts as the major locus of implementation, and emphasise the primary health care (PHC) approach.
- (c) The three spheres of government, NGOs and the private sector will unite in the promotion of common goals.
- (d) The national, provincial and district levels will play distinct and complementary roles.
- (e) An integrated package of essential PHC services will be available to the entire population at the first point of contact.

The health sector's mission, goals, objectives and implementation strategies are articulated in this and subsequent chapters.

1.1 HEALTH SECTOR MISSION, GOALS AND OBJECTIVES

Mission statement

**To provide leadership and guidance to the
National Health System in its efforts
to promote and monitor the health of
all people in South Africa,
and to provide caring and effective services
through a primary health care approach.**

In order to realise the above mission, it is envisaged that the National Health System (NHS) will incorporate all stakeholders, i.e. the Government sector, NGOs (including religious and grassroots organisations), the private sector and, especially, the communities.

It is essential to obtain the active participation and involvement of all sectors of South African society in health and health-related activities. All sections of the community, all members of households and families and all individuals should be actively involved, in order to achieve the health consciousness and commitment necessary for the attainment of goals set at the various levels. The people of South Africa have to realise that, without their active participation and involvement, little progress can be made in improving their health status.

Health teams and workers at all levels should develop a caring ethos and commit themselves to the improvement of the health status of their communities. They should not only be responsible for the patients who attend their health facilities, but also have a sense of responsibility towards the majority of the population in their catchment areas.

Every effort should be made to ensure the improvement in the quality of services at all levels. An essential package of primary health care interventions will be made universally accessible. Emphasis should be placed on reaching the poor, the under-served, the aged, women and children, who are amongst the most vulnerable.

In addition, the management of services should be decentralised and focus on improving

the district health system. District teams will have to be established and trained to enhance their capacity for planning, implementation, supervision, monitoring and evaluation of health activities. Mechanisms should be developed to enhance intersectoral collaboration at the national, provincial, district and community levels.

Restructuring the health sector has the following aims:

- (a) To unify the fragmented health services at all levels into a comprehensive and integrated NHS;
- (b) to reduce disparities and inequities in health service delivery and increase access to improved and integrated services, based on primary health care principles;
- (c) to give priority to maternal, child and women's health (MCWH); and
- (d) to mobilise all partners, including the private sector, NGOs and communities in support of an integrated NHS.

1.1.2 Goals and objectives

(a) To unify fragmented health services at all levels into a comprehensive and integrated NHS:

- (i) reorganise the Department of Health, so that it can fulfill its designated functions;
- (ii) integrate the activities of the public and private health sectors, including NGOs and traditional healers, in a way which maximises the effectiveness and efficiency of all available health care resources; and
- (iii) reorganise the health care system based on primary health care services, with effective referral systems at the primary, secondary and tertiary care levels.

(b) To promote equity, accessibility and utilisation of health services:

- (i) increase access to integrated health care services for all South Africans, focusing on the rural, peri-urban and urban poor and the aged, with an emphasis on vulnerable groups;
- (ii) establish health care financing policies to promote greater equity between people living in rural and urban areas, and between people served by the public and private health sectors; and
- (iii) distribute health personnel throughout the country in an equitable manner.

(c) To extend the availability and ensure the appropriateness of health services:

- (i) establish a district health system in which all communities are covered by a basic health unit which offers an essential package of care;
- (ii) ensure a functioning referral system at the primary, secondary and tertiary levels;
- (iii) improve access to comprehensive health services;
- (iv) ensure the universal availability of high quality, low cost essential drugs; and
- (v) ensure that every South African develops his or her potential fully, with the support of community-based nutrition promotion activities.

(d) To develop health promotion activities:

- (i) promote a healthy environment;
- (ii) improve the psychological well-being of people and communities;
- (iii) ensure access to health-related information, community support and health services for adolescents;
- (iv) reduce alcohol and other drug abuse, with particular emphasis on tobacco, glue, cocaine, Mandrax, heroin and marijuana;
- (v) promote healthy behaviour to prevent sexually transmitted diseases (STDs) and HIV transmission;
- (vi) prevent the transmission of communicable diseases such as tuberculosis, and the development of hypertension and diabetes;
- (vii) help the disabled to become independent and reach their potential for achieving a socially and economically productive life; and
- (viii) reduce the incidence of intentional and unintentional injuries.

(e) To develop the human resources available to the health sector:

- (i) promote the optimal use of the skills, experience and expertise of all health personnel;
- (ii) develop education and training programmes aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve;
- (iii) ensure that the composition of human resources in the health sector reflects the demographic pattern of the general population;

- (iv) promote a new culture of democratic management in the health sector; and
- (v) ensure a caring and compassionate health sector.

(f) To foster community participation across the health sector:

- (i) involve communities in various aspects of the planning and provision of health services;
- (ii) establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers; and
- (iii) encourage communities to take greater responsibility for their own health promotion and care.

(g) To improve health sector planning and the monitoring of health status and services:

- (i) develop a national health information system that will: facilitate the measurement and monitoring of the health status of the South African population; enable the evaluation of the delivery of health services; and support effective management at all levels of the health service;
- (ii) ensure that those responsible for the health status of South Africa's population are kept up to date with the information generated;
- (iii) monitor the health impact of the implementation of the RDP, including the development of a nutritional surveillance mechanism; and
- (iv) building capacity at the provincial, district, local and community levels to develop plans based on priority issues and ensure appropriate and cost-effective interventions.

Chapter 2

Reorganising the Health Service: Priority for Primary Health Care

Changes dictated by the South African Constitution include the devolution of certain responsibilities for health services to the provincial and municipal levels. To give effect to this mandate, it is essential that, inter alia, a district health system (DHS), in which responsibility for service delivery is entrusted to the district level, be established as soon as possible.

Restructuring the organisation of the health services, therefore, requires that distinct functions be assigned to the national department, the provinces and the districts/municipalities. These are listed below. Furthermore, it requires that the new structures be staffed by skilled people, to ensure efficiency and effectiveness in management and administration. Private sector health services will also have a major role to play in the National Health System (NHS).

2.1 DEPARTMENT OF HEALTH

2.1.1 Functions of the national department

The Department of Health has a responsibility to -

- (a) Provide leadership in the formulation of health policy and legislation, including the development of a NHS;
- (b) provide leadership in quality assurance, including the formulation of norms and standards;
- (c) build the capacity of the provincial health departments and municipalities, to enable them to ensure the provision of effective health services;
- (d) ensure equity in the allocation of resources to the provinces and municipalities and their appropriate utilisation;
- (e) provide leadership in planning for and the strategic management of the resources

available for health care;

- (f) provide services which cannot be cost-effectively delivered elsewhere;
- (g) develop co-ordinated information systems and monitor the progress made in the achievement of national health goals;
- (h) provide appropriate regulation of the public and private health sectors, and regulate health-related activities in other sectors;
- (i) support the provinces and municipalities in ensuring access to cost-effective and appropriate health commodities; and
- (j) liaise with national health departments in other countries and international agencies.

2.1.2 Organisational structure of the national department

A new organisation structure for the Department of Health has been established.

A specific goal has been set that the Department of Health will be representative, i.e. its staffing pattern will reflect the national demographic structure.

(a) POLICY CO-ORDINATING UNIT

Responsible for defining, co-ordinating, integrating, synthesising, reviewing and monitoring fundamental strategic health policy matters and key institutional relationships within the NHS.

(b) INTERNATIONAL HEALTH LIAISON : DIRECTORATE

Responsible for formulating policy proposals and mobilising financial, material and human resources for the upliftment of South Africa's people by promoting national and international co-operation in the implementation of the RDP.

(c) POLICY AND PLANNING BRANCH

Responsible for developing strategic health policy, formulating operational and technical policy, allocating health resources, co-ordinating research and developing a national health information system.

(i) National Health Systems : Chief Directorate

Responsible for ensuring the development of a functional NHS at all three levels of government, with effective co-ordination amongst all role-players including the public, private and voluntary sectors; responsible, at the national level, for facilitating and monitoring the development of the District Health System.

○ Health Promotion and Communication : Directorate

Responsible for: co-ordinating and supporting health promotion initiatives and, in collaboration with the provinces, developing clear and transparent criteria for establishing national health promotion priorities, including training and capacity-building; ensuring that all decisions, policies and laws emanating from other organs of state are health-promoting, and that opportunities for health promotion are maximised in all settings and in relation to all topics; developing effective channels for the communication of and liaison on health policy, and ensuring that health policies are marketed through the launching of campaigns, using print and audiovisual media to create awareness and stimulate public debate.

○ Systems Development, Legislation and Policy Co-ordination : Directorate

Responsible for ensuring the development of a co-ordinated NHS and facilitating and monitoring the development of the District Health System; that departmental policies are co-ordinated, consistent and coherent; that national health legislation is drafted, as and when required.

(ii) Hospital and Academic Health Service Complexes : Chief Directorate

The Chief Directorate has three main responsibilities:

○ Hospital Development : Sub-directorate

Responsible for ensuring that hospitals use resources efficiently, that their services are coordinated and that they support PHC services. This unit will also be expanded to take on responsibility for coordinating and controlling the budgets of academic central hospitals.

○ AHSC Development : Sub-directorate

Responsible for ensuring that the policy developed for academic health centres (AHSCs) enables them to remain an integral part of the NHS; that the training provided is in accordance with a national human resource policy and appropriate to the needs of South Africa.

(iii) Operational and Technical Policy : Chief Directorate

Responsible for developing policies, norms and standards for the health services in consultation with the relevant examining and statutory bodies and interested stakeholders.

○ Health Services : Directorate

Responsible for: developing norms and standards for basic packages of health services, their delivery and the quality of care and developing systems and methodologies for quality assurance and the maintenance of good quality care.

○ Environmental Health : Directorate

Responsible for: developing policies, norms and standards for environmental health; ensuring that basic environmental needs are met and that environmental factors inimical to health are minimised; developing an

environmental surveillance and evaluation system to monitor the effectiveness of environmental interventions.

○ **Food Control : Directorate**

Responsible for developing standards for food hygiene, additives, labelling and identification; and ensuring food safety through regulation and public education, as well as the ratification of and participation in international standards.

○ **Oral Health : Directorate**

Responsible for developing policies, norms and standards for oral health services aimed at the effective distribution and utilisation of resources, training and orientation of appropriate professionals and the adoption of public health interventions.

(iv) Health Resource Planning : Chief Directorate

Responsible for planning the optimal utilisation of health care resources.

○ **Health Finance and Economics : Directorate**

Responsible for the planning of national health care finances, ensuring that the national health budget is restructured to support RDP priorities (and other governmental priorities), and monitoring and evaluating public and private health expenditure.

○ **Human Resource Planning : Directorate**

Responsible for: developing a national human resource audit, policies, plans and strategies for implementation: to ensure the availability, equitable redistribution and appropriate mix of human resources.

○ **Health Facilities : Directorate**

Responsible for developing a comprehensive plan for the distribution of

health facilities in the public and private sector that ensures equity in underserved areas.

(v) Health Information, Evaluation and Research : Chief Directorate

Responsible for developing and maintaining a national health information system, evaluating health programmes rendering epidemiological support and co-ordinating health research.

○ National Health Information System : Directorate

Responsible for developing (and maintaining) a health information system that begins at the local level and feeds into the district, provincial and national levels.

○ Health Systems Research Epidemiology : Directorate

Responsible for public health surveillance, epidemiology and ensuring the use of health systems research in planning, evaluation and management of the health services.

- Responsible for developing a national research and funding strategy, and facilitating and co-ordinating an essential national health research programme.

(c) REGULATION, SERVICES AND PROGRAMMES BRANCH

Responsible for: regulating health matters and the procurement of supplies and services; rendering support services at the national and departmental levels; establishing health programmes and promoting occupational health.

(i) Registration, Regulation and Procurement : Chief Directorate

Responsible for promoting the registration, regulation and procurement of health supplies and services.

○ **Medicines Administration : Directorate**

Responsible for the regulation of medicines and related substances and the development of effective medicine supply systems.

○ **Health Technology : Directorate**

Responsible for the evaluation, regulation and registration of health technology.

○ **Medical Schemes, Supplies and Pharmaceutical Services: Directorate**

Responsible for promoting the sound management of medical schemes and pharmaceutical services, including the procurement of medical supplies.

(ii) **National Programmes : Chief Directorate**

Responsible for the management of national health programmes in accordance with the objectives of the RDP.

○ **Maternal, Child and Women's Health Services : Directorate**

Responsible for: developing an effective and equitable health care system, with priority for mothers and children; managing the maternal, child and women's health programmes, including the prevention and management of genetic disorders.

○ **Nutrition: Directorate**

Responsible for developing policies, strategies and guidelines for a national integrated nutrition programme.

○ **Communicable Disease Control : Directorate**

Responsible for promoting the control of communicable diseases.

○ **HIV/AIDS and Sexually Transmitted Diseases (STDs): Directorate**

Responsible for co-ordinating the national effort to prevent the spread of HIV/AIDS and STDs.

○ **Chronic Diseases, Disabilities and Gerontology : Directorate**

Responsible for developing strategies and guidelines for the prevention of chronic diseases and the prevention and management of disabilities.

○ **Mental Health and Substance Abuse : Directorate**

Responsible for developing national policies and norms for the prevention and control of mental illness and substance abuse.

(iii) National Services : Chief Directorate

Responsible for rendering national services that cannot be rendered at the provincial and district levels, and promoting priority health programmes.

○ **National Health Laboratory Services : Directorate**

Responsible for facilitating the co-ordination and accreditation of health laboratory services and promoting effective public and private sector collaboration.

○ **National Disaster Services and Medical Advice : Sub-directorate**

Responsible for promoting the prevention of, preparedness for and response to major disasters, and advising other State departments on health and medical matters.

○ **National Forensic Chemistry Laboratories : Sub-directorate**

Responsible for delivering an effective chemical laboratory service at the national level in support of forensic medicine and law enforcement, through

regulatory control of chemical substances injurious to health.

○ **Vaccine Unit : Sub-directorate**

Responsible for the manufacture and supply of vaccines and biologicals.

○ **National Institute for Virology : Directorate**

Mandated to function as a national resource centre of excellence for viral diseases.

(iv) Occupational Health : Chief Directorate

Responsible for the promotion and surveillance of the health of people at work.

The Directorates: Occupational Medicine and Pathological Services and the Sub-directorate: Occupational Hygiene and Toxicology constitute the -

○ **National Centre for Occupational Health**

Responsible for supporting occupational health at all levels, promoting occupational health services and fulfilling statutory obligations in terms of the Occupational Diseases in Mines and Works Act, 1973, as amended and the -

○ **Medical Bureau for Occupational Diseases**

Responsible for discharging duties in terms of, and administering the Occupational Diseases in Mines and Works Act, 1973, as amended (as above).

(v) Departmental Support Services : Chief Directorate

Responsible for establishing and maintaining an effective internal support service for the Department of Health.

○ **Financial Management Services : Directorate**

Responsible for providing financial advice and ensuring that expenditures incurred are in accordance with the various programme descriptions; rendering and maintaining information technology services within the Department; and advising the Department on the procedures to be followed to obtain goods and services.

○ **Administration : Directorate**

Responsible for rendering personnel administration, auxiliary and administrative support services to the Department.

○ **Legal Services : Sub-directorate**

Responsible for drafting legislation, preparing contracts and other legal documents and providing general legal advice and services.

○ **Special Programmes : Sub-directorate**

Responsible for the development of programmes for the achievement of a more representative Department, and monitoring the implementation thereof.

2.2 PROVINCIAL HEALTH DEPARTMENTS

2.2.1 Role and functions of the provincial health departments

The mission of a provincial health department, as mandated by the Constitution of South Africa within the framework of national policies, strategies and guidelines, is to promote and monitor the health of the people in the province, and develop and support a caring and effective provincial health system, through the establishment of a province-wide district health system (DHS) based on the principles of primary health care (PHC).

During the period of transition required for the establishment of a DHS, the provincial authorities (in addition to the functions listed below) will perform functions that will be devolved to the newly-established districts at a later stage. During this critical process, sub-provincial structures such as health regions may be established to assist in carrying

out these functions.

The functions of the provincial health authorities will include, ensuring -

- (a) the provision of regional and specialised hospital services, as well as academic health services, where relevant;
- (b) appropriate human resource management and development;
- (c) the rendering and co-ordination of medical emergency services (including ambulance services);
- (d) the rendering of medico-legal services;
- (e) the rendering of health services to those detained, arrested or charged;
- (f) the planning and management of a provincial health information system;
- (g) quality control of all health services and facilities;
- (h) the screening of applications for licensing and the inspection of private health facilities;
- (i) the formulation and implementation of provincial health policies, norms, standards and legislation;
- (j) interprovincial and intersectoral co-ordination and collaboration;
- (k) co-ordination of the funding and financial management (the budgetary process) of district health services;
- (l) the provision of technical and logistical support to health districts;
- (m) the rendering of specific provincial service programmes, e.g. tuberculosis programmes;
- (n) the provision of non-personal health services;

- (o) the provision and maintenance of equipment, vehicles and health care facilities;
- (p) effective consultation on health matters at the community level;
- (q) the provision of occupational health services;
- (r) research on, and the planning, co-ordination, monitoring and evaluation of the health services rendered in the province; and
- (s) that functions delegated by the national level are carried out.

2.3 THE DISTRICT HEALTH SYSTEM

2.3.1 Principles, long-term goals and role of the District Health System

(a) Principles

A national committee established to develop a DHS, comprising representatives of the national and provincial health departments, has agreed unanimously that there are twelve principles with which planners must comply in the development of the DHS. These are :

- (i) overcoming fragmentation
- (ii) equity
- (iii) comprehensive services
- (iv) effectiveness
- (v) efficiency
- (vi) quality
- (vii) access to services
- (viii) local accountability
- (ix) community participation
- (x) decentralisation
- (xi) developmental and intersectoral approach
- (xii) sustainability

(b) Long-term goals and role of the district

The goal outlined in the RDP is to have a single NHS, based on a district health system that facilitates health promotion, provides universal access to essential health care and allows for the rational planning and appropriate use of resources, including the optimal utilisation of the private health sector resources.

The country will be divided into geographically coherent, functional health districts. In each health district, a team will be responsible for the planning and management of all local health services for a defined population. The team will arrange for the delivery of a comprehensive package of PHC and district hospital services within national and provincial policies and guidelines. In time, all district level staff should be employed on the same salary scales and under the same terms and conditions of employment that apply to public sector health personnel throughout the country.

In view of the variety of conditions that exist among and within the provinces, it is unlikely that a single system of governance can be implemented throughout the country. Therefore, three governance options are suggested:

- (i) The provincial option, i.e. the province is responsible for all district health services through the district health manager. (This option can be exercised where there is insufficient independent capacity and infrastructure at the local level.)
- (ii) The statutory district health authority option, i.e. the province, through legislation, creates a district health authority for each health district. (This option can be exercised in instances where no single local authority has the capacity to render comprehensive services.)
- (iii) The local government option, i.e. a local authority is responsible for all district health services. (This option can be exercised if a local authority, whose boundaries are the same as that of a health district, has the capacity to render comprehensive services.)

2.3.2 Implementation strategies

- (a) Each province will be subdivided into a number of functional health districts.
- (b) The district will serve both as a provider and purchaser of health services, and

select the appropriate strategy on the basis of equity, efficiency and assessment of local conditions.

- (c) Peri-urban, farming and rural areas will fall within the same health district as the towns with which they have the closest economic and social links. The fragmentation and inequity created by the past practice of separating peri-urban and rural health services from the adjacent municipal health services must be eradicated.
- (d) There will be parity in salaries and conditions of service for all public sector health personnel throughout the country, which include appropriate incentives to encourage people to work in underserved areas. This is essential in order to rationalise services, overcome fragmentation and promote equity, particularly between metropolitan, urban and rural areas.
- (e) Financing mechanisms or formulae will be devised, to ensure that district level health services are financed in an equitable and sustainable manner.

The establishment of the DHS is at the core of the entire health strategy, and its rapid implementation, therefore, is of the highest priority.

2.3.3 Functions of a health district

This level of the health care system should be responsible for the overall management and control of its health budget, and the provision and/or purchase of a full range of comprehensive primary health care services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures.

Functions at this level are as follows:

(a) Health care

- (i) Ensuring health promotion services;
- (ii) providing for collaboration with other sectors of Government and NGOs in promoting health and ensuring the rendering of health services in the health district;
- (iii) providing for community participation in health promotion and health service

provision;

- (iv) ensuring the availability of a full range of PHC and other relevant health services in communities, clinics, community health centres, district hospitals and other facilities;
- (v) ensuring primary environmental health services; the promotion and maintenance of environmental hygiene; the prevention of water pollution; enforcement of environmental health legislation, i.e. regarding sanitation, housing, smoke, noise, litter, food hygiene and occupational hygiene; and the identification and control of local health hazards.
- (vi) rendering essential medico-legal services; and
- (vii) ensuring services to those arrested and charged, in collaboration with the relevant authorities.

Note: this package will be subject to the outcome of negotiations between the province and a municipality in terms of the constitutional right of municipalities to render municipal health services.

(b) Administrative, financial and support services

- (i) Ensuring the provision of support services essential to the rendering of health services, including: the accommodation for staff, where necessary; appropriate facilities for the rendering of maternal and mental health services; essential medicines; essential diagnostic services; transport; and the maintenance of equipment, facilities and other assets;
- (ii) establishing and managing the health district's budget in accordance with national and provincial policies and guidelines, and purchasing services as appropriate; and
- (iii) ensuring the promulgation of health by-laws.

(c) Planning and human resources

- (i) Monitoring and evaluating health and health service provision;
- (ii) gathering, analysing and managing health information at the district level;
- (iii) providing for appropriate human resource development; and
- (iv) ensuring the performance of any other health function or duty assigned to the health district.

2.4 INTEGRATING THE PUBLIC AND PRIVATE HEALTH SECTORS

Principle

The activities of the public and private health sectors should be integrated in a manner that makes optimal use of all available health care resources.

The public-private mix of health care should promote equity in service provision.

(a) Integration of private practitioners

Private health practitioners should be integrated with the public sector with regard to the provision and management of services. The central thrust being to enhance the capacity of the NHS to deliver affordable quality health care to all citizens of South Africa.

(b) Implementation strategies

- (i) The policy should apply to all private practitioners including private midwives, general medical and dental practitioners, specialist obstetricians and gynaecologists, paediatricians and private pharmacists.
- (ii) Services delivered by occupational health practitioners, and prison and military health authorities, should be subject to the same principles.
- (iii) In the delivery of a comprehensive and integrated maternal, child and women's health (MCWH) service, an MCWH management team will oversee both public and private sector delivery at each organisational level.
- (iv) Private practitioners will be required to meet national training standards in relation to the services rendered at each level of care.
- (v) Private practitioners will be encouraged to assist in the development of and follow standardised clinical management protocols.
- (vi) Both the public and private sectors will be required to provide information to the National Health Information and Audit Systems.
- (vii) To avoid duplication of expensive equipment within certain geographic areas, all

equipment should be purchased through a system of control, be used optimally by both the public and private sectors, and be properly maintained.

- (viii) Provincial health departments and health districts will be responsible for purchasing services from the private health sector and accredited providers, where required.

(c) Role of non-governmental organisations

Non-governmental organisations (NGOs) should continue to play an important role in the delivery and management of health services.

2.5 INVOLVING THE COMMUNITY

Principles

All South Africans should be equipped with the information and the means for identifying behavioural change conducive to improvement in their health.

People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.

The Department of Health should provide the public with regular updates on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy.

2.5.1 All South Africans should be equipped with the information and the means for identifying behavioural change conducive to improvement in their health

Much of the progress made in improving the health status of individuals depends on the

existence of healthy environments and lifestyles. It is crucial to involve individuals, families and communities in this process.

(a) Implementation strategies

- (i) The national health service should take advantage of all available opportunities to provide individuals, communities and the public at large with relevant information on healthy behaviour.
- (ii) The Department of Health should work in close collaboration with all social groups, especially women's and youth groups, to support the acceptance of and response to messages related to healthy behaviour.
- (iii) The Department of Health should promote and support legislation and policies for creating an environment that is conducive to healthy behaviour.
- (iv) The Department of Health should seek to establish close collaboration with the media to facilitate the wide dissemination of health-related information and positive role-models.
- (v) The Ministry of Health should work in close collaboration with the Ministry of Education and other social ministries, to provide them with the technical support required to develop their potential in health promotion fully.
- (vi) Clinic, health centre, hospital and community health committees should be provided with the required technical support and motivation to become advocates of positive behavioural change in the communities they represent.
- (vii) The Minister of Health should mobilise political leaders at all levels to lend their support to health promotion efforts.

2.5.2 People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services

In accordance with the democratisation of South African society, mechanisms for the participation of the people in the National Health System will be established at all levels.

(a) Implementation strategies

- (i) Clinic, health centre and hospital and community health committees should be established to permit service users to participate in the planning and provision of services in health facilities.

- (ii) Each community should know which CHC is responsible for providing it with the essential PHC package; therefore, the catchment area of each CHC must be clearly defined and known to all partners.
- (iii) The essential PHC package should be negotiated between the providers and the communities, to ensure that priorities perceived by the communities are addressed and that the communities have a clear understanding of their entitlements.
- (iv) The communities should elect the individuals who will represent them with regard to health matters.
- (v) The roles and powers of elected representatives should be clarified.
- (vi) Simple community-based information systems should be established by communities with the support of the health staff, to provide the information needed for the identification of priorities, the monitoring of progress made towards locally-established objectives and decisions on actions to be taken.
- (vii) Representatives of the communities should play a pivotal role in identifying underserved groups, and establish strategies to reach them in partnership with the primary health team.
- (viii) Women should be enabled and supported in playing a major role in local health committees.

2.5.3 The Department of Health should provide the public with regular updates on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy

The NHS is undergoing major changes which are bound to raise questions and create anxieties. Therefore, to facilitate the process, promote consensus and engender support, consultation must be extensive, the rationale behind changes clearly explained and regular updates on progress made widely disseminated to the public.

(a) Implementation strategies

- (i) Periodic national health summits should be established as a mechanism for public

- participation, make policy recommendations and identify new areas requiring attention.
- (ii) Similarly, provincial and district health summits should be held to review the progress made and plan improvements to the system, as well as structure local inputs to the national summits.
 - (iii) National, provincial and district annual reports should be compiled and disseminated to the public.
 - (iv) The national, provincial and district health authorities should develop a mechanism for responding timeously to enquiries raised by the public.
 - (v) The Minister of Health should provide parliamentarians and other political representatives with the information they require to respond adequately to questions raised by their constituencies.
 - (vi) Officials of the Department of Health should seek opportunities to present and explain issues of concern to the public.
 - (vii) The NHS should make use of appropriate mechanisms to measure the level of consumer satisfaction with the services provided, and disseminate the results.

2.6 PRIMARY HEALTH CARE

2.6.1 The priority of the National Health System

The new South African health system adopts the PHC approach because this approach is the most effective and cost effective means of improving the population's health. The approach involves a health system led by PHC services, which are at the base of an integrated district health system.

2.6.2 Definition of the PHC package

The PHC package will comprise the services listed below. The provision of these services will be promoted and evaluated by district health teams and relevant support personnel. The actual scope of the package of services will be determined by the available resources and will be implemented on a sustained and incremental basis over a 10 year period.

Table 3.2 : PHC services to be provided through the district health system

Services	Relevant health personnel
Personal promotive and preventive services : Health education Nutrition/Dietetic services Family planning Immunisation Screening for common diseases	PHC nurses; health educators Nutritionists; dieticians PHC nurses PHC nurses PHC nurses - Referral to generalist doctors as appropriate
Personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases.	PHC nurses - Referral to generalist doctors as appropriate
Maternal and child health services : Antenatal care Deliveries Post-natal and neonatal care	Midwives - Referral to generalist doctors as appropriate
Provision of essential drugs	Pharmacists and assistants; PHC nurses
PHC level investigative services : Radiology Pathology	Radiographers; X-ray technicians Laboratory technicians - Referral to generalist doctors as appropriate
Basic rehabilitative and physical therapy services	Physiotherapists and assistants; occupational therapists and assistants
Basic oral health services	Dental therapists; oral hygienists - Referral to dentists as appropriate
Basic optometry services	PHC nurses - Referral to optometrists as appropriate
Mental health services	Psychiatric nurses; social workers
Medical social work services	Social workers
Services organised and provided at the district level	
Health education	Health educators
Health-related nutritional support	Nutritionists; dieticians

Services	Relevant health personnel
Communicable, non-communicable and endemic disease prevention and control	Epidemiologists; public health specialists, Epidemiology assistants Public health officers; generalists doctors
School and institutional health services for children : Oral health Audiology Optometry	PHC nurses Dental therapists Audiology technicians Optometrists
Health-related water and sanitation services and other environmental health services	Environmental health officers
Community mental health and substance abuse services	Generalist doctors; PHC nurses; social workers
Occupational health & safety services (*)	Health inspectors Epidemiologists; public health specialists Generalist doctors
Community nursing and home care services, including care of the terminally ill	Generalist doctors; PHC nurses
Essential accident and emergency services	Emergency trained personnel; drivers
Community geriatric services and care of the elderly	Generalist doctors; PHC nurses
Health services support : Epidemiology and health information system Health monitoring Planning and Administration	Epidemiologists; health information system specialists Health planners; administrators
Basic medico-legal services (*)	Pathologists; generalist doctors

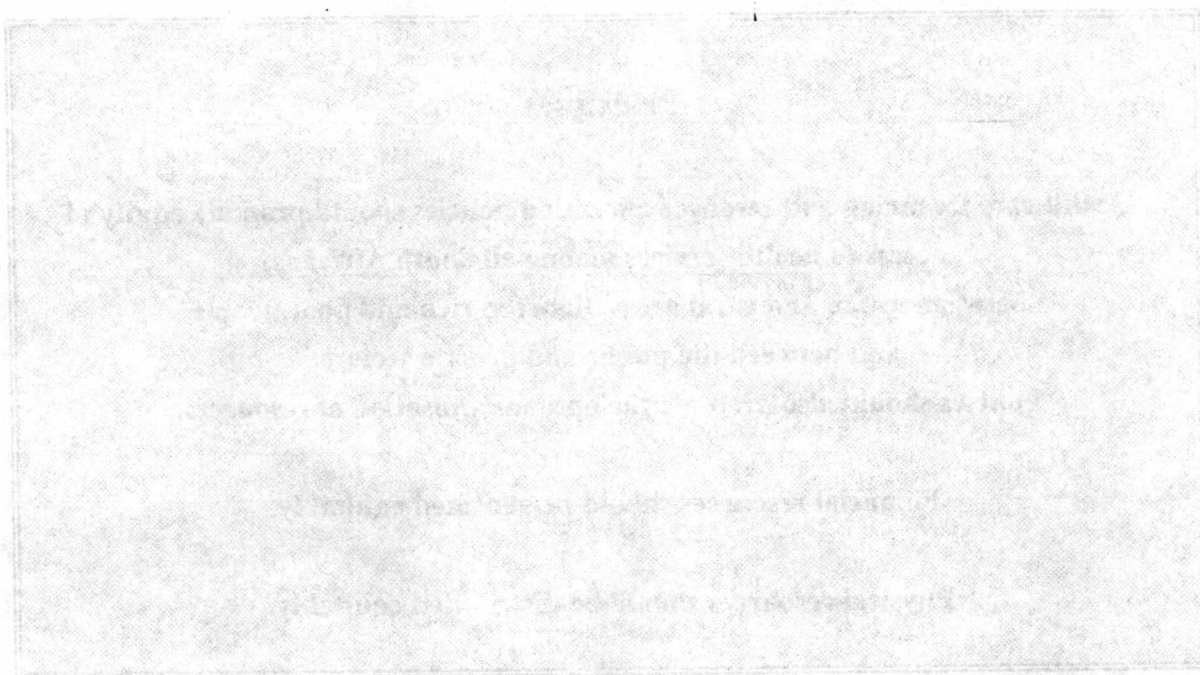
* These services are likely to be provided at the district level, but may be in part or completely funded from sources other than the health vote.

2.6.4 Public-private mix at the district level

District Health Authorities will supervise and allocate budgets to public providers and, where appropriate in the case of personal ambulatory care, purchase services from accredited private providers. There will thus be an opportunity for the ultimate emergence of some form of provider competition, especially in densely populated areas of the country. These arrangements will encourage improved governance, both at the district and provider levels.

Because of potential problems envisaged with the too rapid introduction of accredited private providers, public facilities will remain the dominant PHC providers funded by the government for the next few years. Accredited private providers will be introduced gradually, particularly in currently under-served areas. Priority will be given to sessional work by private providers in public facilities. In accordance with the principle of devolution of authority to the district level, DHAs will themselves make decisions regarding the appropriate public-private provider mix in their districts at different points in time.

Where full and/or part-time practitioners are in short supply, private practitioners' services will be used through referral contracts, and patients will be referred to a general practitioner by a PHC nurse in the public facility. This amounts to a significant reform of the district surgeon system. The overall effect of these reforms will be to facilitate the emergence of flexible and creative arrangements between DHAs and local practitioners and to maximise private doctors' contributions to the public health system.



THE GOAL: BASIC HEALTH CARE FOR ALL SOUTH AFRICA'S WITHIN 10 YEARS

South Africa has well developed high technology hospitals in the main cities, but underdeveloped basic health services, especially in the former rural homelands. As a

Chapter 3

Financial and Physical Resources

In 1992-93, South Africa spent approximately 8,5% of GDP on health services, both public and private. This represents a very high level of spending for a country at South Africa's level of development. However, the distribution of resources is highly inequitable and wasteful. A small proportion of the population benefits disproportionately from services rendered by the private sector, which are comparable to those offered in more affluent countries. At the same time, the majority of the South African population has very limited access to any form of services. Moreover, there are considerable inequities and inefficiencies in the distribution of public health resources, spending being weighted heavily in favour of certain provinces, urban areas and curative, hospital-based care.

Principles

Health care financing and resource allocation policies should promote equity of access to health services among all South Africans, between urban and rural areas, between rich and poor people, and between the public and private sectors.

Policies should also promote the optimal utilisation of resources.

Financial resources should be allocated equitably.

Physical resources should be distributed equitably.

3.1 THE GOAL: BASIC HEALTH CARE FOR ALL SOUTH AFRICANS WITHIN 10 YEARS

South Africa has well developed, high technology hospitals in the main cities, but underdeveloped basic health services, especially in the former rural homelands. As a

consequence, essential health care is deficient for the poorer two thirds of the population. To rectify this situation, national health policy affords first priority to the development of the district health system, which comprises integrated PHC and district hospital services. The goal is to provide for an increase in the average number of public PHC consultations per person from a low baseline of 1,8 in 1992/93 to 2,8 by the end of the century and to 3,5 over the following five years (Table 3.1). Priority will be given to the most underserved areas and the intention is to bring the provision of PHC services for the poorer two thirds of the population up to the level of that for the better off one third by the year 2000.

Table 3.1 : Expected increase in use of public primary health care services

Quintiles of (previous) magisterial districts by average income ¹	Population (% total) ¹	<u>Average annual consultations per person</u>		
		1992/93 ¹	2000/01	2005/06
Top	37	2,6	2,8	3,5
Bottom four	63	1,3	2,8	3,5
Total	100	1,8	2,8	3,5

1. Derived from McIntyre, D. et al., *Health Expenditure and Finance in South Africa*, Health Systems Trust and World Bank, Durban, 1995, Tables 2.5 and 7.4.

3.2 AFFORDABILITY

The Department of Health has developed a medium term expenditure framework for the public health sector. The framework projects public health spending by level of care and in total to the year 2000. It indicates that it is broadly affordable to provide basic health care for all South Africans within a 10 year period, with two provisos. The first is that there is a redistribution of public health resources. The second proviso is that there are new sources of public health finance over and above general government revenue. The main proposed new financial sources are social health insurance and retention in the health service of fees collected by public hospitals. Despite the country's economic constraints, therefore, the Department of Health maintains the policy of providing essential health care to the whole population within 10 years, in line with RDP commitments.

3.3 NEED FOR REDISTRIBUTION OF PUBLIC HEALTH RESOURCES

Because of economic constraints, there is a need to redistribute public health resources, both geographically and by level of care.

Redistribution of health resources from better served provinces to under served provinces has been effected through the Health Function Committee system. In this system, public health finance was allocated by the government nationally and was distributed to provinces on the basis of a weighted capitation formula, which took into account the relative need of provincial populations for public health services. The sector by sector Function Committee system has now been replaced by a system of unconditional block grants to provinces and the central mechanism of health resource allocation is no longer available. In the new system of fiscal decentralisation, provincial health allocations will be determined by the nine provincial treasuries and governments. Equitable geographical health allocations will be much more difficult to achieve in this context. As a means of defining provincial health resources, it will be important to develop provincial medium term health expenditure plans, which will form the bases for local health service developments.

Because of the unbalanced development of health services in South Africa, it is also necessary to redistribute resources from high technology hospitals to district health services. This policy is one which will require continuous defence in the political arena. The health sector differs from other sectors in that there is major disjunction between established policy and popular demand. Health policy - worldwide and nationally - prioritises prevention and PHC services, because these are the most effective, and the most cost effective, health care means to achieve better health. But everywhere spontaneous demand is mainly for curative and hospital services. Popular demand for high technology hospitals, especially when exerted by urban middle classes, tends to be translated over time into political decisions to use public funds for hospital provision - hence the relative over provision of hospitals all over the world, with South Africa as no exception. Provincial governments will come under the pressure of this urban demand for hospital treatment. It is easy to adopt a PHC policy in theory, but opposition will surface as the process of resource redistribution gets under way and begins to bite. There needs to be a mechanism for ensuring that - in each set of provincial resource decisions - public health resources are allocated in accordance with national PHC priorities and funds for

District Health Services are protected from local political pressures acting in favour of high technology hospitals.

3.4 NEED FOR PROTECTION OF FUNDS FOR THE DISTRICT HEALTH SERVICES

Despite the context of economic austerity, health (and other social) services must be improved for disadvantaged populations within the next few years. The key to improving basic health care is the district health system. It was in order to achieve protection of District Health Services funding that the Financial and Fiscal Commission proposed conditional 'minimum standards' grants to provinces for health (and education). The grants earmarked funds for PHC and district hospital services. The FFC grant projections provided for *both* the priority allocation of resources to the district health system and the phasing in of geographical equity in access to basic health care. To work towards the goal of providing essential health care for all South Africans within 10 years, the FFC projected real growth in District Health Services spending (Table 3.2).

Table 3.2 : Financial and Fiscal Commission projection of allocations to the district health system by province (1996 rand - millions)

Provinces	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
W. Cape	713	764	791	820	850	882
E. Cape	1 690	1 826	1 900	1 977	2 058	2 143
N. Cape	167	177	182	188	194	200
KwaZulu-Natal	2 018	2 172	2 255	2 341	2 433	2 528
Free State	663	720	751	783	817	853
North West	846	919	958	1 000	1 043	1 089
Gauteng	1 462	1 602	1 679	1 760	1 846	1 937
Mpumalanga	644	694	721	749	779	810
Northern	1 252	1 342	1 390	1 440	1 493	1 548
South Africa	9 454	10 216	10 626	11 058	11 511	11 989

Source: *Financial and Fiscal Commission's Recommendations for the Allocation of Financial Resources to the National and Provincial Governments for the 1997/98 Financial Year*, May 1996, Table 6.

In the absence of conditional DHS grants from central government, as proposed by the FFC, DHS funding should be earmarked by agreement between provincial health departments and treasuries, in the context of provincial medium term expenditure plans. The FFC projections may be used as benchmarks of DHS expenditure which would result in basic health care being provided to all South Africans within a 10 year period.

3.5 NEW SOURCES OF PUBLIC HEALTH FINANCE

3.5.1 Retention by health service of public hospital fee revenue

The ability to protect DHS voted allocations would be facilitated by securing additional finance for secondary and tertiary hospitals, making it possible to lessen the demand of the higher levels of care on the health vote. Additional finance would also facilitate improvement in the quality of care in public hospitals.

Revenue generation from user fees is currently at a low level in most public hospitals.

One of the most important reasons for this is the lack of incentive for hospital managers to collect fees, since all generated income accrues to the provincial revenue fund. Also the quality of care in public hospitals is often low and this has resulted in a shift of paying patients to private hospitals (as well as in a demand for new private hospitals, even in small towns).

The Department of Health will work towards improvement in the quality of care and amenities in public hospitals by, inter alia:

- promoting reform in hospital management, including the introduction of decentralised management in line with government policy on public sector reform; and

In a context of decentralised management and improving care in public hospitals, revenue retention will be introduced to create an incentive for hospital managers to increase the efficiency of fee collection and to provide them with funds which can be used flexibly.

These funds will be utilised to improve the quality of hospital services and the working conditions of hospital staff. These measures should in turn attract further paying patients.

Revenue retention will be phased in over a number of years and the retained funds will be split between the collecting hospitals and provincial health departments. This will provide an incentive for hospitals to collect fees, while allowing provincial health departments to distribute some of the income to needy facilities which are unable to generate significant fee revenue. A greater proportion of the retained funds collected by higher level hospitals will be channelled to the provincial health departments, while a greater proportion of the retained funds generated by lower level hospitals will remain with the collecting facilities.

3.5.2 Social health insurance

Another important means of increasing public health finance will be the introduction of social health insurance. Currently large numbers of employed workers are not members of medical schemes and they, and their families, often attend public hospitals without paying the prescribed fees, even though they can afford to do so. Also medical scheme members and their families may attend public hospitals when their scheme cover is exhausted and again may not pay the prescribed fees. A social health insurance scheme will be introduced which will require all formally employed people to be insured for the costs of treatment of themselves and their dependants in public hospitals. Contributions will be shared between employers and employees, and will be related to income and family size.

3.6 FUNDING OF TERTIARY AND HIGHLY SPECIALISED PUBLIC HEALTH SERVICES

It is expected that, within 10 years, 'routine' tertiary health services will be provided in at least some regional hospitals in all provinces. In the meantime, provinces without such services will have to refer patients to provinces which do provide them. 'Client' provinces will pay 'provider' provinces for these services, but the level of charge in the next several years will take into account the fact that equity in provincial government funding will not yet have been achieved.

By contrast, services which are highly specialised, expensive and relatively rarely needed, would be uneconomical to locate in every province. Most of these services are currently provided in academic central hospitals. Services provided by one or a small number of units in the country will become available, through referral mechanisms, to the whole population. Although academic central hospitals are located in particular provinces, they are national resources and should, in time, treat only appropriately referred patients. Their location and development will be planned centrally in accordance with national health policy and they will be financed from a fund held by the Department of Health. Services at these hospitals are being identified and costed.

3.7 FUNDING OF ACADEMIC RELATED HEALTH SERVICE COSTS

Academic health services complexes incur extra *service* costs as a result of their academic functions. (The costs of teaching and research as such are met by the universities.) The additional service costs associated with teaching and research have been termed the 'national increment for teaching, education and research' (NITER).

The NITER grant to provinces with academic health services complexes has been a lump sum estimate based on historical expenditures. A more rational and equitable funding mechanism will now be introduced in the form of a standard allocation for each enrolled medical student. For the time being, the number of medical students will be used as a proxy for all academic activity that requires additional health service provision. More refined methods of estimating academic related service costs based on the numbers of clinical medical, dental and other students (including postgraduates) will be developed. With a per student funding mechanism, any historically determined excessive spending patterns of particular academic complexes will no longer be rewarded.

The current unbalanced distribution of academic health training reflects the country's apartheid history and efforts are being made to distribute medical and related professional training more evenly among universities and provinces. With funding on a per student basis, 'the money will follow the students' and NITER allocations will be distributed more equitably. In addition NITER funds, managed by the Department of Health, will also be used for 'pump priming' of presently under resourced academic health services complexes in advance of an increase in clinical student numbers.

3.8 REVISED PROCEDURES FOR BUDGETING

3.8.1 Aims

Health budgeting procedures have been revised. The aims of the new approach are to:

- (i) Create awareness of the activities for which a health department is responsible;
- (ii) align health department activities with the goals of the government and establish new activities where current activities do not address all such goals;
- (iii) re-examine the rationale for, and extent of, the need for an activity;

- (iv) determine the cost of each activity from zero;
- (v) prioritise all the activities of a health department on the basis of cross-cutting criteria which have been established by the Department of Health; and
- (vi) create a database which will -
 - enhance the ability of the government to evaluate spending agencies' requests in a rational manner;
 - provide the information required for policy decisions; and
 - improve strategic financial management in the health sector.

3.8.2 Budget reprioritisation

- (a) **Budgetary controls will promote the following:**
- (i) Shift of expenditures towards primary health care;
 - (ii) commissioning of buildings and equipment for the delivery of PHC services;
 - (iii) management of patients at the appropriate level of care;
 - (iv) improved efficiency with regard to the use of resources;
 - (v) establishment of, or improved, decision support systems for health care managers at all levels;
 - (vi) reduced wastage and loss of drugs;
 - (vii) eliminating duplication of facilities and services;
 - (viii) limited inappropriate level care in academic hospitals;
 - (ix) reduced number of tertiary care beds;
 - (x) better use of underutilised hospitals; and
 - (xi) greater cost recovery at higher level facilities.

(b) **Criteria for reprioritisation**

The criteria for reprioritisation developed by the Department of Health are the following:

- (i) Services must be accessible to the majority of the population and focus on the most vulnerable groups, especially women and children, and the rural, peri-urban and urban poor;

- (ii) activities should have maximum impact on the health status of the entire population (with the emphasis on women and children), based on cost-effective interventions targeting those areas with the highest infant, under-five and maternal mortality rates;
- (iii) services should be comprehensive and provided in an integrated manner; and
- (iv) the probability of success, acceptability and participation by communities should be taken into account.

3.9 PHYSICAL RESOURCES SHOULD BE DISTRIBUTED EQUITABLY

The Department of Health is engaged in several processes in an attempt to redress the current imbalances in the distribution and condition of health facilities and equipment in South Africa. These include:

- (a) A comprehensive audit of community health centres and hospitals, the results of which will form a baseline for future capital allocations and, in close collaboration with other government departments, for ongoing investment in facilities and maintenance; and
- (b) investment in the expansion of PHC clinics.

3.10 SPECIFIC PROPOSALS FOR PUBLIC/PRIVATE MIX IN SOUTH AFRICA

3.10.1 The current realities of South Africa require a strong Public Health Sector. Such a public health sector will have to accommodate more people and significantly improve the quality of care against a background of limited resources from the fiscus. In this regard a number of strategies are critical. They include the following :

- Changes in management structure in all facilities to promote decentralised decision making which is critical to reform which will facilitate significantly enhanced efficiency operations in the hospital sector, especially if this is linked with the ability to retain revenues generated.
- To raise the degree of cross subsidisation to levels adequate to ensure improved access to good quality care for the millions of unemployed and poor, it will be

useful to draw in more paying patients back to the public hospital sector.

3.10.2 (a) At present, South Africa has about 3 beds\1 000 of population. Of these 80% are in the public sector and 20% in the private sector. There are a number of proposals in this regard :

- ☐ this national ratio of 80:20 be maintained;
- ☐ any new licences in future be aimed at correcting historical inequities and also ensure diversification of ownership;
- ☐ within the above framework, contractual arrangements be entered into with the private sector based on negotiated tariffs for utilisation of all hospital beds in a province before consideration is made for more beds to be created (be it in the private or public sector). This opens the possibility for the use of the private sector hospital beds for public patients at agreed upon tariffs and vice versa;
- ☐ No new licenses for hospital ownership where practising medical practitioners and specialists are shareholders;

3.10.2 (b) There must be licensing of entry of highly specialised equipment based on geographical grids. Greater cross utilisation between public/private sectors should be promoted.

- ☐ A closely linked issue is the need for licensing of practices on the basis of certificate of need on a geographical basis. This should aim to promote equitable distribution of our limited resources.

3.10.3 Contracting of Services

We have some accumulated experience on the contracting out of services - both clinical and non-clinical. Within the context of provisos outlined in the document, there is a place for selectively engaging in this practice.

The aim of contracting out should be clearly thought through to specifically address the more fundamental need in a particular context. In the more rural and deprived communities of South Africa, the fundamental aim of contracting out should be to extend services to communities where access is hampered by lack of public facilities and where the private sector is in a position to or can be attracted to meet the needs of these communities. This form of intervention may also be appropriate for the peri-urban informal settlements. A possible strategy for this is the accreditation of Private Providers to serve patients who would otherwise depend on public sector facilities. Such private providers may be groups of independent general practitioners or non-governmental organisations.

In the urban areas the central thrust of most contracting out reforms is the introduction of competition in the provision of services, while financing is retained in the public domain. It is argued that such reform would address the pervasive inefficiency problems in the public sector while retaining the positive equity effects of the public sector.

In general, experience suggests that a number of conditions need to hold for contracting to be a viable option. These include:

- * range, cost and quality of services under contract should be comparable to direct public provision;
- * the public sector should have enough capacity to develop and negotiate contracts, as well as monitor performance of contractors;
- * efficiency of contracting depends on a number of factors including the distribution of risk between government and contractor, and incentives in the contract;
- * services provided under contract should be consistent with patterns of public services organisation and delivery;
- * contractual arrangements should not create sustained dependence and lack of public sector capacity, or inability to seek alternatives to contracting in the future.

3.10.4 Public sources of finance presently account for 40% of health sector funding. Most of this goes to public sector facilities. There is limited money flowing from the private sector sources to the public sector - what exists is largely through user fees (estimated at R650 million in 1992/93).

Furthermore, this amount has been declining over the past few years. If the public sector is to continue providing for the majority of South Africans as envisaged in this document, a number of interventions are necessary and they include the following :

- (i) greater absorption by the public sector of funds presently utilised in private sector. The policies on revenue retention, managerial autonomy and admission of private patients in public hospitals attempt to address this issue;
- (ii) given the unlikely increase in fiscal allocation, we have to ensure greater payment for hospital care by those who can afford it. The proposal currently being explored of some form of social health insurance attempts to address this issue;
- (iii) Medical Schemes - as a private source of funding will continue albeit in a more regulated environment.

The following set of regulatory mechanisms are required to reverse the recent deregulation of the private health insurance market, which has resulted in serious instability, increasing costs and reduced coverage:

- (a) medical schemes may not exclude an individual on the basis of health risk. Contribution rates for the full package of benefits will be set according to income and number of dependants.
- (b) medical schemes are obliged to continue providing health benefits to continuation members (i.e. pensioners, widows, widowers), and to individuals for a limited period after their becoming unemployed. In addition, the practice of transferring private patients to public hospitals once their medical aid benefits are exhausted, should be discontinued.

3.10.5 Regulation of the Private Sector

The regulatory responsibility and capacity of the public sector is probably the single most important determinant of the public/private mix in many countries. Many of the policies mentioned above seek to coordinate public and private sector activities, and to use regulation as a means of influencing private sector behaviour rather than of control. For example, the policy on accreditation of private providers attempts to entice these providers into the public health care system.

A number of regulatory mechanisms are available to the public sector, which include, subject to provisions of the Constitution, controlling prices, quantity, distribution and location of private sector; and mechanisms for regulating quality of services. The existence of a strong regulatory capacity is essential to the success of any policies that encourage private sector participation. In addition, it is important to recognise that government may be only one of many regulatory agents; others could include financing intermediaries, professional groups and patient organisations.

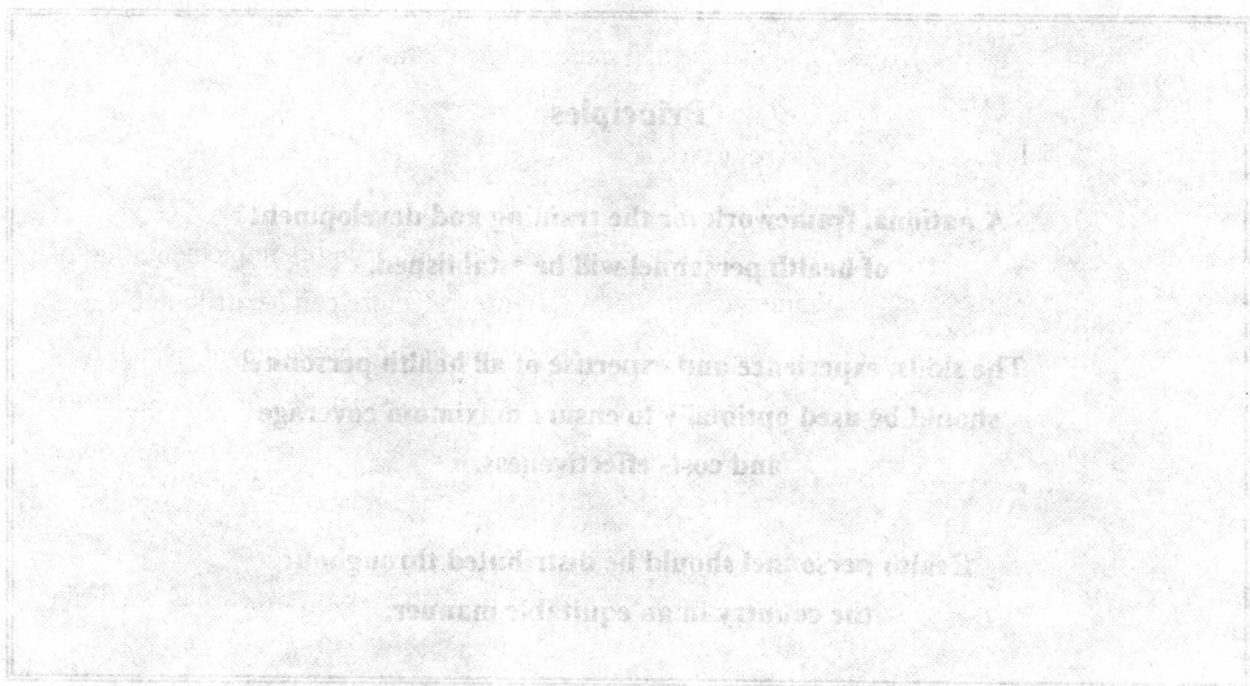
3.10.5.1 Strategies for regulation

It is important to learn some lessons from failures in the implementation of regulatory framework in many countries. Failure can be attributable to a range of factors, including failure on the part of government, which may be more or less benign. Other sources of failure may be due to 'regulatory capture' where the regulatory body is effectively neutralised by the power of the institution which it is supposed to be regulating.

However, a central weakness in the regulatory framework has been the tendency to lay down rigid regulations about what the private sector can and cannot do. It is important that government creates appropriate incentives and disincentive (a carrot and stick approach), to encourage appropriate behaviour. For example, the development of positive regulatory measures which professional bodies find in their interest to adopt may be easier and faster to implement. The public sector should also have the capacity to monitor the professional bodies in their regulatory function.

In addition, government may want to review the activities of existing regulatory agencies and mechanisms, and may need to develop new agencies and mechanisms. Regulatory reform should be supported by research which identifies possible poor practises (eg excessive referrals and inappropriate use of expensive technology). Ultimately, the need for information and better data will be critical if government is to better manage the interface with the private sector.

4.1 PLANNING HUMAN RESOURCES



4.1.1 A NATIONAL FRAMEWORK FOR THE TRAINING AND DEVELOPMENT OF HEALTH PERSONNEL WILL BE ESTABLISHED

- (a) Implementation strategies
- (i) A national audit of the number and distribution of trained health personnel will be undertaken.
 - (ii) A audit of training institutions and their capacities will be undertaken, and the relevance of existing curricula assessed.

Chapter 4

Developing Human Resources for Health

Human resource development is a critical factor in the implementation of health and social development. A policy should provide guidelines for the recruitment, selection and placement of health personnel, based on national needs and affirmative action; design education programmes aimed at developing competent personnel; promote the optimal use of globally competent, caring and critically-minded personnel functioning within a multidisciplinary team; and promote a new culture of change management in the health sector, based on participatory leadership.

4.1 PLANNING HUMAN RESOURCES

Principles

A national framework for the training and development of health personnel will be established.

The skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost-effectiveness.

Health personnel should be distributed throughout the country in an equitable manner.

4.1.1 A NATIONAL FRAMEWORK FOR THE TRAINING AND DEVELOPMENT OF HEALTH PERSONNEL WILL BE ESTABLISHED

(a) Implementation strategies

- (i) A national audit of the numbers and distribution of trained health personnel will be undertaken.
- (ii) An audit of training institutions and their capacities will be undertaken, and the relevance of existing curricula assessed.

- (iii) On the strength of (i) and (ii) above, guidelines for future training and upgrading of personnel will be formulated, based on a principle of excellence.

4.1.2 THE SKILLS, EXPERIENCE AND EXPERTISE OF ALL HEALTH PERSONNEL SHOULD BE USED OPTIMALLY TO ENSURE MAXIMUM COVERAGE AND COST-EFFECTIVENESS

(a) Implementation strategies

(i) Composition of basic primary health care teams (PHCTs)

Basic PHCTs should include a mix of health personnel with appropriate skills to deal with common conditions and execute prompt and appropriate referral to the next level of care. Such a team should be based at a basic health unit (BHU) such as a clinic, community health centre or a doctor's rooms (public/private).

A PHCT should include community health nurses, midwives, doctors, primary health care nurses, enrolled nurses and nursing auxiliaries, oral hygienists/therapists, clerical and support staff and rehabilitation personnel.

Problems that cannot be dealt with at the primary level must be referred to the secondary level. At each of these levels, an appropriate health personnel mix will be available. The existing PHCT population ratio of 1: 30 000 should be reduced to 1: 15 000 over a five year period. This increased availability of health personnel will provide coverage for the additional 1 000 primary care clinics required.

(ii) Composition of referral teams at the district level

The referral team should consist of medical and nurse practitioners, clinical nurses with advance training, e.g. psychiatric nurses, pharmacists, dentists, clinical psychologists, environmental health officers and assistants, enrolled nurses and nursing auxiliaries, advanced midwives and supplementary health personnel, according to the needs of the community.

Specialist personnel will be stationed at the secondary and tertiary levels for referral care. These will include specialist nurse clinicians, super and subspecialists

and more specialised allied health workers, such as orthopaedic technicians and educational psychologists.

(iii) Upgrading the skills of mid-level health workers

Consideration should be given to supporting existing categories of mid-level workers through distance learning in order to upgrade their skills. Those with two years of training, be they monovalent or polyvalent in their range of clinical skills, should be provided with a career path with appropriate exit points. Staffing in the peripheral areas should be aimed at nurturing skilled generalists; separate categories of mid-level workers should be avoided.

(iv) Training of doctors

The existing number of medical schools (8) should be retained and the intake should reflect the demographic composition of the country. The number of admissions and graduates should be based on an assessment of the country's needs, as determined by the National Human Resource Audit, with regular reviews to meet the changing needs. In addition, South Africa's role in the human resource development initiatives of the region should be considered.

(v) Medical assistants

Medical assistants, most of whom are returned exiles, should be admitted to a closed register under the control of the Interim National Medical and Dental Council (INMDC). Returned exiles only should be accommodated, and no further training of medical assistants should be approved.

- The cut-off date for registration should be 1 January 2000.
- Medical assistants should be appointed on appropriate salary scales.

(vi) Relationship between community health workers and the public health system

The incorporation of community health workers with the public service should not be considered at this stage. Where necessary, training should take place at the district level, with accountability to the provincial health authority. The feasibility

of district financial support for such training should be investigated. Community rehabilitation health workers and health carers should only be trained through the addition of skills to physiotherapist or occupational therapist assistants, where a distinct career path with exit points has been identified, and not on an ad hoc basis.

(vii) Traditional practitioners and birth attendants

Traditional practitioners and traditional birth attendants (TBAs) should not, at this stage, form part of the public health service, but should be recognised as an important component of the broader primary health care team.

The regulation and control of traditional healers should be investigated for their legal empowerment. Criteria outlining standards of practice and an ethical code of conduct for traditional practitioners should be developed to facilitate their registration. Where TBA's are utilised, they should be educated and supported by the public health sector.

(viii) Foreign health graduates

The distribution and competency levels of foreign graduates working in South Africa should be monitored at the national level. Clinical competence and the ability to communicate in at least one South African language will be a prerequisite for registration. They should be recruited to serve in under-served areas. Foreign doctors from countries with an oversupply should be permitted to practice, once they have been certified and registered by the INMDC, conditional upon a job offer from a provincial health authority. Government-to-government programmes should enjoy preference over individual applications. The registration of volunteer medical doctors should be considered by the INMDC.

(ix) Review of legislation

Legislation pertaining to the health professions must be reviewed. Health-related legislation pertaining to the scope of practice of optometrists and the prescription of certain medication by psychologists should also be reviewed including -

- the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974); Ethical Rule 9(ii);

- the Medicine and Related Substances Control Amendment Act (Act No. 94 of 1991); and
- Section 38A of the Nursing Act (Act No. 50 of 1978), with reference to the "diagnosing, prescribing and treatment" in the Regulations regarding the Scope of Practice for Nurses.

(x) Role of training institutions

Appropriate, multidisciplinary community-problem and outcome-based education programmes in accordance with the National Qualifications Framework (NQF) should be developed to support and enhance the PHC approach.

(xi) Vocational Training

Consideration should be given, as part of curricula review, for the introduction of vocational training to improve the competence of our health professionals.

This process will be introduced for medical doctors beginning January 1998. The period of vocational training must equip our professionals to better confront the challenges of independent practice. This necessitates that such training be carried out also in Primary Care Settings.

(xii) South African-trained health professionals abroad

South African-trained health professionals abroad should be recruited and J-1 visa holders, based on a concept of need, should be followed up to honour their commitment to return to South Africa.

4.1.3 HEALTH PERSONNEL SHOULD BE DISTRIBUTED THROUGHOUT THE COUNTRY IN AN EQUITABLE MANNER

(a) Implementation strategies

(i) National planning system

A new, uniform system for the distribution and financing of personnel at all levels of health care will be developed at the national level. Norms and standards will be

developed for the selection and appointment of health professionals, thereby determining a profile of human resources in relation to the skills and competencies required, and to conduct quality assurance and personnel performance appraisal.

(ii) Addressing the maldistribution of personnel

The maldistribution of human resources should be addressed primarily through an incentive-driven process, with service requirements of a maximum of two (2) years in an underserved area after completion of graduate or post-graduate studies.

Incentives should be developed, the magnitude of which should be based on the level of inhospitability of the working environment. All categories of professional staff should benefit from such incentives.

New bursary schemes linked to districts and provinces should be established for health science students, while existing bursary and other training schemes with service obligations should be retained. Students resident in identified underserved areas should receive preferential consideration.

Professional nursing students should be excluded from bursary schemes and the current system of being paid a salary during their training, should be continued.

Urgent attention should be given to upgrading clinics, to ensure adequate staff recruitment.

(iii) Obligatory service requirements

All health professionals, generalists and specialists, should spend at least two years in a public sector non-tertiary institution, prior to entering health practice. Registrars' training should include one year's public sector experience in an underserved area, which should form an integral part of such training.

(iv) Remuneration packages

The Government should review the salary packages of all health personnel. The Remuneration of Town Clerks Act, 1984 (Act No. 115 of 1984), Sections 8 and 9, should be reviewed and the Government should adopt the best salary equalising option that is financially viable.

4.2 EDUCATION AND TRAINING

Principles

Education and training programmes should be aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve.

Particular emphasis should be placed on training personnel for the provision of effective primary health care.

New policies and strategies for human resource development should address priority education and training needs.

4.2.1 EDUCATION AND TRAINING PROGRAMMES SHOULD BE AIMED AT RECRUITING AND DEVELOPING PERSONNEL WHO ARE COMPETENT TO RESPOND APPROPRIATELY TO THE HEALTH NEEDS OF THE PEOPLE THEY SERVE

Education and training programmes should comprise relevant, reality-based curricula which are aimed at attaining competence within the psychomotor and affective domains of education objectives; should provide comprehensive, integrated, community problem-based health care delivery education for competent practice within a multidisciplinary team ideology; and should be co-ordinated, reviewed and rationalised to meet the health needs of the country.

(a) Implementation strategies

(i) Training appropriate to the level of care

The ability of health professionals to deliver approved health service packages at

various levels of health care should be developed. The following categories of health workers should be regarded as a training priority:

- PHC nurses and advanced midwives
- community psychiatric nurses and psychologists
- paediatric nurses
- nutritionists
- environmental health officers and assistants
- epidemiologists
- district health managers.
- chronic disease managers
- psychologists
- occupational therapists and physiotherapists.

(ii) Co-ordination of training

The large number of health personnel education programmes offered by a variety of institutions should be co-ordinated and, if necessary, rationalised. The Human Resources Development Directorate of the Department of Health should establish a co-ordinating education committee (CEC) which should include representatives of universities, technikons, nursing colleges, the Departments of Education and Health, health service providers, health science students, non-governmental organisations and the public, to facilitate an interdisciplinary approach.

The function of the CEC for health care training and education programmes will include the selection of training of all professionals, curriculum review, community-based education, integration of educational experiences for different professionals, continuing education, recertification and accreditation.

The activities performed at this level should include the planning, implementation, monitoring, evaluation, review and co-ordination of all health personnel education programmes.

(iii) Career path development and continuing education

The development of career paths and continuing education for all health professionals should be promoted. The system of visiting consultants should be

structured in such a way that specialist categories function as educators at the primary health care level.

(iv) Ability assurance and registration

Recertification for competency and safe practice and the updating of health professions should be the responsibility of the interim professional councils or their successors in title.

(v) Training of oral health personnel

The training of all oral health personnel, including dental technicians and dental assistants, should be undertaken in academic oral health services complexes.

4.2.2 PARTICULAR EMPHASIS SHOULD BE PLACED ON TRAINING PERSONNEL FOR THE PROVISION OF EFFECTIVE PRIMARY HEALTH CARE

(a) Implementation strategies

(i) PHC-orientated curricula

Health sciences curricula should be restructured to reflect community needs more accurately, and teaching should place greater emphasis on community and outcome-based programmes. The fundamentals of a community needs-based health sciences curriculum are primary health care, social sciences, health promotion, ethics, basic management, community participation, conflict resolution and communication, basic counseling, epidemiology, research methodology and information use, and first aid (emergency care).

Provision should also be made for the development of educational programmes on the rational use of essential generic drugs. Nutrition support, monitoring and rehabilitation should be incorporated with the training of all primary health care providers.

Health personnel at all levels should receive training in the analysis and use of data collected in terms of the National Health Information System for South Africa (NHIS/SA).

(ii) Primary health care orientation of existing personnel

An understanding of, and emphasis on primary health care should be instilled in all existing health personnel through appropriate reorientation programmes with ongoing evaluation and monitoring components.

(iii) Emphasis on generalist training

Training offered by academic health services complexes should reflect the emphasis on generalist as opposed to specialist training. An expert task group should be established to evaluate post-graduate education in view of this emphasis.

(iv) School of Public Health

There exists a need for a National School of Public Health to complement the existing schools of public health initiative. The Department of Health will support the development of a National School of Public Health which - as a school without walls - will use the resources of all academic, service and research organisations, and complement other public health programme initiatives in the country.

4.2.3 NEW POLICIES AND STRATEGIES FOR HUMAN RESOURCE DEVELOPMENT SHOULD ADDRESS PRIORITY EDUCATION AND TRAINING NEEDS

(a) Implementation strategy

The subsidy system for educational institutions should reflect priority education and training needs. This system should be reviewed by the Departments of Health and Education, and make provision for a more equitable allocation of subsidies, especially for historically Black tertiary institutions.

4.3 CREATING A CARING ETHOS

Principle

**The experience of people using the health system
should be one of caring and compassion.**

(a) Implementation strategies

(i) Charter of Community and Patients' Rights

A Charter of Community and Patients' Rights should be designed in consultation with health service providers and users in support of the democratisation of society.

(ii) Rights of health care personnel

The rights of health care workers should be defined and respected, so that an ethos of caring is nurtured, and not undermined or exploited. The security and safety of staff should also be ensured.

(iii) Campaign of caring

An active campaign to engender a "culture of caring" throughout the health services should be launched by senior officials at all levels, including the Ministry. The following are among the activities which should be undertaken:

- Health care providers should be rewarded for compassionate and caring service.
- The selection of health sciences students should include criteria for caring and compassion.
- Ethics courses on health care, properly supervised, should feature prominently in training programmes.

- Peer pressure could be used as a means of ensuring compassionate and caring attitudes among health personnel.
- Competency in the major South African languages should be encouraged by health training institutions, and appropriate training should be offered in conjunction with professional courses. A mandatory African language should be considered.
- Clinical examinations for all health sciences students should include credit for compassion and caring displayed.
- Guidance for a career in the health professions should be offered at schools.

(iv) Support of health care personnel

An efficient and effective support system for health care personnel, particularly those in rural areas, should be developed and the following implemented:

- An improved system of communication for health care workers in rural areas should be developed as a matter of urgency.
- Funds should be made available at the national level for the improvement of physical health care structures and equipment.

4.4 CHANGING THE NATURE OF MANAGEMENT

Principles

Management authority should be decentralised to the provincial and district levels to allow for a greater degree of autonomy.

Health service managers should be supported in acquiring the skills required to manage a decentralised health service.

A participative, democratic management style and management by objectives should be engendered.

Effective evaluation techniques and procedures should be introduced to assess management efficiency at all levels of the health services.

4.4.1 MANAGEMENT AUTHORITY SHOULD BE DECENTRALISED TO THE PROVINCIAL AND DISTRICT LEVELS TO ALLOW FOR A GREATER DEGREE OF AUTONOMY

(a) Implementation strategies

(i) Decentralised management

Capacity will be built to ensure effective management at the provincial, district and local levels. Such decentralisation will be aimed at promoting innovation and efficiency where a health management team (HMT) constitutes the structural unit. Such a team should consist of a health service manager, a chief nurse, medical practitioners and other appropriate staff, co-opted as the needs of the community served are determined. However, monitoring and assessment of upholding of norms, standards and guidelines will be conducted at the national level.

(ii) District health management teams

District health management teams should be trained and empowered to develop and supervise integrated comprehensive health services, using the primary health care approach.

4.4.2 HEALTH SERVICE MANAGERS SHOULD BE SUPPORTED IN ACQUIRING THE SKILLS REQUIRED TO MANAGE A DECENTRALISED HEALTH SERVICE

(a) Implementation strategy

- (i) A health management training committee comprising representatives of selected educational and training institutions, the health services, student organisations and consultants should be established.
- (ii) An inventory of all health services management training should be compiled by this committee, with a view to optimising and, where necessary, rationalising such training.
- (iii) Formal and in-service courses in health systems management emphasising democratic management principles should be developed.
- (iv) Qualification requirements for senior and mid-level management posts should be reviewed.
- (v) A particular effort should be made to recruit management trainees reflecting the demographic structure of the population.

4.4.3 A PARTICIPATIVE, DEMOCRATIC MANAGEMENT STYLE AND MANAGEMENT BY OBJECTIVES SHOULD BE ENGENDERED

(a) Implementation strategies

(i) National Human Resource Development Consultative Forum

The Consultative Forum will consist of all stakeholders in the health sector. The purpose of the Forum will be to share information, discuss matters of mutual concern, such as personnel and education needs, resource distribution and referral systems, and ensure that policy-makers are aware of the needs of and challenges facing health professionals. It will be managed and facilitated by the Human

Resource Development Directorate of the Department of Health.

(ii) Training in participative management and conflict resolution

Senior health care personnel should receive training in participative management, negotiation, labor relations, conflict resolution and management by objectives.

4.4.4 EFFECTIVE EVALUATION TECHNIQUES AND PROCEDURES SHOULD BE INTRODUCED TO ASSESS MANAGEMENT EFFICIENCY AT ALL LEVELS OF THE HEALTH SERVICES

(a) Implementation strategy

Existing tools for personnel evaluation should be reviewed by a multi-professional committee consisting, amongst others, of representatives of the Public Service Commission, the departments of health at the national, provincial and district levels, employees, the communities and labour relations experts.

4.5 BUILDING CAPACITY

Principles

The clinical skills of health workers should be upgraded.

The skills of managers at all levels should be developed, if substantive health reform is to be sustained.

Institutional capacity to support human resource planning and management should be developed.

Research capacity focusing on essential health research strategy should be implemented to support health sector development.

4.5.1 THE CLINICAL SKILLS OF HEALTH WORKERS SHOULD BE UPGRADED

(a) Implementation strategy

The clinical skills of health professionals should be developed in accordance with approved health care packages in existence at the various levels of service delivery. Particular attention should be given to the training of PHC nurses, advanced midwives, community psychiatric nurses, paediatric nurses, chronic disease nurse-clinicians, psychologists, nutritionists and health managers.

In view of the reliance on nurses and PHC nurses in both primary care and referral teams, an investigative committee, representative of all the stakeholders, should be appointed to -

- (i) review the existing one and four year nursing courses in terms of cost-effectiveness and appropriateness;
- (ii) investigate whether nursing education should be offered by universities or technikons, and whether responsibility for training should reside at the national or the provincial level; and
- (iii) examine the existing one year training programme for nursing auxiliaries with a view to creating a separate, non-professional category of nursing which would later progress along a career path to the professional nursing programme.

4.5.2 THE SKILLS OF MANAGERS AT ALL LEVELS SHOULD BE DEVELOPED, IF SUBSTANTIVE HEALTH REFORM IS TO BE SUSTAINED

(a) Implementation strategy

The development of management skills development in the following areas should be accelerated:

- (i) management by objectives
- (ii) participative and change management
- (iii) leadership development
- (iv) community participation
- (v) financial and fiscal management
- (vi) strategic and operational planning

- (vii) programme management and evaluation
- (viii) policy development and implementation
- (ix) policy analysis.
- (x) monitoring and evaluation

4.5.3 INSTITUTIONAL CAPACITY TO SUPPORT HUMAN RESOURCE PLANNING AND MANAGEMENT SHOULD BE DEVELOPED

(a) Implementation strategy

Structures and systems should be developed to support the effective and efficient delivery of health services:

- (i) A human resource development unit should be established within the HRD Directorate at the national level.
- (ii) A nationally uniform system of planning the personnel establishment at service delivery points should be established.
- (iii) A national information management system should be established.
- (iv) The communication skills of all health professionals should be developed to enhance communication and understanding between patient and practitioner. Communication skills should also be a factor in promotion and advancement.
- (v) Job descriptions of health professionals at all levels of service delivery should be so specified that duplication and/or fragmentation is avoided.
- (vi) Human resource development units and programmes should be rationalised to promote cost-effectiveness and efficiency in the development of human resource capacity.
- (vii) New and vacant posts should be filled in all the health services. This must be done through the reallocation of budgets and personnel from under-utilised to under-served areas and health services.
- (viii) Additional posts should be created at the point of delivery at all levels of health of care in critical instances.
- (ix) A policy to enable greater mobility of personnel between positions in the district, provincial and national health services should be developed.
- (x) Managers should be appointed on a contractual basis, ensuring equal rank at the district, provincial and national levels until full-time posts are created, and adequately trained personnel are available.

4.5.4 RESEARCH CAPACITY FOCUSING ON ESSENTIAL HEALTH RESEARCH STRATEGY SHOULD BE IMPLEMENTED TO SUPPORT HEALTH SECTOR DEVELOPMENT

(a) Implementation strategy

The funding of human resource development research be based on the priorities of the RDP. A national register of all health-related HRD research should be established.

4.6 AFFIRMATIVE ACTION

Principles

Affirmative action policies should be aimed at transforming the public health services into a non-racial, non-sexist organisation.

The personnel profile of the health system should reflect broadly the composition of the relevant labour market at all organisational levels.

4.6.1 AFFIRMATIVE ACTION POLICIES SHOULD BE AIMED AT TRANSFORMING THE PUBLIC HEALTH SERVICES INTO A NON-RACIAL, NON-SEXIST ORGANISATION

(a) Implementation strategy

A strategic change management programme should be developed at the national level to facilitate a process of institutional change at all levels, thereby ensuring a spirit of openness and involving all stakeholders prior to the implementation of policy. This will ensure -

- (i) the integration of the health services;
- (ii) the development of skills to promote effectiveness and efficiency, while increasing

representativeness at the administrative, managerial, supervisory, professional and technical levels; and

- (iii) that imbalances of the past in the composition of the labour force with regard to race and gender are addressed.

4.6.2 THE PERSONNEL PROFILE OF THE HEALTH SYSTEM SHOULD REFLECT BROADLY THE COMPOSITION OF THE RELEVANT LABOUR MARKET AT ALL ORGANISATIONAL LEVELS

(a) Implementation strategy

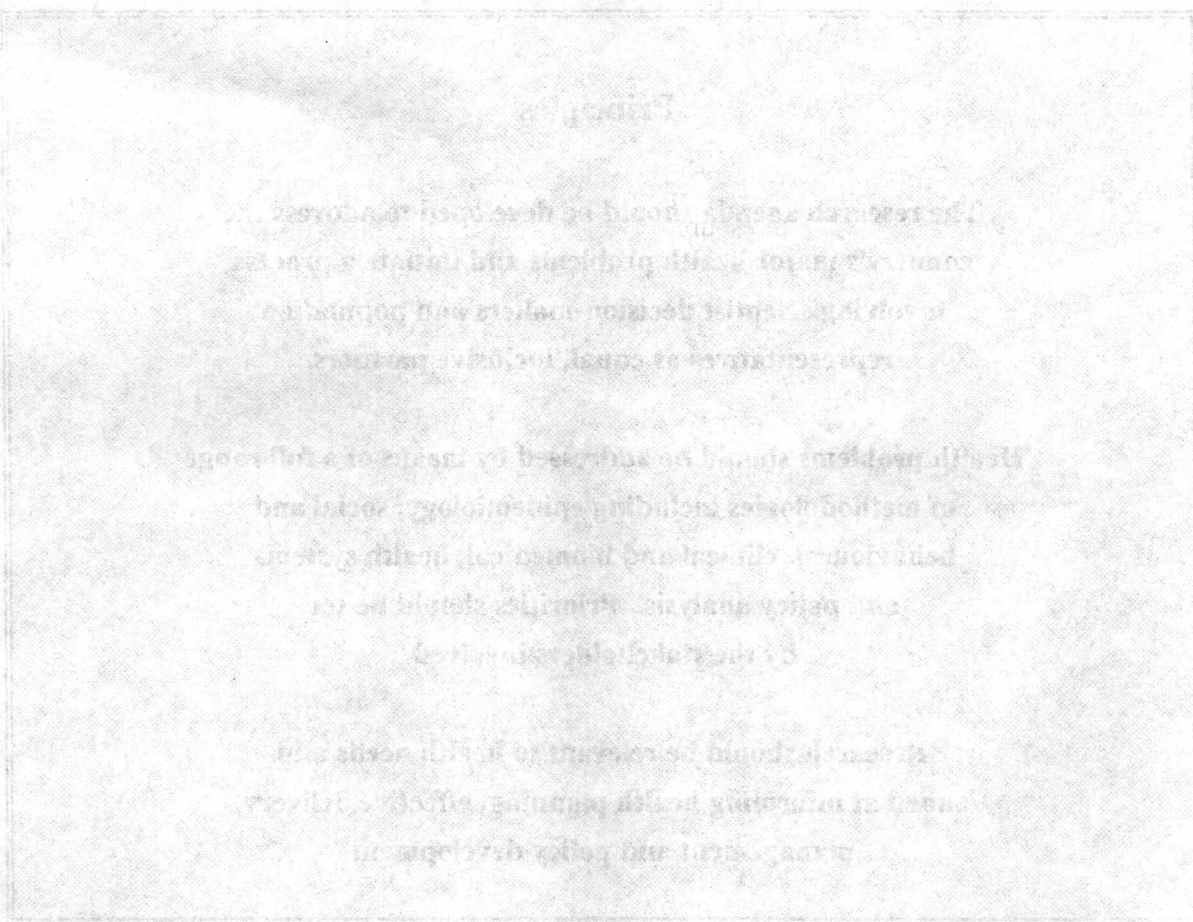
(i) Affirmative action in appointments

- A realistic affirmative action policy, linked directly to recruitment, job description and career advancement, performance appraisal, training and study programmes and promotion should be developed.
- Sound human resource systems should be established to ensure an adequate supply of suitably qualified health personnel, while also improving the representativeness of the public health service.
- The present criteria governing appointment to management positions and the determination of remuneration packages should be reviewed, in order to advance disadvantaged persons with potential.
- A special effort should be made to train Black health service managers.
- Mechanisms should be established to review the representation of women in the higher echelons of management at all levels of health care.
- Gender sensitivity should be applied in recruitment and promotion practices, conditions of service and retirement practices, e.g. housing subsidies for married women and equalising pension schemes and ages of retirement.
- A standing committee should be established to monitor the process of affirmative action.
- To set benchmarks that will serve to guide and monitor adherence to the time frames set for the implementation.

(ii) Affirmative action in education and training, and in health research

Racial, gender and geographic inclusivity should be ensured in all health personnel education and training programmes.

- ☐ A representative staff structure should be promoted at academic health complexes.
- ☐ The admission of students to training and educational institutions should reflect national demography.
- ☐ Student selection should be co-ordinated at the national level in order to implement and monitor affirmative action policies.
- ☐ The process of capacity-building will require strict monitoring.



THE RESEARCH AGENDA SHOULD BE DEVELOPED TO ADDRESS THE COUNTRY'S MAJOR HEALTH PROBLEMS AND INITIATE A PROCESS INVOLVING SCIENTIST, DECISION-MAKERS AND POPULATION REPRESENTATIVES AS EQUAL INCLUSIVE PARTNERS.

The process of setting priorities should be all-inclusive and allow all role-players jointly to determine the agenda. The main role-players are community researchers and health

Chapter 5

Essential National Health Research

Essential national health research (ENHR) is an integrated strategy for organising and managing health-related research. It is not a particular type of research or research methodology, but rather a process whereby a country can direct its research towards its greatest health problems. Its goal is to promote health and development in a way that achieves equity and social justice. The ENHR strategy aims to utilise the full range of health research methodologies including epidemiology, social and behavioural, clinical and biomedical, health systems and policy analysis.

Principles

The research agenda should be developed to address the country's major health problems and initiate a process involving scientist decision-makers and population representatives as equal, inclusive partners.

Health problems should be addressed by means of a full range of methodologies including epidemiology, social and behavioural, clinical and biomedical, health systems and policy analysis. Priorities should be set by the stakeholders involved.

Research should be relevant to health needs and aimed at informing health planning, effective delivery, management and policy development

5.1 THE RESEARCH AGENDA SHOULD BE DEVELOPED TO ADDRESS THE COUNTRY'S MAJOR HEALTH PROBLEMS AND INITIATE A PROCESS INVOLVING SCIENTIST DECISION-MAKERS AND POPULATION REPRESENTATIVES AS EQUAL, INCLUSIVE PARTNERS

The process of setting priorities should be all-inclusive and allow all role-players jointly to determine the agenda. The major role-players are community researchers and health

service providers. The process should identify the research agenda that will address the country's health problems. The following guidelines should be used in the priority-setting process:

- (a) Burden of disease (as measured by disability-adjusted life years);
- (b) Cost-effectiveness of interventions aimed at the burden of disease;
- (c) Institutional human resource availability to implement interventions at the community level; and
- (d) Health priorities that reflect the communities' needs.
- (e) Health profiles

5.1.1 Implementation strategies

(a) Task force

It is recommended that a task force be formed which - together with the Chief Directorate: Health Information, Evaluation and Research of the Department of Health - should promote and facilitate the development of the ENHR process and mechanism.

(b) Identification of stakeholders

All role-players must be identified and intersectoral functional networks developed, based on common interest and functionality.

(c) Consultation in determining priorities

A central information centre for health, which collects and collates research data from all available sources inside and outside the country, should be established.

5.2 HEALTH PROBLEMS SHOULD BE ADDRESSED BY MEANS OF A FULL RANGE OF METHODOLOGIES INCLUDING EPIDEMIOLOGY, SOCIAL AND BEHAVIOURAL, CLINICAL AND BIOMEDICAL, HEALTH SYSTEMS AND POLICY ANALYSIS. PRIORITIES SHOULD BE SET BY THE STAKEHOLDERS INVOLVED

To address the priorities identified successfully, a concerted effort in the various disciplines will be required. Any single problem will require an integrated approach, so that the most cost-effective solutions can be achieved. To achieve these goals, the research agenda will have to be goal-orientated, and human resources will have to be developed to articulate the communities' needs.

5.2.1 Implementation strategies

(a) Capacity development

- (i) Education in the health and basic sciences for the majority of the population is regarded as a priority investment.
- (ii) A culture of research and technology is essential for the future development of the country. Well-trained scientists and technologists are a prerequisite for general development.
- (iii) Government should make a concerted effort to ensure that the present research infrastructure is maintained and developed to be more appropriate to needs.
- (iv) South Africa should build capacity, through the training of the technologists required to address health priorities.
- (v) Mentorship, modelling and linkages between historically advantaged and disadvantaged institutions and researchers should be promoted.

(b) Research agenda

The research agenda should -

- (i) be action-orientated focused, and relevant to the health needs of the country to inform the country of the strategies to be followed;
- (ii) be cost-effective and aimed at improving the efficiency of the health services; and

- (iii) develop effective health delivery, planning, management and policy through informed research and other forms of information.

(c) Funding

- (i) The Department of Health should co-ordinate public health research activities, to ensure that research results and recommendations are disseminated and implemented.
- (ii) A system of tendering for research identified as a priority should be implemented, to allow for the fairly rapid redistribution of resources for health research.
- (iii) An incentive-driven process should be developed to encourage more public health research.

5.3 RESEARCH SHOULD BE RELEVANT TO HEALTH NEEDS AND AIMED AT INFORMING HEALTH PLANNING, EFFECTIVE DELIVERY, MANAGEMENT AND POLICY DEVELOPMENT

Health Systems Research will be an important field of research in developing the health system and services. Research will aim at identifying mechanisms for improving health delivery, quality of care, patient and systems management and policy development. Through Health Systems Research the concept of the Department of Health being a 'Learning Organisation' will be promoted by embracing evidence or information based decision making.

5.3.1 Implementation Strategies

- (i) Capacity building and training in basic skills associated with collecting and using available information
- (ii) Foster a culture of using information for making decisions
- (iii) Health service providers should contribute substantially to defining research agendas that impinge upon health care delivery
- (iv) Research agenda should be fully aligned with most important health problems.

Chapter 6

Health Information

The lack of reliable health information is one of the major obstacles to the effective planning of health services in South Africa. The health sector has, therefore, given priority to the development of a new national health information system and aims to contribute to the promotion of an information culture in South Africa. The Minister of Health established a Committee in 1994 to facilitate the development of a national strategy for the implementation of a comprehensive National Health Information System for South Africa (NHISSA). The Committee consists of representatives of the provincial MECs for Health, the Department of Health, other relevant Government departments, academic and research institutions, and the private sector.

Analysis of the 1994 status of health information systems in South Africa conducted by the NHISSA Committee, found that existing information systems were fragmented and incompatible. They were unco-ordinated and not comprehensive; software and hardware were incompatible and not user-friendly; most systems were manually driven, with minimal computerisation; and there was inadequate analysis interpretation and use of data at the local level.

It is anticipated that new attitudes and tools will have to be developed to improve the collection and use of data for the effective management of available resources.

Principles

The National Health Information System (NHISSA) should be nationally co-ordinated in order to support the effective delivery of services at all levels of the health system.

The NHISSA should be used to monitor the implementation and success of the health priority programmes, both of the Department of Health and the Reconstruction and Development Programme (RDP)

Reporting of NHISSA data at all levels should be timeous, accurate and complete.

6.1 THE NATIONAL HEALTH INFORMATION SYSTEM (NHISSA) SHOULD BE NATIONALLY CO-ORDINATED IN ORDER TO SUPPORT THE EFFECTIVE DELIVERY OF SERVICES AT ALL LEVELS OF THE HEALTH SYSTEM

For the NHISSA to fulfill its objectives - which include ensuring the availability of information on cost, efficiency, volume and coverage as well as the measurement of the South African population's health status - it will have to be co-ordinated at all levels.

6.1.1 Implementation strategies

(a) Establishment of a comprehensive national health information system

A comprehensive NHISSA will be developed as an overall parent system comprising various components. Individually and collectively, these components will provide the various types of information needed to support the health care delivery system in South Africa.

At the national level, an NHIS Advisory Committee will be established to strengthen stakeholders' involvement in the development and implementation of the NHISSA. The Committee will also promote the use of NHISSA data at all levels

and liaise closely with the strategic planning sections of the departments of health at the national and provincial levels.

At the provincial level, committees will be established to facilitate the implementation of a streamlined health information system, based on the national guidelines. The provinces have a key role to play in the development of the NHISSA and promoting the use of data for planning. They will also be responsible for facilitating the development of a district health information system. In so doing, the provinces should consult all key role-players including NGOs, the private sector and academic and research institutions.

(b) Components of the NHISSA

The NHISSA was conceived as a parent system that encompasses various subsystems. The following component systems are envisaged:

(i) Management information

- ☐ National Health Care Management Information System
- ☐ Human Resources Management Information System
- ☐ Financial Management Information System
- ☐ Facilities Management Information System
- ☐ Equipment Management Information System
- ☐ Transport Management Information System
- ☐ Pharmaceutical and Other Consumables Management Information System
- ☐ Service Coverage (i.e. utilisation, coverage, access).

(ii) Surveillance

- ☐ Socio-demographic Surveillance
- ☐ Environmental Surveillance
- ☐ Disease Surveillance
- ☐ Nutrition Surveillance
- ☐ Health Systems Surveillance

Provincial and district level working groups will be established to facilitate the development and implementation of these systems on an incremental basis. In addition, community level surveillance will be developed and implemented with the

communities' active participation. District health teams will assist the communities to develop the capacity to assess their own problems and identify appropriate remedial actions.

(c) The private sector

The system developers will collaborate with the private sector to ensure that its information systems are included in the NHISSA.

(d) Provincial variations

The NHISSA will accommodate provincial variations in accordance with specific needs at the provincial and district levels.

(e) Piloting the NHISSA

The NHISSA will be piloted nationally on an incremental basis.

6.2 THE NHISSA SHOULD BE USED TO MONITOR THE IMPLEMENTATION AND SUCCESS OF THE HEALTH PRIORITY PROGRAMMES, BOTH OF THE DEPARTMENT OF HEALTH AND THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)

6.2.1 Implementation strategies

(a) Minimum data set and indicators

A minimum data set will be established at the national level, in accordance with international indicators. The ICD-10 system, which has been adopted by the NHISSA Committee, will be used.

(b) A user-friendly NHISSA

Minimum standards for technology, coding systems, application software, the database management system, etc. will be adopted in the course of developing the NHISSA to ensure its user-friendliness, and facilitate the collation, analysis and use of data.

(c) National Nutrition Surveillance System

A National Nutrition Surveillance System will be implemented as part of the NHISSA. A research strategy and surveillance system for growth monitoring (especially community-based), which will address the nutritional status of pregnant and lactating women, preschool children, levels of micronutrient deficiency and food consumption, will be developed and implemented.

Nutritional status, especially that of young children, will be among the key indicators of social well-being and an outcome measure of RDP projects.

(d) Mortality and morbidity data

Cause-specific mortality and morbidity data (especially for children and women) will be gathered and published widely. They will serve as indicators of development, thereby ensuring that priority health problems are addressed continuously.

(e) Use of NHIS data

Emphasis will be placed on the use and feedback of data at all levels, especially at the point of collection. Regular NHISSA bulletins will be produced at the national level. It is envisaged that mechanisms for data dissemination will be established at the provincial and district levels. It is essential that data be made available to decision-makers, planners and communities, and that it is used to influence resource allocation and reduce inequity.

6.3 REPORTING OF NHISSA DATA AT ALL LEVELS SHOULD BE TIMEOUS, ACCURATE AND COMPLETE

6.3.1 Implementation strategies

(a) Training

Health workers will be trained appropriately, to ensure the accuracy, timeousness and comprehensivity of reporting NHISSA data.

(b) Monitoring timeousness and comprehensivity of reporting

Monitoring forms will be developed and built into the system, to facilitate the monitoring of timeous and comprehensive reporting. At the provincial and district levels, supervisory checklists should include questions related to this activity.

Chapter 7

Nutrition

Nutrition is a basic human right, and a prerequisite for the attainment of a person's physical and intellectual potential. Nutrition is an outcome of developmental processes in society, and not simply a service to be delivered. Improving nutrition is thus an ethical imperative and a sound economic investment which is politically rewarding.

Malnutrition in South Africa has two major components:

The first is undernutrition, which manifests itself in infants and young children, and pregnant and lactating women. South Africa has a high incidence of low birth weight babies (LBW) - about 16%. The 1994 survey conducted by the South African Vitamin A Consultative Group found that one in three children in South Africa had marginal Vitamin A deficiency status; one in five had iron-deficiency anaemia; one in four were stunted and one in ten were underweight for age.

The second component comprises chronic diseases of lifestyle, which manifest typically in adulthood as obesity-related diseases, ischemic heart disease, hypertension, diabetes and certain cancers.

The Department of Health is committed to taking the lead in advocating optimal nutrition. It is also committed to developing and implementing an integrated nutrition strategy based on human right, developmental in orientation, monitored for impact, sustainable, environmentally sound, people and community-driven, and which targets the most vulnerable groups, especially women and children. The guiding principles and implementation mechanisms of such an integrated nutrition strategy are elaborated below.

Principles

Nutrition for all South Africans should be promoted as a basic human right and an integral component and outcome measure of the country's social and economic development.

Nutrition programmes should be integrated, sustainable, environmentally sound, people and community-driven, and should target the most vulnerable groups, especially children and women.

Nutritional well-being should be promoted and monitored within nationally-defined goals. There should be a clear nutrition information strategy.

7.1 SOUND NUTRITION FOR ALL SOUTH AFRICANS SHOULD BE PROMOTED AS A BASIC HUMAN RIGHT AND AN INTEGRAL COMPONENT AND OUTCOME MEASURE OF THE COUNTRY'S SOCIAL AND ECONOMIC DEVELOPMENT.

Effective nutrition interventions are social and economic investments, vital for economic growth. They have been shown internationally to yield high economic returns. Since adequate nutrition is necessary for and an essential outcome of development in a country, nutrition interventions should be viewed and monitored within the overall guiding principles of the Reconstruction and Development Programme (RDP). Because nutritional status, especially of young children, is a sound indicator of overall development and social well-being, the nutritional status of young children should be one of the outcome measures of the RDP.

7.1.1 Implementation strategy

The RDP highlights the Government's commitment to addressing problems of undernutrition and hunger. As a lead agency, the Department of Health must play a key

role, not only in developing a strategy within its own line function, but also in terms of advocacy. This will ensure that nutrition is specified and monitored as an outcome of the RDP and other socio-economic programmes being planned within Government departments, inter-governmental organisations (IGOs), NGOs and the private sector.

7.2 NUTRITION PROGRAMMES SHOULD BE INTEGRATED, SUSTAINABLE, ENVIRONMENTALLY SOUND, PEOPLE AND COMMUNITY-DRIVEN, AND SHOULD TARGET THE MOST VULNERABLE GROUPS, ESPECIALLY CHILDREN AND WOMEN

An Integrated Nutrition Strategy has been developed, the objective of which is to set in motion fundamental processes leading to a sustained improvement in the nutritional status of children, especially those under five years of age. The strategy will also improve the quality of life of women through an adaptive process of assessment, analysis and action.

Effective nutrition intervention programmes are dependant on political commitment, intersectoral collaboration and community participation. They should also be environmentally sound and target the most vulnerable groups.

Political commitment, although already embodied in the RDP, requires continued advocacy to sustain it. Integrated nutrition programming takes into account three underlying clusters of factors which determine nutrition status: household food security, the malnutrition-infection syndrome and the caring capacity of households.

From the Department of Health's perspective, a three-pronged integrated nutrition programme should be set in place, giving particular attention to -

- issues of intersectoral linkages and collaboration;
- community mobilisation and participation;
- targeting of the most vulnerable groups;
- effective response to specific problems;
- monitoring, evaluation and management information systems;
- development of human resources and institutional capacities; and
- sustainability in terms of processes, resources and impact.

7.2.1 Implementation strategies

Within the Department of Health, three major components of an integrated nutrition strategy should be implemented, namely:

- a health facility-based component;
- a community-based component; and
- a nutrition promotion programme, comprising communication, advocacy and relevant legislation; and
- a national nutrition surveillance system.

(a) Health facility-based nutrition programme

In keeping with the emphasis on an integrated, comprehensive primary health care (PHC) service, a health facility-based nutrition programme should be established as an integral part of the PHC package. This will address the major problems of undernutrition and micronutrient deficiencies and prevent the chronic diseases of lifestyle through an optimal dietary approach. Because of the high rates of undernutrition in young children and women, special attention will have to be given to the maternal, child and women's health component of PHC.

Essential elements of a health facility-based programme should include:

- (i) Provision of disease-specific nutritional support and counseling;
- (ii) growth monitoring and promotion through the universal use of standardised growth cards for all infants and young children at clinics;
- (iii) nutrition education for care givers of infants, young children, and pregnant and lactating women, the emphasis being on -
 - measures that render health facilities baby and woman-friendly, and protect and promote breast-feeding and its successful management;
 - the introduction of appropriate and locally available complementary foods;
 - child feeding practices during periods of diarrhoea, other infections and immunisations; and

○ the importance of regular growth monitoring.

(iv) follow-up and assessment by health staff through visits to community resource persons providing advice, counseling or referral to other supportive services;

(v) provision of food supplementation to malnourished children and pregnant women, including -

- through the protein-energy malnutrition (PEM) scheme; and
- reducing the number and types of food supplements available from clinics, to reflect foods forming the bulk of the normal diet within a community;

(vi) addressing micronutrient deficiencies - particularly iron and sub-clinical vitamin A deficiencies in infants and young children, and iron and folic acid deficiencies in women, especially during pregnancy - through education, micronutrient supplementation and fortification of staple foods; and

(vii) ensuring appropriate nutritional management of diarrhoeal and other infectious diseases.

To do this effectively, PHC staff should devote sufficient time to nutrition-related activities. In addition, adequately trained and dedicated nutrition staff should be developed.

(b) Community-based nutrition programme

A community-based nutrition programme has several advantages:

- (i) Sustainability is more likely;
- (ii) information, education and communication (IEC) is more focused, targeted and relevant, ensuring the incorporation of new ideas and practices;
- (iii) external dependency is lessened; and
- (iv) implementation will be contextual.

Instead of developing predesigned programmes, the Department of Health will

provide gender-sensitive, multisectoral support to communities in solving their own nutrition problems. The Department will achieve this through the facilitation of the fundamental processes of assessment, analysis and action cycles in a capacity-building and empowering fashion. It will also be achieved through the multisectoral mobilisation of relevant structures at community level; developing projects that will strengthen household food security; care of children and women; and providing health services - while promoting a healthy environment.

An important objective of this programme will be the achievement of positive behavioral change regarding knowledge of, attitude towards and practice in respect of health and nutritional well-being, including the allocation of resources by individuals, households, the community and decision-makers at large. Appropriate labour-saving technologies will be promoted. The programme will also be linked to other community initiatives that promote child survival, protection and development.

Although the provision of services will target the most vulnerable individuals and communities - especially the poor - in a simple, flexible and adaptive way, the programme will be aimed at mobilising all members of households as well as community leaders and structures, both public and private. All people: women and men, children and adults, the affected and the unaffected, the vulnerable and the non-vulnerable will thus be mobilised to participate. Growth monitoring and promotion through the weighing of children will be an important tool in such mobilisation.

The community-based nutrition programme should combine the relevant projects of the Primary School Nutrition Programme (PSNP) and the National Nutrition and Social Development Programme (NNSDP) within the context of the RDP. Links of the PSNP with the Department of Education should be strengthened, to establish nutrition education in primary schools, and links with the Department of Agriculture to promote household food security.

While the major thrust of the community-based programme will be aimed at ensuring the active participation of individuals, families and communities in assuming responsibility for the improvement of their nutrition status, community participation should be complemented by awareness, commitment and the support of leadership in the higher levels of Government, relevant NGOs and external

support organisations. Nutrition personnel, together with community development resource persons, community-based organisations and NGOs should assist communities in identifying and implementing key intervention strategies.

Once the new community-based nutrition programme has been established, it is expected to become a true community development strategy, with nutrition surveillance as the primary management and monitoring tool.

(c) Nutrition promotion: communication, advocacy and legislation

Promoting the realisation that nutrition is an outcome of complex intersectoral processes in society and that poverty is the basic determinant, is fundamental to building a broad alliance which will support nutrition strategies that combat poverty, while drawing on trans-sectoral collaboration. In order to achieve national consensus, the definition of common nutrition-related goals and effective policies, strategies, programmes, actions and legislation, it is necessary to influence the perceptions, understanding and demands of policy-makers, civil servants and the general public. The highest level decision-makers are especially critical to this process.

A nutrition promotion programme which leads to positive behavioral change in policy and among decision-makers and the general public should, therefore, be a key part of an integrated nutrition strategy. The aim is to build national awareness and consensus about the nutritional situation in South Africa, the most critical causes of undernutrition and the course of action to promote and protect optimal nutrition.

The strategy will consist of three major components:

- (i) A focused approach to a programme of communication and public information will be adopted, using the mass media and health staff. They will have to be trained in communication skills and have a sound understanding of the major causes of malnutrition in the groups with whom they communicate. Seminars or retreats for senior staff to inculcate a sound vision of nutrition and lay a firm foundation for official strategies and intersectoral programmes should be arranged. The consistency of messages communicated will be of paramount importance.

Priority areas of programme communication will be:

- Breast-feeding: its successful initiation, management and protection, as well as the development of a Code for the Marketing of Breast Milk Substitutes;
- sound infant and young child-feeding practices: frequent feeding, increased energy dense foods, feeding during diarrhoeal bouts and other illnesses;
- the major disease causes of childhood undernutrition: their prevention and treatment;
- areas in which there is controversy or in which popular perceptions are in conflict with up-to-date technical information, e.g. food handouts and the dangers of creating dependency, and focus on nutrients (food groups) rather than food as a whole; and
- the prevention and control of diseases of lifestyle.

(ii) Advocacy will be initiated to -

- develop consensus among policy-makers at the national, provincial and district levels concerning issues of nutrition and the major cause of undernutrition. (The focus will be on controversial areas, or those in which perceptions are in conflict with up-to-date technical knowledge);
- formulate public policies to improve nutrition, with emphasis on responses to poverty alleviation, the care of vulnerable groups over the short and long term, and linking strategies to health and RDP programmes, especially the RDP's Lead Projects;
- develop a comprehensive nutrition policy for South Africa, based on sufficient consensus on the nature of nutrition problems, their causes and appropriate actions;
- incorporate nutrition considerations and components into developmental and intersectoral policies, plans and programmes. (This will ensure that the nutritional status of children is adopted as an outcome measure of the RDP at the national, provincial and district levels, and that information generated by the nutrition surveillance systems is disseminated);
- ensure the strengthening of food safety, security and quality;
- develop measures on land reform that will ensure that the vulnerability of the landless and the landless poor is reduced;

- formulate policies for implementing income transfers that will improve the entitlement package of the rural and urban poor;
 - develop policies that will ensure the availability and equitable distribution of essential food items through a public distribution system;
 - develop a formula based on basic food prices and their nutritional adequacy. (This will be incorporated in policies that will ensure the linkage and adjustment of minimum wages to increases in market prices, as well as the strict enforcement and timely revision thereof); and
 - develop policies that will ensure the empowerment of women through literacy and education programmes.
- (iii) Legislation relevant to nutrition will be reviewed, strengthened, implemented and enforced -
- to protect breast-feeding, and to control the marketing of infant foods;
 - for the mandatory iodisation of all salt for human and animal consumption;
 - for the mandatory fortification of appropriate staple foods, e.g. fortification of maize meal with riboflavin, nicotinamide, thiamine, folate, vitamin B6, and other nutrients; and exploration of the fortification of a food vehicle with vitamin A;
 - to ensure food safety and quality; and
 - for the expansion of the Food Legislation Advisory Group (FLAG) to be representative of all stakeholders.

7.3 NUTRITIONAL WELL-BEING SHOULD BE PROMOTED AND MONITORED WITHIN NATIONALLY-DEFINED GOALS; THERE SHOULD BE A CLEAR NUTRITION INFORMATION STRATEGY

There is a need for the development of an integrated nutrition information system in South Africa to identify the trends, nature, extent and severity of the different types of nutrition problems and their causes. Such a system would also assist in monitoring and evaluating the impact of nutrition programmes and facilitate informed decision-making processes at various levels for policy, strategy and programme development and implementation.

Apart from facilitating the improved targeting of nutrition programmes and analysis of the possible causes of malnutrition, the system also has a fundamental role to play in monitoring and evaluating the nutritional goals of the RDP. Nutritional status can provide an overall indicator of the success of the Programme. In a people-driven process such as the RDP, decision-makers at all levels must have a clear understanding of problems to be addressed and employ a common framework within which the progress made towards achieving the desired goals can be gauged. A nutrition information system (NIS) provides such a framework. An NIS can thus be considered a priority for South Africa.

The aim of the system is to improve decision-making at all levels, with a view to solving the problems of malnutrition in vulnerable groups, especially young children and pregnant women. This can be done through the provision of timely, appropriate, accurate and relevant information on an ongoing basis. The emphasis should be on information for action, and efforts should be made to avoid paralysis of action through overzealous analysis.

7.3.1 Implementation strategies

In defining an effective NIS for South Africa, national process and impact goals should be defined in keeping with the strategies of the RDP, World Summit for Children (WSC) and International Conference on Nutrition (ICN).

(a) Critical strategic factors

For a nutrition information system to be effective, it must address the five critical and strategic factors that ensure its success. Thus, it should -

- (i) enhance the perceptions and knowledge, particularly of politicians and other decision-makers, so that the malnutrition problem is made "visible" and perceived as a "priority social problem";
- (ii) increase effective demand for nutrition-relevant information to motivate action;
- (iii) improve the capacity to assess, analyse and design resource-relevant actions;
- (iv) ensure adequate resources for maintaining the Nutrition Information System (NIS) over a reasonable period of time (5-10 years); and
- (v) ensure adequate resources for action.

It is important to note that, while it is frequently possible to mobilise resources to solve half the problem, this often creates the climate for solving the entire problem.

Thus, three strategies will be implemented simultaneously at three levels: household, community/district/provincial and national. In implementing these main strategies, the Department of Health will develop sub-strategies to cover the following aspects:

- (i) Appropriate and standard tools such as road-to-health cards and charts can be used by communities for growth monitoring and promotion of children under three years. They can also be used to measure the nutritional status of pregnant women.
- (ii) Monitoring of pre-school children of three years and older, and of school entrants;
- (iii) monitoring and evaluation of the management and impact of nutrition programmes; and
- (iv) surveys on specific nutrition issues, such as micronutrient deficiencies.

(b) Nutrition information strategies at household and community level

The primary objectives of a household and community level nutrition information strategy are threefold. The first is to increase household and community level awareness of the nutritional needs of the most vulnerable individuals, particularly the promotion of children's growth.

The mother constitutes the first line of protection and support, the father and/or care givers and children the second and the community the third. The type of decisions which can and should be taken at the household and community levels depends on the use of resources within the household, those accessible within the community or obtainable from higher levels of society. Normally, the mother assesses and analyses the problem, sometimes with the aid of an outsider, e.g. the village or community health worker. Here, communication is informal and interpersonal.

However, the mother is frequently the "assessor, analyst and actor" at the same time. A nutrition information strategy can be developed at this level, which should improve the perception of the problem and make it more visible. Growth monitoring and promotion (GMP) assists in this effort. This necessitates GMP

sessions taking place as close to the household level as possible. Though more efficient than clinic-based GMP, household/community-level GMP should complement rather than replace clinic-based GMP. At the household and community levels, GMP should be used not only to direct the required action, but also to justify such actions.

(c) Nutrition information strategy at the district/provincial level

The objectives of a nutrition strategy at these levels are similar to those at the household and community levels but here the main users of nutrition information will be the relevant decision-making systems. These levels have more human, organisational and economic resources at their disposal than households and communities. A community, district or provincial growth chart could be used to make the malnutrition problem more visible and mobilise resources for more targeted action. At these levels, the nutrition information strategy will comprise GMP and nutrition surveillance based at the community level and in PHC, notably at clinics and health centers.

(d) Nutrition information strategy at the national level.

At the national level, the decision-making process is far more complex. Two categories of decisions affect nutrition. The first are those related to direct actions like supplementary feeding, micronutrient supplementation or fortification, nutrition education, promotion of breast-feeding, community-based GMP, etc. The second are decisions and actions which have an implicit consequence for nutrition, like interventions in agriculture, on wages and prices, on marketing and social services or on cost recovery and fiscal, trade and monetary policies. Both categories are important for improving nutritional well-being, and nutrition information systems should strive to link up with them.

The primary objectives of a nutrition information strategy at the national level are threefold. First, to improve decisions on targeting nutrition-relevant services. Secondly, to improve decisions on the use of existing resources for nutrition improvement, thereby improving their availability and access. Thirdly, to build consensus on the nature of and trends in the nutrition problem, and to monitor the impact of interventions.

(e) Linking the different levels of nutrition information strategies

Since decision-makers participate in both horizontal and vertical decision-making processes, it is a challenge to the nutrition information system to link the many decision-making assessment, analysis and action processes at the different levels so that they can become mutually reinforcing. Thus, to improve decision-making processes with potential impact on nutritional status, nutrition-relevant information emanating from the different levels has to be shared.

A strategy should be developed to build capacity and capability for information analysis at each level, thereby enabling each level to provide information about the following:

- (i) When and where support is needed at the next lowest level: a targeting mechanism that will reach communities and households that need extra support on a selective basis;
- (ii) how to use the resources controlled at that level: improving resource utilisation to reach such households; and
- (iii) when to seek assistance and support from the next highest level: linking up with higher levels for technical and resource support.

Child growth monitoring in the formal health care system should be complemented by community-based growth monitoring to ensure universal coverage, and by nutrition information systems developed to incorporate data from both these sources. Community-based growth monitoring and promotion is an essential element of a community-based nutrition programme, which assists communities with their own planning, programme management and evaluation.

The nutrition information system (NIS) should be closely linked to the health information system (HIS) and other information systems, for example, the household survey programmes of the Central Statistical Service (CSS). This will not only permit the assessment of nutrition status over time, but also the possible causes of changes in the situation. The Nutrition Directorate is responsible for the timely acquisition of nutrition information in order to provide reports to the Minister of Health and the Office of the RDP at regular intervals.

Chapter 8

Maternal, Child and Women's Health

In restructuring South Africa's health services from a largely curative-based and fragmented system to a more community-orientated one - based on primary health care principles - the emphasis will be on improving preventive, promotive and curative services for children and women.

The Department of Health is committed to achieving universal access to health services for children including infants, children under five, adolescents and women, while improving the quality of services provided. This will enable the health sector to make its contribution to the reduction of infant, child and maternal morbidity and mortality in keeping with the goals of the RDP. The principles that will apply are stated below:

MATERNAL, CHILD AND WOMEN'S HEALTH SERVICES SHOULD BE ACCESSIBLE TO MOTHERS, CHILDREN, ADOLESCENTS AND WOMEN OF ALL AGES, THE FOCUS BEING ON THE RURAL AND URBAN POOR AND FARM WORKERS

The provision of MCHW services in South Africa hitherto has been fragmented and poorly co-ordinated, with inadequate resources being provided. Furthermore, inadequate planning, implementation, supervision, monitoring and evaluation of these services has occurred. As a result, there is unequal access to MCHW services, especially in the rural areas, as well as high-density and peri-urban areas, informal settlements and among workers in farming communities.

Principles

Maternal, child and women's health (MCWH) services should be accessible to mothers, children, adolescents and women of all ages, the focus being on the rural and urban poor and farm workers.

MCWH services should be comprehensive and integrated.

Clear objectives and targets should be set at the national, provincial, district and community levels in accordance with the goals of the RDP, the health sector and the United Nations Convention on the Rights of the Child.

Individuals, households and communities should have adequate knowledge and skills to promote positive behaviour related to maternal, child and reproductive health.

MCWH services should be efficient, cost-effective and of a good quality.

Women and men will be provided with services which will enable them to achieve optimal reproductive and sexual health.

8.1 MATERNAL, CHILD AND WOMEN'S HEALTH (MCWH) SERVICES SHOULD BE ACCESSIBLE TO MOTHERS, CHILDREN, ADOLESCENTS AND WOMEN OF ALL AGES, THE FOCUS BEING ON THE RURAL AND URBAN POOR AND FARM WORKERS

The provision of MCWH services in South Africa hitherto has been fragmented and poorly co-ordinated, with inadequate resources being provided. Furthermore, inadequate planning, implementation, supervision, monitoring and evaluation of these services has occurred. As a result, there is unequal access to MCWH services, especially in the rural areas, as well as high-density and peri-urban areas, informal settlements and among workers in farming communities.

8.1.1 Implementation strategies

(a) Reorganising MCWH services

MCWH services will be reorganised at all levels to facilitate the planning, implementation, supervision, monitoring and evaluation of services, and ensure the effective coverage of the majority of children and women.

(i) National level

A MCWH Directorate will be established by the Department of Health at the national level. It will co-ordinate and facilitate the reorganisation of MCWH services, formulate policy, set norms and standards, undertake national level planning and support provincial activities.

(ii) Provincial level

MCWH units will be established at the provincial level to oversee the planning, implementation, supervision, monitoring and evaluation of integrated MCWH services in the various districts. The national Directorate and provincial MCWH units will be adequately staffed with people trained in the planning and management of MCWH services.

(iii) District level

The planning and implementation of MCWH programmes (child and reproductive health) will be district-focused and community-based. District health teams will be trained to enhance their capacity for planning, implementing, supervising, monitoring and evaluating MCWH services. The co-ordination of MCWH activities will be undertaken within the framework of local government structures.

(iv) Community level

At the community level, households and communities will be targeted for relevant information. In addition, community health promoters will be trained to facilitate community action.

The role of non-governmental and other grassroots organisations in promoting community participation and involvement in health development will be recognised. Health workers in the various facilities will be expected to be familiar with their catchment population and participate in community-based MCWH activities.

(v) Intersectoral collaboration

Intersectoral collaboration, and the mobilisation of all stakeholders to support services aimed at the improvement of children's and women's health, will be undertaken.

(vi) Advisory committees

MCWH advisory committees will be established. They will comprise members with technical expertise as well as community and non-governmental representatives. Integrated primary health care advisory committees, whose responsibilities will include MCWH, will be established at the district level.

(b) Resource allocation

The Department of Health and provincial health departments will ensure the allocation of adequate resources, to provide comprehensive and integrated MCWH services.

The health sector aims to provide access to community health centres and clinics in rural, peri-urban and urban areas at a coverage rate of 1:20 000 by the year 2000. Where necessary, such facilities will be constructed, equipped and provided with adequately trained staff.

(c) Human resource development

Health workers will be orientated towards primary health care concepts and principles. Their skills will be upgraded, and they will be trained and encouraged to develop a caring ethos towards their patients.

In addition, health workers will be encouraged to become involved in community-

based health care activities. They will be orientated to expand their responsibility beyond patients attending their own facility.

(d) Monitoring and evaluation

District health teams' capacity for monitoring and evaluating MCWH services will be built through training, and streamlining the health information system. The focus will be on the use of data at all levels, especially at the point of collection.

8.2 MCWH SERVICES SHOULD BE COMPREHENSIVE AND INTEGRATED

In most South African health facilities, MCWH services are provided at separate locations within the same health facility. Furthermore, the services are often not comprehensive, especially at clinic and community health centre levels. MCWH will form an integral part of primary health care services.

8.2.1 Implementation strategies

(a) One-stop, "supermarket" approach

All health facilities, as far as possible, will render MCWH services on a one-stop, "supermarket" basis. Existing health facilities should review the allocation of available space and, where possible, relocate MCWH services closer to one another. The optimal integration of MCWH services must be ensured in the design of all future health facilities.

(b) Minimum package of MCWH services

The minimum package of MCWH services that is to be provided at the various levels of care will be developed further, and implemented in accordance with the functions attributed to each level of care.

(c) Training

Relevant training should be undertaken to facilitate the integration of MCWH services.

(d) Co-ordination with other services

MCWH services should be co-ordinated with other health services, including the following:

- ☐ Environmental health and sanitation
- ☐ Nutrition
- ☐ Disability.

(e) Intersectoral collaboration

This should be encouraged, as the health status of women and children will benefit from interventions in other sectors.

(f) Non-governmental organisations

Collaboration with NGOs is of great importance, since much of the work done in the area of MCWH is undertaken by such organisations.

8.3 CLEAR OBJECTIVES AND TARGETS SHOULD BE SET AT THE NATIONAL, PROVINCIAL, DISTRICT AND COMMUNITY LEVELS IN ACCORDANCE WITH THE GOALS OF THE RDP, THE HEALTH SECTOR AND THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

8.3.1 Implementation strategies

(a) Formulation of health sector goals and objectives

In consultation with the provinces, and drawing on the reports of the Ministerial Committees appointed in 1994, the Department of Health will compile health sector goals to be achieved by the year 2000. These goals will be based on those of the RDP, the World Summit for Children and the Convention on the Rights of the Child.

Where such goals do not exist, e.g. in the field of youth and adolescent health, targets and objectives will be developed through participatory consultation with relevant groups.

Specific and achievable MCWH objectives should be set at the provincial and district levels, using national goals and objectives as a framework.

A participatory process will be adopted at the community level to enable communities to set their own objectives.

(b) Moral and ethical basis

There should be a moral and ethical basis for the provision of MCWH and other services, in accordance with the Convention on the Rights of the Child.

Health planners, managers and other health workers should be committed to the attainment of RDP/health sector goals, as well as those elaborated in the Convention on the Rights of the Child. Planners should allocate adequate resources to programmes that impact on the health of children and women.

Furthermore, it is essential that health workers develop a caring ethos and improve their attitude towards their patients and the community at large. The Department of Health will work closely with training institutions, health professional organisations, non-governmental organisations and the private sector to address this issue effectively.

(c) Annual plans

Annual health plans will be drawn up by the provinces and districts. These should include distinct targets to be achieved.

(d) Monitoring and evaluation

The impact and efficiency of MCWH will be assessed through the monitoring of various performance indicators. The performance of the provinces will be monitored at the national level, while district performance will be monitored at provincial level. Achievements at the community and local levels should be monitored effectively at district level.

The health information system should be utilised at all levels to provide the required information. In addition, the health sector will utilise household surveys

and other relevant surveys and studies to assess progress made with achieving MCWH objectives.

8.4 INDIVIDUALS, HOUSEHOLDS AND COMMUNITIES SHOULD HAVE ADEQUATE KNOWLEDGE AND SKILLS WHICH PROMOTE POSITIVE BEHAVIOUR RELATED TO MATERNAL, CHILD AND REPRODUCTIVE HEALTH

There is great potential for targeting individuals, households and communities with relevant health information. This will increase their knowledge base and facilitate its application to help prevent or solve common health and health-related problems affecting mothers and children. The capacity for effective communication, planning, implementation, monitoring and evaluation at various levels is, however, lacking, especially at the district and community levels.

The majority of health workers have poor communication skills and are unable to develop health messages based on formative audience research. Much of the health educational material produced is inadequately pretested, and little or no evaluation of its impact on behavioural change is undertaken.

8.4.1 Implementation strategies

Whereas information is a tool for raising awareness of health and health-related issues, the translation of information requires skill and adequate resources, organisation and management at all levels, especially at the community level.

(a) Needs assessment

Assessment of the needs and existing capacity of the health sector to provide effective communication on women and children will be undertaken by the Department of Health's Directorate: Health Promotion and Communication.

(b) Communication strategy

Based on this assessment, a communication strategy for the health sector will be developed, the emphasis being on the promotion of MCWH. It is envisaged that this strategy will, inter alia, address health workers' training to improve their communication skills and ability to undertake formative research; develop and

pretest health information materials, and monitor and evaluate their impact on behaviour change; use the media (including traditional media) to promote the health of women and children; and form alliances with relevant stakeholders.

(c) Communication plans

Communication plans will be developed at the national, provincial, district and community levels, based on the communication strategy to be developed in terms of (b) above.

(d) Household level involvement

At the household level, the individual and other household members, i.e. mothers, fathers and siblings, as well as other caregivers, should be involved actively in the promotion of child health. Roles in the household should include:

- (i) early recognition of common health problems, including diarrhoea and acute respiratory infections;
- (ii) maintenance of appropriate personal hygiene;
- (iii) supporting and participating in health promotion activities, including immunisation and breast-feeding;
- (iv) ensuring adequate child-feeding practices; and
- (v) disseminating health education messages to other members of the household.

8.5 MCWH SERVICES SHOULD BE EFFICIENT, COST-EFFECTIVE AND OF A GOOD QUALITY

8.5.1 Implementation strategies

(a) Norms and standards

Norms and standards will be established. Standardised case management protocols for various priority health problems will be developed, including the following:

- (i) common conditions affecting children, including acute respiratory infections, diarrhoea, measles, malaria and severe malnutrition;
- (ii) antenatal, intranatal and neonatal care, as outlined in the Perinatal Education Programme (PEP);

- (iii) advanced midwifery training in accordance with the Decentralised Education Programme for Advanced Midwives (DEPAM);
- (iv) all aspects of adolescent health; and
- (v) all other aspects of reproductive health, through the proposed Reproductive Health Education Programme.

(b) Training of health workers

Health workers will be trained to improve their skills in the provision of quality, integrated MCWH services. Health managers will be trained in micro-planning, focusing on improving the coverage and effectiveness of MCWH services.

(c) Tools

A set of tools will be developed to improve planning, implementation, supervision, monitoring and evaluation.

(d) Cost-effectiveness studies

Cost-effectiveness studies will be conducted at the provincial level. Provincial and district managers will be trained in the appropriate methodology for the analysis of cost, resource use and effectiveness.

8.6 WOMEN AND MEN WILL BE PROVIDED WITH SERVICES WHICH ENABLE THEM TO ACHIEVE OPTIMAL REPRODUCTIVE AND SEXUAL HEALTH

8.6.1 Implementation strategies

- (a) Information on sexuality and reproduction will be provided.
- (b) Services for the diagnosis, management and counselling of HIV/AIDS and STD patients will be made available at all health centres.
- (c) Confidentiality will be enforced in accordance with individual preferences.
- (d) PAP smears and breast examinations will be conducted at scheduled intervals and provision will be made for appropriate management, when required.

- (e) Family planning services, which will be made available to women and men, will provide information and consultation on a wide range of methods of family planning. Clients can then decide for themselves which are the most appropriate methods.
- (f) Human genetic counselling will be provided at all levels, commencing at the community level.
- (g) Peer group education on sexuality and life skills will be encouraged.
- (h) Greater emphasis will be placed on the presentation and management of climacteric and menopausal symptoms, with a view to improving the quality of life.

Chapter 9

HIV/AIDS and Sexually Transmitted Diseases

The HIV epidemic is well established in South Africa. Approximately 1,8 million people are already infected, and more than 700 new infections occur every day.

Statistics from the national annual antenatal clinic surveys indicate that the epidemic has increased tenfold in the last five years. At present, the doubling rate of infection is estimated to be between 13 and 15 months. The results of the annual survey conducted in October-November 1995 show that 10,4% of women attending antenatal clinics of the public health services were infected. The prevalence of HIV in each province was found to be as follows: KwaZulu-Natal 18,2%; Mpumalanga 16,2%; Gauteng 12,0%; Free State 11,0%; North-West 8,3%; Eastern Cape 6,0%; Northern Cape 5,3%; Northern Province 4,9%; and Western Cape 1,7%. It is evident that the virus is spreading more rapidly among young people aged between 15 and 30 years, women and mobile persons.

It is clear that HIV/AIDS is one of the key health issues affecting our population, and that the State's commitment to developing a comprehensive and co-ordinated national AIDS programme is essential. In terms of this commitment a National AIDS Control Programme was formed. It is based on the National AIDS Plan for South Africa, which was developed through a consultative process by the National AIDS Convention of South Africa (NACOSA).

The Plan identified various mechanisms for the control of HIV including behavioural strategies; early detection and treatment of classical sexually transmitted diseases (STDs); maintenance of safe blood supplies; and popularisation and extensive distribution of barrier methods. These have been adopted and are being implemented in terms of the National AIDS Control Programme.

Overall, the Programme aims to reduce the transmission of STDs and HIV infection, and provide appropriate care, treatment and support for those infected. The Programme endeavours to co-ordinate the efforts of all role-players to ensure the optimal use of resources.

It is recognised that HIV/AIDS cannot be prevented without addressing the socio-economic factors which underlie its spread. The cause and impact of AIDS extends beyond the health sector, requiring the commitment of and intervention by all sectors - the State, private sector, non-governmental organisations (NGOs) and community-based organisations (CBOs).

The implementation of the National AIDS Control Programme focuses on five central objectives:

- (a) To prevent the spread of the epidemic through the promotion of safer sexual behaviour, adequate provision of condoms and control of STDs;
- (b) to protect and promote the rights of people living with HIV or AIDS by ensuring that discrimination against such people is outlawed;
- (c) to use the mass media to popularise key prevention concepts and develop life skills education for youth in and out of school;
- (d) to reduce the personal and social impact of HIV/AIDS through the provision of counselling, care and social support, including social welfare services for persons with HIV/AIDS, their families and the community; and
- (e) to mobilise and unify local, provincial, national and international resources to prevent and reduce the impact of HIV/AIDS.

The following principles will therefore be adopted for the control of HIV/AIDS in South Africa:

Principles

Civil society and the Government sector will be involved mutually in containing the spread and impact of HIV/AIDS.

People living with HIV or AIDS will be involved in all prevention, control and care strategies. There will be no discrimination against people infected with HIV/AIDS, and their legal rights will be protected.

The emphasis will be on adequate capacity-building at all levels, to accelerate HIV/AIDS prevention and control measures.

9.1 CIVIL SOCIETY AND THE GOVERNMENT SECTOR WILL BE INVOLVED MUTUALLY IN CONTAINING THE SPREAD AND IMPACT OF HIV/AIDS

The HIV/AIDS epidemic is rooted in society's fabric. This multifaceted epidemic, with its medical, social, psychological and economic dimensions, requires the involvement of all sectors of society. The Government has a particular role to play in implementing control strategies for HIV infection and STDs. To improve the effectiveness and ensure the credibility of such strategies, it is important that Government benefits from the collective experience of civil society.

9.1.1 Implementation strategies

(a) Ensuring government commitment

The Government is committed to achieving the National AIDS Control Programme's objectives and will, within the confines of the limited resources available, ensure that an appropriate level of funding is provided for its implementation.

The Government's role is to lead and guide the process. It cannot implement the National AIDS Control Programme on its own, hence the need for co-ordinating and linking the strategies and activities of a wide range of role-players. In this regard, the initiatives and efforts of NACOSA, the National Association of People Living with HIV/AIDS (NAPWA), NGOs, CBOs and the private sector are recognised and affirmed.

To consolidate the roles of the various Government departments, a multi-sectoral, interdepartmental approach will be adopted. In this regard, an interdepartmental task team will be convened to develop a multisectoral approach to the problem.

(b) Establishing mechanisms to involve all members of civil society and other stakeholders

Mechanisms for the co-ordination and active participation of all stakeholders should be created to facilitate the participation of civil society in HIV/AIDS control.

(i) National AIDS Convention of South Africa

NACOSA was formed after a national conference entitled "South Africa United Against AIDS" held on 23-24 October 1992. The Conference was held to develop a national strategy for HIV/AIDS control, develop strategic plans and co-ordinate the implementation of planned activities.

The National AIDS Control Programme will maintain a strong, mutually collaborative relationship with NACOSA, which will be pursued with the NACOSA Steering Committee at the national level and provincial NACOSA committees. This should ensure that NACOSA continues to provide guidance to the Programme. It also makes allowance for participation in the Programme by all sectors of South African society.

(ii) National HIV/AIDS and STD Advisory Group

A national HIV/AIDS and STD Advisory Group will be established to -

- review and comment on the Programme's policies, plans and activities;
- assist and advise the Programme with regard to securing resources for programme activities;
- establish technical subcommittees on specific issues as and when required;
- encourage linkages between the Programme and other role-players in AIDS/STD control; and
- serve as a resource for *ad hoc* advice on HIV/AIDS and STD- related activities, both within and outside Government.

The HIV/AIDS and STD Advisory Group intends to be as broadly representative as possible. In appointing members, cognisance will be taken of the need to ensure the representativeness of all stakeholders affected by the epidemic.

The Advisory Group will meet once every six months - or more frequently, if necessary - and its members will be appointed by the Director-General for Health. Meetings of the Advisory Group will be funded by the National AIDS Control Programme, which will also provide a secretariat.

The Programme Director and two other Programme staff members, appointed by the Director, will be *ex officio* members of the Advisory Group.

Nominations to serve on the Advisory Group will be open to the public.

Requests for nominations will be advertised through a multi-media strategy.

This will include the use of radio, national and local newspapers, the

NACOSA and the HIV/AIDS-STD Directorate.

Membership tenure of the Advisory Group will be three years.

(iii) Committee on NGO funding

To facilitate the contribution of NGOs and CBOs to HIV/AIDS prevention and control, a committee will be formed to co-ordinate support for NGO/CBO activities. This committee will -

- develop an NGO funding policy for the Programme;
- process NGO applications for Government funding of HIV/AIDS/STD-related activities, and rank them in order of priority; and
- review the progress made by NGOs/CBOs.

(iv) Involvement of the private sector

The private sector should be actively concerned with the support of HIV/AIDS prevention and control measures. The resources available to this sector should be mobilised accordingly, in support of activities within the overall framework of the National AIDS Plan developed by NACOSA.

(v) Working relationships with international agencies

A commitment to working with international agencies has been given. Technical and other support will be obtained as needed from the international community including UN Agencies such as the WHO, UNICEF, UNDP and UNAIDS.

(vi) Co-ordination of research on HIV/AIDS and STDs

It is as important to co-ordinate research on HIV/AIDS-STDs as it is to ensure the use of data generated. A committee will be established to -

- develop a research policy for the Programme in accordance with the Essential National Health Research (ENHR) policy of the Department of Health;
- review applications for research funding and rank them in order of priority within the research funding guidelines of the Department; and
- make recommendations to the Ethical Committee of the Department of Health.

(c) Developing key strategies

Within the framework of the NACOSA AIDS Plan and current understanding of the epidemic, the following key strategies have been identified:

(i) Life-skills programme targeted to the youth

There is general consensus in South Africa about the need for HIV/AIDS-STD education for youth in and out of school.

Studies have shown that appropriate sexuality and AIDS education may delay the onset of sexual activity, and promote the use of safer sex practices among students who are sexually active. It is envisaged that HIV/AIDS-STD education will be a component of a broader education programme, which will include other aspects of health and family-life education such as nutrition, substance abuse and environmental awareness.

Life-skills are required by young people to respond appropriately to the challenges and hurdles they face. Such skills will enable young people to develop self-esteem and self-confidence.

While such education will endeavour to be sensitive to the moral and cultural ethos of different communities, it will, nevertheless, ensure that factual information is provided to the youth.

The National Youth Development Forum and the South African National Students' Congress will be supported in their efforts to provide life-skills training to their constituents.

(ii) Use of mass communication media to popularise key prevention concepts in AIDS

HIV infection and AIDS in the South African context are largely influenced by a number of socio-economic factors, making disadvantaged communities more susceptible to infection. Economically depressed communities are further disadvantaged by lack of access to AIDS and condom information, and to the supportive infrastructure required to stabilise and reverse infection trends.

The socio-economic implications of the disease are likely to undermine dramatically the achievements of the reconstruction and development process. The current media strategy, therefore, focuses on the prevention of infection and overcoming discrimination against HIV-infected individuals. This emphasis will be reviewed as the epidemic progresses, and shifts in strategy become necessary.

Communication techniques will be applied to popularise key prevention concepts in AIDS, including the following:

(iii) Appropriate treatment and management of patients seeking treatment for STDs

There is a close relationship between classical STDs and HIV. Appropriate treatment and management of classical STDs will, therefore, impact on HIV transmission. Historically, classical STDs have been a neglected area of health care provision. The emphasis in future will be on improving the quality of STD services in both the public and private sectors. This will ensure that such care is available to all health care users, promoting the use of the syndromic approach to STD management.

(iv) Improved access to barrier methods

The use of barrier methods has proved to be one of the most effective ways of ensuring a high level of protection against the spread of STDs and HIV infection. An important task of the National AIDS Control Programme, therefore, is to ensure that a range of barrier methods is made freely available to everyone, and that health care workers are trained to assist people in their correct use. In particular, there is a commitment to promoting the use of female barrier methods.

(v) Promotion of appropriate care and support

A commitment has been made to ensure that all persons infected with HIV or suffering from AIDS enjoy access to a continuum of appropriate care and support. Such treatment should include access to counselling services and drugs for treatable opportunistic infections.

Now is an opportune time to develop national, cost-effective plans for the medical management of people living with HIV or AIDS before the epidemic grows. The provision of care is largely the responsibility of the Department of Health at all levels. The relevant Directorate will facilitate and support this matter through the development of guidelines.

The following will, therefore, be undertaken in close collaboration with the relevant Chief Directorates of the DOH:

- management protocols for men, women and children;
- strategies to improve tuberculosis control;
- guidelines for the delivery of care at the appropriate level, along a continuum from home to hospital to hospice, with appropriate discharge and referral patterns;
- procurement of drugs for treatable opportunistic infections; and
- training of health care workers to provide appropriate care.

A commitment to ensuring that counselling services complying with the minimum standards developed by the NACOSA are available to all communities, has been made.

(d) Internal and external channels of communication

The National AIDS Control Programme will ensure that communication is facilitated between the Programme and the various role-players, including role-players in the Department of Health, the private sector, civil society, NGOs and CBOs.

This will include making sure the general public is kept informed of the Programme's activities, achievements and problems encountered. To facilitate this, a clearing house will be established and kept current, to ensure that new material is disseminated widely.

9.2 PEOPLE LIVING WITH HIV OR AIDS WILL BE INVOLVED IN ALL PREVENTION, CONTROL AND CARE STRATEGIES. THERE WILL BE NO DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV OR AIDS, AND THEIR LEGAL RIGHTS WILL BE PROTECTED

9.2.1 Implementation strategies

(a) Involvement of people living with HIV or AIDS

People living with HIV or AIDS will be involved in all decision-making forums of the national HIV/AIDS and STD control programme. This should include their involvement in prevention, education and care-giving activities.

(b) Non-discrimination and legal rights: testing

No HIV testing shall be undertaken before informed consent has been obtained. Test results shall be confidential and only disclosed with the person's consent. It has been recommended that HIV testing should only be conducted within the guidelines set down in law and by the South African Medical and Dental Council (SAMDC).

Testing for the purposes of anonymous, linked or unlinked sero-prevalence studies should adhere to the parameters set out in the WHO guidelines.

HIV testing should be conducted in accordance with the Department of Health's testing policy guidelines.

(c) Legal reform

The National AIDS Control Programme commits itself to a broad programme of legal reform. This will ensure the creation of a non-discriminatory environment which supports the Programme's public health interventions. This includes legislative interventions to outlaw discriminatory practices.

(d) Non-discrimination and equity

The Programme commits itself to ensuring justice and equity for all persons living with HIV or AIDS.

(e) Addressing the vulnerability of women

The National AIDS Control Programme recognises the vulnerability of women to the epidemic and it is, therefore, committed to ensuring that all its projects are gender-sensitive. It is also committed to introducing multi-disciplinary, special gender programmes throughout the country.

9.3 THE EMPHASIS WILL BE ON ADEQUATE CAPACITY-BUILDING AT ALL LEVELS, TO ACCELERATE HIV/AIDS PREVENTION AND CONTROL MEASURES

9.3.1 Implementation strategies

(a) Developing human resources

The Government is committed to the development of human resources in the public service, NGOs and CBOs to ensure a greater capacity for dealing with the epidemic's varying challenges.

In particular, adequate training will be provided to improve counselling services throughout the country.

(b) Ensuring safe blood supplies

Since 1985, all blood donated through recognised blood transfusion service centres has been tested for HIV. It is necessary to ensure the safe supply of blood, despite the rise in HIV. To this end, it is essential that blood and blood products are not pooled until all testing precautions have been taken. Blood donors should not be paid and transfusions should only be given in essential cases.

(c) Capacity for effective communication and health promotion

In order to achieve the desired behavioural change for the prevention and control of HIV/AIDS, pre-tested messages and the ability to target priority groups will have to be developed. Formative research will be conducted to enrich this process and ensure that education, counselling and supportive care activities are sensitive to culture, language and social circumstances.

(d) Capacity for monitoring and evaluation

The National AIDS Control Programme is committed to the ongoing monitoring and evaluation of priority interventions. The capacity for monitoring and evaluation will be strengthened at all levels.

(e) Universal precautions

Protocols will be developed to reduce the risk of occupational exposure to HIV by staff in different settings.

(f) HIV/AIDS surveillance

Existing mechanisms of HIV surveillance will be strengthened and expanded to include the monitoring of STDs, indicators of AIDS and indicators to ensure that the impact of policy and behavioural changes are measured.

(g) Co-ordination of activities

The National AIDS Control Programme commits itself to co-ordinating and facilitating AIDS programmes, research and other AIDS-related activities in the country.

Chapter 10

Infectious and Communicable Disease Control

Infectious and Communicable Diseases include Tuberculosis (TB), hepatitis, measles, polio, diphtheria pertitis, malaria, and other diseases such as cholera and leprosy. The control of Communicable diseases which are largely preventable is a vital function of the Department of Health. The Department is committed to effective control of this set of diseases by a number of strategies including improving access to Primary Health Care, improving preventive strategies, accelerating vaccination programmes and improved clinical management.

South Africa is facing one of the worst TB epidemics in the world and TB is one of South Africa most important public health problems. In 1995 there were over 90 000 new cases of TB and an estimated 3,000 deaths. The incidence of TB is currently estimated at over 224/100,000. The interaction between HIV and TB has enabled the HIV epidemic to contribute to a further increase in TB incidence. Other factors contributing to the increased incidence of TB is the development of multidrug resistant TB which is difficult and expensive to treat. An effective control strategy is required to prevent South Africa's TB epidemic from spiralling out of control.

Department of Health has taken the unprecedented step of declaring TB a top national health priority. This action is aimed at motivating key role players and decision makers to invest adequate resources in TB management and help mobilize role players and communities to improve TB control activities. TB cure rates will be an indicator for the success. Other planned activities for TB intervention will include cooperation and agreement with neighbouring countries on joint control strategies, ensuring adequate skills at provincial and district levels and integrating services at clinic level. A Tuberculosis Operational Centre has been established to monitor the progress of the TB Control Programme and to provide technical support for the provinces.

With regard to the Expanded Programme on Immunization (EPI), a national review has been conducted. Hepatitis B has been included in the EPI schedule. The Haemophilus influenza type B vaccine and an active Acute Flaccid Paralysis (AFP) surveillance system will soon be implemented. It indicates that the last reported polio case was in 1989. As a follow up to a comprehensive review a comprehensive cold chain system is to be implemented. Following a successful sub-national polio campaign and a mass national polio and measles campaigns in 1996. A mass national measles campaign is also scheduled for 1997.

South Africa is experiencing one of the worst Malaria epidemics in decades. Exacerbating the malaria problem is the spread of parasite resistance to malaria drugs of choice and changes in mosquito vector species. The current vector does not always rest inside on the wall services after taking blood from the human host which makes the insecticides sprayed on the walls less effective. Malaria control strategies should be reviewed and intensified. Since malaria is a regional problem collaboration among Southern African countries is being initiated to enable a regional approach in the control of Malaria.

Principles

Communicable Disease Control Services (CDCS) should be accessible and integrated into comprehensive primary health care services.

CDCS should be efficient, cost-effective and of good quality.

Health care staff should be adequately trained in clinical management and on strategies of Communicable Disease Control (CDC).

Communities and individuals should be adequately informed on CD and should be constructively involved in CDC activities

The CDC Programmes should ensure accountability through the use of recording and reporting system, by establishing a financial management system, and through regular evaluation and review.

Communicable Disease Control Services should ensure effective infection control, including control and management of epidemics.

10.1 CDCS SHOULD BE ACCESSIBLE AND INTEGRATED INTO COMPREHENSIVE PRIMARY HEALTH CARE SERVICES

The prevention, diagnosis and treatment of CD are essential components of comprehensive primary health care. TB is the most common opportunistic infection in people infected with HIV and kills more people than any other infectious disease. Given the high incidence of TB in South Africa, it is important that TB should be managed in a primary care setting.

Immunisation is one of the essential elements of primary health care services. Services should be available to all children and mothers on a daily basis at all clinics, community health centres and out patient departments of hospitals.

Malaria cannot yet be totally integrated into primary health care. Passive diagnosis and treatment can be fully integrated but active detection, diagnosis and treatment still play a vital role in malaria control. Vector control through spraying of structures with insecticides is still a specialised service being managed at regional level.

Strengthening CD services through appropriate management structures will help to strengthen primary care services.

10.1.1 Implementation Strategies

(i) Health Facility Level

TB and malaria diagnosis and treatment services should be available in all primary health care facilities. Collaboration between many service providers including Departments of Health, nongovernmental organisations and the private sector will make TB diagnostic and treatment services more accessible. TB Coordinators at district, provincial and national levels will facilitate this collaboration. EPI services should be available at every primary health care facility and should be supported by mobile services.

(ii) District Level

Every district should have a coordinator responsible for TB and one for EPI who may also be responsible for other communicable diseases. This coordinator will

ensure that the CDC strategy is properly implemented and will provide technical support and supervision to health care providers. The coordinator should also participate in the district health management team to ensure that CDCS services are fully integrated with other health services.

(iii) Provincial Level

Integration at provincial level should be achieved by coordination and communication with other programmes. Given the magnitude of the TB epidemic, the EPI programme and the malaria epidemic and the need to coordinate activities within and outside the Department of Health, a full time Coordinator should be appointed for each programme in every province. A coordinator should also be appointed to manage the response to outbreaks of diseases such as haemorrhagic fevers e.g. Ebola and Congo Fever, Cholera and Plague. These coordinators should also liaise with the national managers of these diseases.

(iv) National Level

Integration at national level should be achieved by coordination and communication with other key role players. The functions of the National TB, EPI and Vector-borne Diseases (mainly Malaria) and Other diseases (such as Cholera and Leprosy, as well as outbreak response) Control Programmes should include strategic and operational planning, policy formulation, advocacy to ensure understanding and commitment to effective disease control, production of health education materials, development of standardised training materials, monitoring and evaluation. A strong team is required at national level to provide adequate technical support to the provinces.

(v) Establishment of a Peripheral Microscopy Network

In order to diagnose smear-positive (infectious) TB cases, microscopy services must be accessible to primary health care services. International recommendations suggest that there should be approximately one microscopy centre per 100,000 population. Microscopy services should be provided in the context of laboratory services for primary health care. Sputum smear results should be available quickly enough to be convenient for health workers and patients (preferably on the same day the sputum sample is taken). This service can be incorporated into the already

well established microscopy services in the provinces where malaria is prevalent.

10.2 CDCS SHOULD BE EFFICIENT, COST-EFFECTIVE AND OF GOOD QUALITY

The DOTS strategy has proven to be a cost-effective way to control the spread of TB, even in poor socioeconomic conditions and high levels of HIV infection. The quality, quantities and costs of the medicines used in the TB and Malaria programmes, as well as the vaccines used in the EPI programme, should be assured by a national tendering and contract system.

10.2.1 Implementation Strategies

(i) Demonstration and Training Districts

In order to implement the full TB Directly Observed Treatment Strategy (DOTS) strategy, demonstration and training districts should be established. Once these sites achieve success as demonstrated by high smear conversion rates and high cure rates, they will act as templates for other districts. The demonstration and training districts will expand to cover the entire country by 1999. In this way, South Africa will be able to achieve the goal of curing 85% of new smear-positive TB cases by the year 2000.

The national EPI in collaboration within the WHO and UNICEF have trained personnel on provincial and district levels.

(ii) Uniform drug management approaches nationally using standard treatment guidelines for the Essential Drug list are important since the proliferation and use of different management schemes would contribute to an increase in Multi-drug resistant tuberculosis.

(iii) Early identification and treatment of opportunistic infections for TB/HIV will contribute to effective management of both TB and HIV/AIDS.

10.3 HEALTH CARE STAFF SHOULD BE ADEQUATELY TRAINED ON CDC STRATEGIES

The capacity of primary health care workers to implement the CDC strategies should be strengthened by training all health staff (both those in training and those in service).

10.3.1 Implementation Strategies

(i) Pre-service training

TB, Immunisable Diseases, Vector-borne Diseases such as Malaria and Rabies, as well as some of the Other diseases, should be incorporated into the training curricula of medical students, nurses, laboratory technicians and allied health professionals.

(ii) In-service training

Initial training is required to orientate working health professionals to new strategies. Subsequently, ongoing refresher training is required. At least one staff member in every primary health care facility should be familiar with one of the above-mentioned strategies.

10.4 COMMUNITIES SHOULD BE INVOLVED IN CDC ACTIVITIES

For the TB programme the essential element of the DOTS strategy is Directly Observed Treatment (DOT). DOT supports TB patients by observing them swallow their TB drugs to ensure that they complete treatment and are cured. TB treatment should be made as accessible and convenient for TB patients as possible. TB patients can receive DOT at clinics, at the workplace or in their communities. Every TB patient should choose a treatment supporter to provide DOT, in consultation with a health worker. Rigorous DOTS should be instituted in hospitals during the initial treatment period for TB.

Communities are already involved with malaria control where their houses are sprayed annually for vector mosquito control. Closer involvement should be developed in future in areas where mosquito-proof bed nets and other personal precautionary measures can be introduced.

10.4.1 Implementation Strategies

(i) Employers

Many of those who develop CD e.g. TB are working. As far as possible, after the acute phase such people should receive treatment under supervision at their place of employment. Treating TB sympathetically means that others who suspect they have the disease are encouraged to come forward and be treated early in their disease.

(ii) Community-based

Any responsible community member can provide the DOT for TB. District Coordinators should encourage increased involvement of communities through health education, and liaison between health services and community-based organisations.

10.5 EDUCATION OF INDIVIDUALS ON CD SHOULD BE ADEQUATE

Individuals should know the symptoms of the most important diseases such as TB, childhood diseases and malaria. They should know which diseases can be prevented and that all of them can be cured if diagnosed in time. There should be no discrimination against people suffering from TB.

10.5.1 Implementation Strategies

(i) World TB Day

Every year on March 24, the world focuses its attention on TB. March 24 was the day in 1882 when Dr Robert Koch announced his discovery of the bacillus that causes TB. World TB Day should be used as an opportunity to inform the general public about DOTS and to reduce the stigma attached to TB.

(ii) Health promotion materials

Media releases, posters, pamphlets, comic books and videos on CD prevention and control should be produced and distributed.

10.6 THE CDC PROGRAMMES SHOULD ENSURE ACCOUNTABILITY THROUGH THE USE OF RECORDING AND REPORTING SYSTEM, BY ESTABLISHING A FINANCIAL MANAGEMENT SYSTEM, AND THROUGH REGULAR EVALUATION AND REVIEW

The TB recording and reporting system uses cohort analysis to measure treatment outcomes. This system allows the measurement of key programme indicators including the cure rate of new smear-positive TB patients. The goal of the TB Control Programme is to cure 85% of new smear-positive TB patients by the year 2000. Linking financial expenditures to cure rates will give a measure of cost-effectiveness. Measuring and reporting cost-effectiveness will allow the Department of Health to be accountable for TB control activities.

Recording and reporting on the Vaccine Preventable Diseases, Vector-borne disease and Other diseases to analyse their cost-effectiveness should also be established and continued.

Information and surveillance data of communicable diseases will be used for further planning, and management of communicable Diseases.

10.6.1 Implementation Strategies

(i) Implementation of the recording and reporting system

The TB register and accompanying documentation should be made available to all health care facilities which diagnose and treat TB. Health workers in these facilities, District Coordinators and Provincial Coordinators should be trained to complete the forms and to use the information for management purposes.

Report systems on the Vaccine Preventable, Vector-borne and Other diseases should also be continued and established where not yet available. An active Acute Flaccid Paralysis surveillance system was implemented to notify and de-notify cases.

(ii) Supervision

The TB register and quarterly reports should be reviewed by District Coordinators during monthly supervisory visits to health facilities to ensure the accuracy of the information which is reported. Similarly, the reports of the other diseases mentioned above should also be reviewed by District Coordinators, their reports by Provincial Coordinators and the reports of Provincial Coordinators should be reviewed by the National Manager on a quarterly basis.

(iii) Financial management system

A system compatible with the State financial management system should be implemented to account for TB, EPI, Vector-borne Diseases and Other Diseases expenditures.

(iv) Evaluation and review

Regular evaluation and review of the TB, EPI, Vector-borne Diseases and Other Diseases Control Programmes should be done to ensure that the programme is on the right track to achieve its goals.

10.7 COMMUNICABLE DISEASE CONTROL SERVICES SHOULD ENSURE EFFECTIVE INFECTION CONTROL INCLUDING CONTROL AND MANAGEMENT OF EPIDEMICS

Epidemic control and management is an important activity of the department. The Department of Health with relevant partners will ensure effective infection control to protect health and laboratory workers as well as individuals at risk of various infectious diseases. Epidemics will be carefully monitored, managed and contained to protect communities from morbidity and mortality associated with communicable and infectious disease.

10.7.1 Implementation Strategy

A epidemic management system will be developed across the country. In each province and region a coordinator who liaises with the national department will be appointed to manage the response to outbreaks of diseases such as haemorrhagic fevers, Cholera, and

Plague. The epidemic management system will cover a broad range of stakeholders as well as neighbouring countries to ensure effectiveness in epidemic management.

Infection control will be strengthened and continuously monitored in health and health related facilities. Measures will be instituted to ensure that safety guidelines for infection control are adhered to in health and medical environments as well as in social environments such as schools, kindergartens and shelters.

(iii)

Financial management system

A system compatible with the State financial management system should be implemented to account for TB, EPL, Vector-borne Diseases and Other Diseases expenditures.

(iv)

Evaluation and review

Regular evaluation and review of the TB, EPL, Vector-borne Diseases and Other Diseases Control Programmes should be done to ensure that the programme is on the right track to achieve its goals.

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10.7.1 Immunisation Strategy

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Chapter 11

Environmental Health

The Department of Health, in collaboration with other relevant sectors, is responsible for the improvement of South Africa's environmental health status. It therefore endeavours to limit the health risks which arise from the physical and social environment.

The broad aim of environmental health services is to address environmental health priorities as defined by, *inter alia*, the RDP, the World Health Organisation's Global Strategy for Environment and Health, the UNCED 92 Agenda 21 Strategy and the relevant Year 2000 Health Goals and Objectives set out in Chapter 21 of this document.

The Basic Subsistence Facilities Report published by the Department of Health in January 1995 illustrated the water and sanitation situation as follows:

(a) Drinking water

- ☐ Rural population: 52% have no access to potable drinking-water
- ☐ Marginal urban population: 2,7% have no access to potable drinking water

(b) Latrine facilities

- ☐ Rural population: 54% have no facilities
- ☐ Marginal urban population: 34% have no facilities

(c) Domestic refuse removal/disposal

- ☐ Rural population: 61,5% have no access to a refuse removal system
- ☐ Marginal urban population: 70,6% have no access to a system

Because of rural inequalities in socio-economic development as well as rapid industrialisation and urbanisation, South Africa experiences a wide range of environmental health impacts.

Principles

Every South African has the right to a living and working environment which is not detrimental to his/her health and well-being.

All persons should have access to knowledge on environmental health matters and the services available to them.

Environmental health services should be accessible, acceptable, affordable and equitable. They must be implemented with the active participation of the communities.

Environmental health services should contribute positively towards sustainable physical and socio-economic development.

The establishment of effective environmental health surveillance is essential to determine whether or not the services are functional and effective and have a positive health impact.

11.1 EVERY SOUTH AFRICAN HAS THE RIGHT TO A LIVING AND WORKING ENVIRONMENT WHICH IS NOT DETRIMENTAL TO HIS/HER HEALTH AND WELL-BEING

11.1.1 Implementation strategies

The health sector will collaborate with other sectors to implement the following strategies:

(a) Human resource development for environmental health

This will be undertaken through the support of formal and informal training programmes which are sensitive to the country's needs. All environmental health practitioners should be technically competent to deal with the

management of health risks in the physical and social human environments in order to promote a sustainable and healthy environment.

(b) Intersectoral collaboration

In view of the multidimensional and multidisciplinary nature of the interactive process between the environment and health, the Integrated Environment Health Management Strategy should interface with all sectors which play a role in environmental health risk reduction.

Existing mechanisms for intersectoral collaboration such as the Interdepartmental Liaison Committee of the Departments of Health and Water Affairs and Forestry, and the National Sanitation Task Team (NSTT) will be utilised to promote intersectoral action.

(c) Distribution of environmental health services

Based on community needs and related risk assessments as they impinge upon the quality of physical and social environments, environmental health service interventions including the promotion of clean water, adequate sanitation provision and food safety will be aimed at addressing needs and reducing the associated risk on a prioritised basis.

(d) Environmental health: a "shared responsibility"

The environmental health sector will be responsible for the provision of accessible services and support communities in managing environmental health risks. Ultimately, however, each individual must take responsibility for the maintenance of a healthy environment.

(e) Environmental health legislation

A community development rather than a law enforced approach will be followed in creating environmental conditions conducive to good health. Environmental health legislation will comply with the requirements contained in the Interim Constitution's Bill of Rights and will be based on integrated, appropriate and uniformly applicable legislation.

11.2 ALL PERSONS SHOULD HAVE ACCESS TO KNOWLEDGE ON ENVIRONMENTAL HEALTH MATTERS AND THE SERVICES AVAILABLE TO THEM

11.2.1 Implementation strategies

- (a) Community empowerment is central to the principles of the RDP. The primary health care approach to the delivery of community-based services involves the active participation of these communities. This will be done through the dissemination of strategic and appropriate environmental health and hygiene information, education and communication (IEC) to develop the communities' capacity for participation.
- (b) Environmental health information will be included in health promotion and marketing activities at all levels. In support of IEC, environmental health information centres should be established.
- (c) Environmental health practitioners, in collaboration with other stakeholders, will ensure that communities are able to plan and implement effective environmental health strategies through an integrated IEC Programme aimed at improving social mobilisation.

11.3 ENVIRONMENTAL HEALTH SERVICES SHOULD BE ACCESSIBLE, ACCEPTABLE, AFFORDABLE AND EQUITABLE. THEY MUST BE IMPLEMENTED WITH THE ACTIVE PARTICIPATION OF THE COMMUNITIES

11.3.1 Implementation strategies

- (a) A comprehensive environmental health service, sensitive to and inclusive of the communities' needs, will be rendered.
- (b) Environmental health services should be representative of the diverse cultural composition of the South African population and be distributed according to the communities' real needs.

11.4 ENVIRONMENTAL HEALTH SERVICES SHOULD CONTRIBUTE POSITIVELY TOWARDS SUSTAINABLE PHYSICAL AND SOCIO-ECONOMIC DEVELOPMENT

The health sector has an important role to play in promoting interaction between health, the environment and overall development.

11.4.1 Implementation strategies

(a) Ensuring health impact assessment

An integrated health and environmental approach should be included in the environmental impact assessment of all major development projects.

(b) Integrating health policy with overall developmental policies affecting the environment

The health sector should participate in developing policy co-ordinating mechanisms at all levels of government and within the private sector and NGO's to ensure the sustainability of a healthy environment.

(c) Establishment of a WHO regional centre for environmental health in South Africa

This should ensure liaison in the spheres of health, environment and development with member states within the AFRO region of the WHO.

(d) Supporting / promoting international conventions/ programmes aimed at ensuring sustainable development

The Department of Health should contribute to implementing the Agenda 21 principles within the health sector, as it relates to programmes such as Healthy Cities, the Montreal Protocol, etc.

11.5 THE ESTABLISHMENT OF EFFECTIVE ENVIRONMENTAL HEALTH SURVEILLANCE IS ESSENTIAL TO DETERMINE WHETHER OR NOT THE SERVICES ARE FUNCTIONAL AND EFFECTIVE AND HAVE A POSITIVE HEALTH IMPACT

11.5.1 Implementation strategies

- (a) Training will be undertaken to improve capacity for planning, implementation, monitoring and evaluation of environmental health issues at the provincial, district and community levels.
- (b) Indicators for monitoring and evaluating the impact of environmental health services will be improved.
- (c) The National Environmental Health Services Surveillance Programme (NEHSSP) will ensure linkages and networking with all stakeholders concerned with environmental health information.

Chapter 12

Mental Health and Substance Abuse

Mental illness is a major cause of morbidity as well as some mortality, particularly amongst citizens at risk in South Africa. The latter refers specifically to communities which have been ravaged by State neglect and abuse for decades. Generally, mental health promotion and the provision of services have been neglected in the past. Common manifestations are interpersonal violence, gender and age-specific forms of violence, trauma, neurosis of living under continual stress, post-traumatic stress reactions and disorders, substance abuse, suicide, and adjustment-related reactions and disturbances in children and the elderly.

Mental health services, like all other services, have been fragmented and are ill-equipped to intervene effectively. Available services are neither appropriate nor accessible to the majority of the population, especially those in rural areas. Successfully improving and promoting the psychosocial well-being of all communities is an essential ingredient in the implementation of the RDP. South Africa has the advantage of a strong NGO presence and other social formations, like concerned and committed business communities, church groups and organised children, youth and women's associations. With the proper co-ordination and support, they could play a major role in the promotion of mental health.

Principles

A comprehensive and community-based mental health and related service (including substance abuse prevention and management) should be planned and co-ordinated at the national, provincial, district and community levels, and integrated with other health services.

Essential national health research should include an analysis of mental health and substance abuse to identify the magnitude of the problem.

Human resource development for mental health services should ensure that personnel at various levels are adequately trained to provide comprehensive and integrated mental health care based on primary health care principles.

12.1 A COMPREHENSIVE AND COMMUNITY-BASED MENTAL HEALTH AND RELATED SERVICE (INCLUDING SUBSTANCE ABUSE PREVENTION AND MANAGEMENT) SHOULD BE PLANNED AND CO-ORDINATED AT THE NATIONAL, PROVINCIAL, DISTRICT AND COMMUNITY LEVELS, AND INTEGRATED WITH OTHER HEALTH SERVICES

In the past, mental health care was largely custodial and based on medical therapy. The focus was limited to occupational therapy and in- and outpatient psychotherapy and counselling. The latter forms of therapy tend to be skewed in favour of the urban, wealthier population in terms of access, quality and personnel.

Mental health services are run as a vertical programme and lack a comprehensive approach as the primary health care philosophy suggests. There is poor intersectoral liaison and co-ordination of services, leading to duplication and fragmentation.

12.1.1 Implementation strategies

(a) National level

At the national level, the Mental Health and Substance Abuse Directorate will be responsible for planning mental health and substance abuse services through a process of consultation with other role-players and consumers. This will ensure the effective co-ordination and integration of the services as well as their monitoring and evaluation. The Directorate will facilitate the development of functions at various levels of care, focusing on the role of communities. The approach should be multi-professional, with the emphasis on preventive and promotive services.

Among other national level functions will be the following:

- (i) evaluating the prevalence of mental health problems and promoting strategies to address problems identified;
- (ii) co-ordinating the restructuring of mental health services, including the development of norms and standard and integration of mental health services into PHC;
- (iii) promoting intersectoral co-ordination and the multidisciplinary team approach;
- (iv) developing norms and standards for the education and training of mental health human resources;
- (v) monitoring research on mental health on a national basis and promoting research in priority areas;
- (vi) monitoring and evaluating mental health services nationally and ensuring equity;
- (vii) exploring the nature and extent of collaboration with traditional healers;
- (viii) reviewing and evaluating legislation relating to mental health and substance abuse to safeguard the human rights of all service users;
- (ix) developing and promoting specific programmes addressing substance abuse, child abuse, women abuse and the management of victims of violence, in collaboration with other sectors;
- (x) planning, providing and monitoring forensic psychiatric services;
- (xi) planning and promoting specific services for the mentally handicapped in collaboration with the relevant stakeholders and users of the services; and

- (xii) planning, developing and promoting specific services for psychogeriatrics to ensure quality of life, in collaboration with other role-players.

(b) Provincial level

The planning, co-ordination, effective supervision, monitoring and evaluation of mental health services will be undertaken at the provincial level. The provincial health authorities should provide a sustainable budget for provincial and district mental health and substance abuse services.

The provincial health authorities will also have other functions, including the following:

- (i) Facilitating intersectoral co-ordination in order to bring together workers from other sectors for example religious, educational, women's, industrial, police, agricultural, youth and sport groups and NGOs;
- (ii) ensuring the comprehensive integration of mental health and substance abuse services with other health services, to avoid verticalisation of the service; and
- (iii) ensuring that mental disability and psychogeriatric services are also included in the health services provided.

(c) District level

At district level, the health authorities will ensure the comprehensive integration of mental health services with other services. Planning of mental health services should be undertaken, with the active participation of various stakeholders, especially the communities.

The following activities will be undertaken at the district level:

- (i) Providing mental health and substance abuse prevention, promotion and rehabilitative services, giving special attention to the planning, implementation and co-ordination of community-based rehabilitation;

- (ii) planning and implementing inpatient and day-patient care for the mentally ill and substance abusers, establishing a 24 hour consultation service for mentally ill patients and victims of substance abuse;
- (iii) providing training for health facility staff;
- (iv) undertaking mental health education programmes in communities;
- (v) establishing and maintaining mental health committees and maintaining collaboration with other sectors, private practitioners, traditional healers and NGOs;
- (vi) providing emergency and crisis interventions and counselling;
- (vii) collecting data, and initiating and contracting out research in accordance with local needs, with the support of relevant institutions; and
- (viii) developing appropriate indicators for monitoring and evaluation.

It is important that data collection, analysis and resultant action be performed at each level and appropriate feedback given, especially to the communities.

(d) Community level

At the community level, non-governmental and other grassroots organisations should be involved in mental health services. Communities should be actively involved in the planning and implementation of community-based mental health care services, as well as substance abuse prevention, management and rehabilitation.

Among the activities to be promoted will be the following:

- (i) the formation of community mental health forums to evaluate causative factors and problems within the communities may facilitate the elimination of the stigma attached to mental illness and reduce substance abuse;
- (ii) development of special programmes addressing aspects of violence within communities, with an emphasis on children and women;
- (iii) provision of health education and information on mental health and substance abuse - especially to the youth - and the establishment of community centres for crisis intervention; and
- (iv) development of special programmes aimed at educating and providing information and support to the mentally disabled and psychogeriatrics,

thereby improving their quality of life in the community.

12.2 ESSENTIAL NATIONAL HEALTH RESEARCH SHOULD INCLUDE AN ANALYSIS OF MENTAL HEALTH AND SUBSTANCE ABUSE TO IDENTIFY THE MAGNITUDE OF THE PROBLEM

Mental health services and substance abuse have been accorded inadequate attention by researchers. There is little doubt that the burden of mental ill health in South Africa is costly in terms of health care expenditure and loss of productive years of life. It is, therefore, essential for research to be directed at both prevention and rehabilitation.

12.2.1 Implementation strategies

- (a) Additional funds should be allocated for research on mental illness, substance abuse and violence, especially at the household level, with emphasis on age and gender differentials.
- (b) Young research interns should be encouraged to conduct research projects on mental health, substance abuse and violence to ensure sustained interest.

12.3 HUMAN RESOURCE DEVELOPMENT FOR MENTAL HEALTH SERVICES SHOULD ENSURE THAT PERSONNEL AT VARIOUS LEVELS ARE ADEQUATELY TRAINED TO PROVIDE COMPREHENSIVE AND INTEGRATED MENTAL HEALTH CARE BASED ON PRIMARY HEALTH CARE PRINCIPLES

12.3.1 Implementation strategies

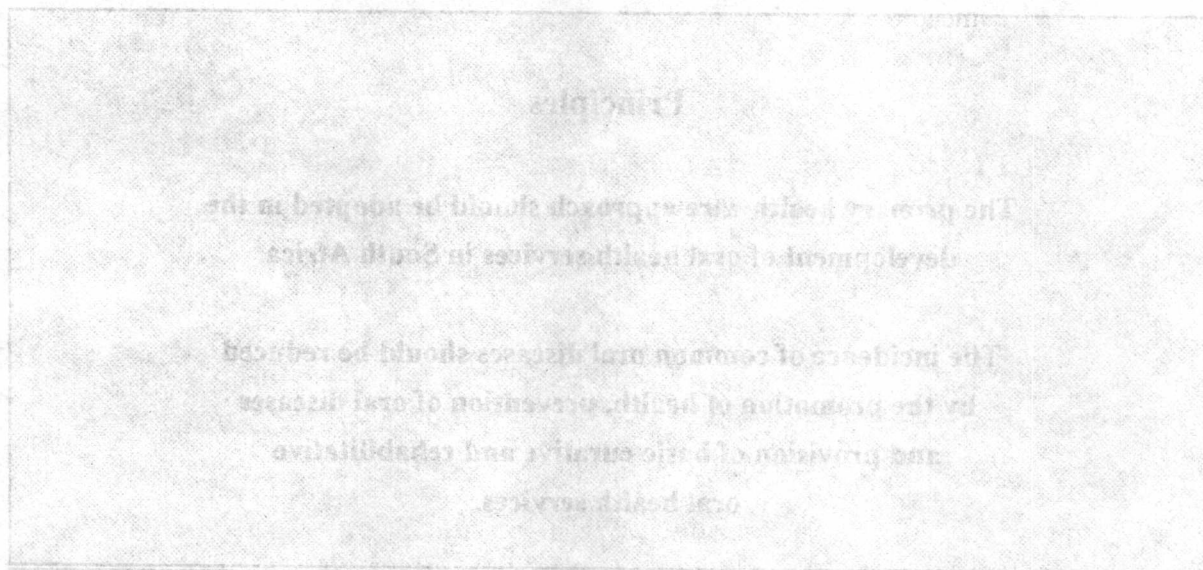
Among the strategies to be adopted are the following:

- (a) district health teams should be trained to improve their capacity for planning, implementing, supervising, monitoring and evaluating mental health programmes at the district and community levels.
- (b) all mental health staff should undergo special training to deal with post-traumatic stress and the impact of violence. Their communication and counselling skills should also be upgraded.
- (c) Staff at the lower referral levels, i.e. clinics and community health centres, should be trained to do basic screening and counselling and to identify and refer

- patients for further assessment and management.
- (d) Drugs required for the management of psychiatric problems must be available at all levels of health care provision as appropriate.

Oral health services in the public and private sectors are delivered by dental practitioners, oral hygienists, dental therapists, technicians and assistants. Like most of the health services in South Africa, a major deterrent to the availability of oral health services has been the inability of poor communities to pay for oral health services. This is made worse by the fact that most oral health providers work in the private sector.

Oral diseases, especially dental caries and periodontal diseases, are among the most common diseases affecting South African society. More than 90% of adults in South Africa suffer from dental caries, and 93% from periodontal diseases. It is worth noting that oral diseases are increasing among major sections of the population, especially the disadvantaged and urbanised groups.



Chapter 13

Oral Health

Oral health services in the public and private sectors are delivered by dental practitioners, oral hygienists, dental therapists, technicians and assistants. Like most of the health services in South Africa, a major deterrent to the availability of oral health services has been the inability of poor communities to pay for oral health services. This is made worse by the fact that most oral health providers work in the private sector.

Oral diseases, especially dental caries and periodontal diseases, are among the most common diseases affecting South African society. More than 90% of adults in South Africa suffer from dental caries, and 93,5% from periodontal diseases. It is worth noting that oral diseases are increasing among major sections of the population, especially the disadvantaged and urbanised groups.

Principles

The primary health care approach should be adopted in the development of oral health services in South Africa.

The incidence of common oral diseases should be reduced by the promotion of health, prevention of oral diseases and provision of basic curative and rehabilitative oral health services.

13.1 THE PRIMARY HEALTH CARE APPROACH SHOULD BE ADOPTED IN THE DEVELOPMENT OF ORAL HEALTH SERVICES IN SOUTH AFRICA

13.1.1 Implementation strategies

(a) Prioritisation of service delivery

- (i) Preventive measures and other oral services should be provided to mothers, children, pregnant women, the physically and mentally disabled and the elderly as a matter of priority.
- (ii) Services at all dental clinics should be aimed at providing all the above groups with at least a minimum package of services.
- (iii) The provision and expansion of oral health services will be accelerated so that an equitable distribution of services is reached in the shortest possible time.

(b) Focus on prevention

- (i) Innovative strategies should be employed to provide a cost-effective oral health service, with the emphasis on prevention. It may prove cost-effective to purchase certain services from the private sector to increase the coverage of services.
- (ii) The oral disease profile suggests that most treatments could be undertaken by oral hygienists or dental therapists. It should be possible to fill a vacant dentist's post in the public service with two dental therapists, or one therapist and an hygienist. This will improve staffing levels at clinics.

(c) Integration of oral health care

- (i) Oral health services should be integrated with other health services at all levels of care.
- (ii) A basic package of oral health services should be provided at all primary health care facilities.
- (iii) Plans for oral health facilities should be included in the design of all primary health care institutions.

(d) Training of oral health personnel

The training of oral health personnel must be reviewed to prepare professionals for different environments and to work among different sections of the population. The deployment and utilisation of oral health personnel should meet all South African's needs, and be in keeping with the new focus of oral health service delivery.

13.2 THE INCIDENCE OF COMMON ORAL DISEASES SHOULD BE REDUCED BY THE PROMOTION OF HEALTH, PREVENTION OF ORAL DISEASES AND PROVISION OF BASIC CURATIVE AND REHABILITATIVE ORAL HEALTH SERVICES**13.2.1 Implementation strategies****(a) Minimum package of oral health care**

A defined minimum package of oral health care should be provided to the priority groups listed above. This package should consist of an annual examination, bitewing radiographs, cleaning of teeth, simple 1-3 surface fillings, fissure sealants and emergency relief of pain and infection control.

(b) Systemic water fluoridation

- (i) Systemic water fluoridation should be implemented immediately, at least in the major metropolitan areas of South Africa, the remaining areas being phased in systematically.
- (ii) Alternative methods of fluoridation, such as the use of fluoride toothpaste and fluoride mouth-rinses, should be introduced in schools and among priority groups.
- (iii) Legislation to enable the fluoridation of milk and salt should be pursued.
- (iv) Dietary supplements (fluorides and vitamins) should be included as part of the Integrated Nutrition Programme.

(c) Reduction of the consumption of refined sugar

A nutrition programme should be introduced to -

- (i) remove or reduce the levels of sugar in infant and baby foods including medicines, fruit juices and vitamin preparations;
- (ii) reduce the levels of added sugars in common foods and encourage the manufacture and consumption of sugar-free foods, snacks and drinks;
- (iii) ensure the availability of accurate information on sugars and their levels on food labels; and
- (iv) emphasise that sugars are nutritionally poor and decrease the nutrient quality of foods.

Chapter 14

Occupational Health

Occupational injuries and diseases have an important role to play in health, particularly in developing and middle-income countries. By affecting the health of the working population, occupational injuries and diseases have profound effects on productivity and the economic and social well-being of workers, their families and dependants.

In recognition of the above and the past neglect of occupational health in South Africa, the development of occupational health services is a key priority area of the RDP and Department of Health.

South Africa has more than 8,2 million workers who spend at least eight hours per day in formal employment in tens of thousands of factories and mines, on farms and other places of work. The health of many of these workers has been affected by:

- chemical agents, resulting in, e.g. skin problems, lung disease and systemic poisoning;
- physical agents, resulting in, e.g. noise-induced deafness;
- biological agents, resulting in, e.g. tuberculosis and Legionnaire's disease;
- ergonomic hazards, resulting in, e.g. back pain; and
- psychological hazards resulting in stress and stress-related diseases.

Occupational health programmes must focus on providing services, conducting research and disseminating information to improve workers' health status. This involves collaboration between disciplines such as occupational hygiene, biochemistry, immunology, toxicology, epidemiology, pathology and occupational medicine. The prime responsibility of occupational health services is to identify, control and prevent adverse health effects caused by the working environment.

Responsibility for occupational health is that of a wide range of authorities and is governed by at least twenty-four pieces of legislation. These authorities include the Departments of Labour, Health, Mineral and Energy Affairs and Agriculture, as well as provincial and local authorities. Their efforts are currently fragmented and insufficiently co-ordinated.

It is evident that health authorities have some responsibility for early detection, management and rehabilitation of individuals suffering from occupational injuries or/and diseases. In the past, however, no special effort was made by the public sector to provide occupational health services,

except in the case of mainly White miners (which has been transferred to the employer in terms of the Occupational Diseases in Mines and Works Amendment Act, 1993) and the establishment of the National Centre for Occupational Health in Johannesburg.

Principles

Effective interdepartmental co-ordination and organisation of the various components of occupational health and safety is required.

The development of occupational health services and associated human resources is required at the national, provincial, regional and district levels.

Norms and standards for a healthy and safe working environment must be developed in collaboration with other departments.

Benefit examinations for the identification of compensable disease in former mine workers should be extended to under-served areas.

The harmonious development of occupational health and safety is required across Southern Africa.

14.1 EFFECTIVE INTERDEPARTMENTAL CO-ORDINATION AND ORGANISATION OF THE VARIOUS COMPONENTS OF OCCUPATIONAL HEALTH AND SAFETY IS REQUIRED

14.1.1 Implementation strategy

A new legislative framework making provision for improved co-ordination of the various components of occupational health and safety (OH&S) is required. The creation of a co-ordinating body along the lines of a health and safety agency with national and

provincial components should result from this framework. Such bodies are common around the world, and there is need for one in South Africa. It will provide a forum for policy-making and standard-setting that is legitimate, credible and authoritative. It will also provide a setting within which a coherent policy framework for OH&S practices in South Africa can be developed. Contributions could be made by organised labour, business and State departments and OH&S specialists.

Occupational health and safety is a multidisciplinary activity and falls within the domain of a number of Government departments, business and labour. The Department of Health supports the Cabinet memorandum which initiated the investigation to establish a health and safety agency at the national and provincial levels.

14.2 THE DEVELOPMENT OF OCCUPATIONAL HEALTH SERVICES AND ASSOCIATED HUMAN RESOURCES IS REQUIRED AT THE NATIONAL, PROVINCIAL, REGIONAL AND DISTRICT LEVELS

14.2.1 Implementation strategy

Employers are primarily responsible for providing occupational health services in the workplace. Only a limited number of occupational health services are available at present. These have generally been developed to serve large workplaces, or smaller workplaces where the internal environment is especially hazardous.

Recent legislation governing the provision of occupational health services includes the Occupational Health and Safety Act (Act No. 85 of 1993), the Lead Regulations of 22 March 1991 and the Hazardous Chemical Substances Regulations of 1995. The specific requirement that all workplaces provide occupational health services should now be investigated.

The provincial health departments have a role to play in the provision of occupational health services to small and medium-sized enterprises, and the public and informal sectors. The ideal model for the provision of services to small and medium enterprises is through the district health system. It is proposed that an occupational health capacity be created in all districts where there is substantial industrial or other productive or commercial activity. Occupational health services at the district level must be integrated with the horizontal model of comprehensive health care delivery, and not run as a vertical programme. The district health service must -

- (a) develop occupational health education strategies;
- (b) develop occupational hygiene;
- (c) develop medical diagnostic (primary level) capacity through the use of occupational health doctors, occupational hygienists, occupational health nurses, environmental health officers and other allied professionals; and
- (d) liaise with the preventive enforcement agencies in the Departments of Labour and Mineral and Energy Affairs.

At the regional level, a secondary diagnostic and rehabilitative capacity for occupational health must be created at regional hospitals. These facilities will serve as referral centres for both private (workplace) and public (district) primary level occupational health services.

An occupational health facility should be created in each province. It should preferably be staffed with occupational medicine and occupational hygiene specialists, and have access to tertiary level investigations and laboratory services.

In the provincial administrations, sub-directorates for occupational health should be created. This will drive (or serve as vertical support for) the implementation of an occupational health strategy and liaise with other Government departments, the private sector, business, labour and interested parties.

At the national level, the Chief Directorate: Occupational Health has the responsibility to promote occupational health, manage the national institute for occupational health (National Centre for Occupational Health) and satisfy the statutory requirements of the Occupational Diseases in Mines and Works Amendment Act, 1993. It has an important role to play in the development of occupational health services in the provinces and in the provision of specialised services, particularly those which cannot be cost-effectively delivered elsewhere.

The National Centre for Occupational Health has a unique mix of disciplines and provides specialised laboratory and other services, research, education, training, information dissemination and international liaison. It also houses the AJ Orenstein Library and the CIS-ILO National OH&S Information Centre.

14.3 NORMS AND STANDARDS FOR A HEALTHY AND SAFE WORKING ENVIRONMENT MUST BE DEVELOPED IN COLLABORATION WITH OTHER DEPARTMENTS

14.3.1 Implementation strategy

Occupational health and safety standards, guidelines and codes of practice are essential. They detail the measures required to protect workers from the effects of inadequately controlled equipment and ventilation and unsafe work practices.

A review of the current situation in South Africa with regard to OH&S legislation and standards is required. This will determine further steps required for South Africa to ratify and comply in full with the various International Labour Organisation OH&S Conventions and Recommendations.

14.4 BENEFIT EXAMINATIONS FOR THE IDENTIFICATION OF COMPENSABLE DISEASE IN FORMER MINE WORKERS SHOULD BE EXTENDED TO UNDER-SERVED AREAS

The statutory obligations of the Department of Health in terms of the Occupational Diseases in Mines and Works Amendment Act, 1993 include benefit (compensation) examinations of former mine workers.

Access to benefit examinations is poor in historically under-served areas (notably the Eastern Cape, Northern Province and KwaZulu-Natal). Consequently, a backlog exists and many thousands of former mine workers may suffer from unidentified compensable diseases.

To rectify this, practitioners in key locations should be identified and trained to conduct these examinations, at least until the backlog has been eliminated.

14.5 THE HARMONIOUS DEVELOPMENT OF OCCUPATIONAL HEALTH AND SAFETY IS REQUIRED ACROSS SOUTHERN AFRICA

14.5.1 Implementation strategy

During the development of the European Community (EC), the Treaty of Rome (1956)

committed the EC to work for "a harmonious development of economic activity". This involves removing barriers to trade which can arise, for example, when laws such as trade regulations, worker protection or environmental standards differ nationally. The Treaty of Rome also called for better working conditions, including the prevention of occupational accidents and diseases and improvements in occupational hygiene.

As in Europe, the formation of a Southern African Economic Area will be critical for the development and wealth (and hence the health) of the Southern African community. Initiatives by the Southern African Development Community (SADC) to form an economic area without barriers to trade are in progress. The move towards common standards, including those for occupational health and safety, will be especially important.

South Africa has special obligations to its Southern African neighbours because migrant labour has been recruited from almost all states south of an east-west line drawn to the north of Angola and Malawi. By far the most industrialised nation in the region, South Africa should play a leading role in the development and harmonisation of OH&S across the Southern African community. The Department of Health will have to play its part in this process, especially through its Chief Directorate: Occupational Health. The establishment of structures to implement the recommendation of the 1994 Conference on Occupational Health in Southern Africa would serve as a start to the development and harmonisation of OH&S standards across Southern Africa.

Chapter 15

Academic Health Service Complexes

Academic Health Service Complexes (AHSCs) are essential national resources. They play an important role in educating and training health care workers; caring for the ill; creating new knowledge; developing and assessing new technologies and protocols; evaluating new drugs and drug usage; and assisting in the monitoring and improvement of health care quality.

It is generally recognised that a major shift is required from the position where academic medicine was based predominantly at the tertiary level. Academic medicine must have a role to play in providing a wide range of services from basic primary health care to more sophisticated services. Each AHSC will consist of one or more faculties or departments of health sciences at one or more universities, technikons or other tertiary educational institutions, together with a number of health service facilities at different levels with which those faculties or departments are associated. Expressed differently, it will comprise several health facilities and a consortium of educational institutions all working together to educate and train a wide range of health professionals, and conduct research.

The following principles have been adopted, to enhance the role of AHSCs in health development in South Africa:

Principles

The activities of different AHSCs will be co-ordinated with those of other stakeholders. Services in provincial and district facilities that are part of an AHSC will be linked with similar facilities, for the benefit of all communities.

AHSCs should be accountable to both the national department and provincial health authorities.

AHSCs should maximise the benefits from available resources and adopt cost-effective approaches.

The curricula of AHSCs will be revised to place greater emphasis on the needs of the communities, in accordance with primary health care principles.

15.1 THE ACTIVITIES OF DIFFERENT AHSCs WILL BE CO-ORDINATED WITH THOSE OF OTHER STAKEHOLDERS. SERVICES IN PROVINCIAL AND DISTRICT FACILITIES THAT ARE PART OF AN AHSC WILL BE LINKED WITH SIMILAR FACILITIES, FOR THE BENEFIT OF ALL COMMUNITIES

There has hitherto been little or no co-ordination of the education, training and research activities of AHSC. Furthermore, the support provided by these complexes to their historic "catchment" areas has been varied and unco-ordinated, resulting in some areas having had no support.

15.1.1 Implementation strategies

(a) Establishment of a national council for AHSCs

A national council for AHSCs will be established to facilitate the co-ordination of these complexes' activities, including -

- (i) the elaboration of their role in the referral system;
- (ii) obtaining agreement on areas of responsibility for the complexes;
- (iii) advising on norms and standards for the complexes;
- (iv) reviewing and making recommendations on the numbers and types of health professionals to be trained; and
- (v) facilitating the re-orientation of the complexes' educational, training and research functions to be more responsive to the needs of the communities.

The National Council for AHSCs should also form subcommittees to facilitate its work. For example, the Council should form a National Committee on Student Selection (NCSS), which would consult widely with all relevant stakeholders, including the universities, on issues such as -

- (i) the establishment of a national student entry form;
- (ii) criteria for admission;
- (iii) standard application fees;
- (iv) review of why certain universities do not receive applications from all sections of the community; and
- (v) academic support programmes.

This committee will have to ensure that the output of AHSCs progressively represents the demographic profile of the country.

(b) Linkages with other facilities

There are currently eight potential AHSCs located in five of the provinces.

There is a need for AHSCs to agree on their areas of responsibility and support for health services at the provincial and district levels. It is expected that these areas of responsibility will be flexible and extend across provincial boundaries. In setting up these "catchment" areas, there must be consultation between the health services-rendering authorities and AHSCs concerned.

Other strategies to be promoted are:

- (i) Development of undergraduate medical teaching according to the principle of "schools without walls", making use of a variety of secondary and

- primary health care services in the provinces and districts; and
- (ii) integration of the service component of an AHSC into the plans of the health services-rendering authorities.

(c) Structured link with the Department of Education

A formal link will be established between the Departments of Health and Education, to ensure regular communication and discuss policy issues affecting the education and training of health professionals. This should ensure that the two departments' policy decisions and budget allocations are well co-ordinated.

15.2 AHSCs WILL BE ACCOUNTABLE TO BOTH THE NATIONAL DEPARTMENT AND PROVINCIAL HEALTH AUTHORITIES

15.2.1 Implementation strategies

(a) Budgeting and communication

In order to facilitate national planning and equity of access, the budgets of academic central hospitals and possibly the budgets of a very few highly specialised services in other hospitals, will be allocated by the Department of Health in consultation with all provinces.

The budgets of other health facilities that form part of the AHSC will be determined by the relevant province or district authority. There is a need for sound channels of communication to be established between the AHSC's, the National and Provincial Health Authorities.

(b) Guidelines for collaboration

Guidelines for joint agreements with the various health services-rendering authorities will be developed to facilitate services provision, research and training. These guidelines will also facilitate collaboration between the different AHSCs.

15.3 AHSCs SHOULD MAXIMISE THE BENEFITS FROM AVAILABLE RESOURCES AND ADOPT COST-EFFECTIVE APPROACHES

15.3.1 Implementation strategies

(a) Rationalising highly specialised services

Highly specialised services rendered by AHSCs should be co-ordinated at the national level, with steps being taken to achieve internal and external rationalisation of services within a region. The number of highly specialised services provided must be based on need.

(b) Improving the referral system

The AHSCs and various authorities should review existing referral patterns to ensure that common and minor ailments are treated at lower levels of the system. Tertiary hospitals should not be overburdened with these cases. Excess beds in some of these hospitals should be transferred to secondary and community hospitals, where the cost of patient care is considerably less.

(c) Improved hospital management

Hospital management responsibilities will increase greatly. Existing staff will be trained to improve their management skills, and posts appropriately filled. This will ensure the efficient management of hospitals by adopting cost-saving measures, generating additional funds by cost recovery and monitoring costs and efficiency. Administration and management in all health facilities will be decentralised to improve management and financial processes.

(d) Resource allocation

An equitable system of allocating resources to AHSCs will be introduced and efforts made to redress past inequities in funding. Funding of training, education and research will be through direct allocation from the national budget. Funding related to service provision will be through the provincial budgets, with the exception of national services.

15.4 THE CURRICULA OF AHSCs WILL BE REVISED TO PLACE GREATER EMPHASIS ON THE NEEDS OF THE COMMUNITIES, IN ACCORDANCE WITH PRIMARY HEALTH CARE PRINCIPLES

15.4.1 Implementation strategies

(a) Upgrading curricula

Under the guidance of the proposed National Council for AHSCs, the curricula for health cadre training, including doctors and nurses, should be revised and upgraded to include primary health care approaches. In so doing, lessons learnt by other countries which have made progress in this area should be considered.

(b) Post-graduate education

A subcommittee of the National Council for AHSCs should be established to evaluate the types and numbers of post-graduate students required, the appropriateness of their training and the extent of continuing education required.

(c) Re-orientation of teaching staff

To facilitate the adjustment of AHSC's education, training and research functions - making them more supportive of primary health care-based interventions - AHSC's teaching staff will have to be re-orientated towards primary health care principles and concepts.

Chapter 16

National Health Laboratory Services

The main problems facing the national health laboratories in South Africa include the fragmentation, duplication and geographic inequity of service provision and the lack of service co-ordination.

Evidence of inadequate facilities, equipment and professional staffing is most apparent in the former homelands and independent states. This is in contrast to the concentration of services in metropolitan and urban areas.

The streamlining of health laboratory services countrywide can only be brought about in close collaboration with other health services. This is in view of the essentially supportive nature of laboratory services and because they are an essential component of health service delivery.

The single largest provider of pathology services to the public sector is the South African Institute for Medical Research (SAIMR), an independent, non-profit-making organisation, whose major trustees include the Department of Health and the Chamber of Mines of South Africa. The SAIMR has a network of over 80 laboratories providing an estimated 60% of non-academic public sector laboratory services in South Africa.

The South African Medical Service of the South African National Defence Force runs its own pathology laboratories to a large extent. The Department of Health, however, administers and provides separate laboratory services for occupational and environmental health services in Johannesburg, and laboratory aspects of malaria control in Gauteng.

The provision of academic laboratory services is undertaken by the academic departments of the various pathology disciplines.

The Ministerial Committee on Laboratory Services has defined National Health Laboratory Services (NHLS) as comprehensive laboratory services which are nationally controlled or co-ordinated. They are responsible for providing the spectrum of laboratory services listed below.

- diagnostic laboratory (pathology) services;

- environmental health laboratory services, e.g. water, food, milk, poisons;
- occupational health laboratory services;
- forensic laboratory services; and
- other laboratory-based activities, e.g. those relevant to the control of malaria and other communicable diseases, pest and other vector control, genetic services, pharmacology and virology services.

Principles

National health laboratory services should be consolidated and co-ordinated.

Quality control and laboratory accreditation should be assured by all laboratories.

Provision of laboratory services should be co-ordinated at the national level by a directorate of the Department of Health. In the longer term, the possibility of establishing a statutory, parastatal co-ordinating laboratory service should be considered.

The activities of academic and non-academic laboratories should be co-ordinated.

Provinces without medical faculties should benefit from interprovincial "catchment areas".

Private sector laboratory services and should support public sector laboratories.

Information gathering by the health laboratory services should be improved.

16.1 NATIONAL HEALTH LABORATORY SERVICES SHOULD BE CONSOLIDATED AND CO-ORDINATED

16.1.1 Implementation strategies

- (a) The tiered system currently in operation should be rationalised, the lowest level developed and services introduced and strengthened in previously under-served areas, using the following approach:

(i) Lowest level

A PHC-orientated service, with a very limited repertoire of tests (e.g. within community health centres).

(ii) Intermediate level

Peripheral laboratories (largely hospital-based) at district/subregional/regional level with extended, but still limited, test repertoires.

(iii) Provincial level

More automated, specialised and "centralised" services, interacting with academic departments for some referred tests and consultations.

(iv) National level

Highly specialised/"non-reproducible" services, e.g. the activities of the National Institute for Virology (NIV).

- (b) A national reference centre, or centre of specific expertise should be recognised. Where possible, the most appropriate provincial centre (NHLS or academic) must be identified and strengthened by allocating more resources at the national level, rather than establishing separate (duplicate) national reference laboratories.
- (c) A directory of esoteric, rare or expensive investigations should be compiled to facilitate the co-ordination of such services and avoid duplication. Such a directory should be updated on an annual basis.

16.2 QUALITY CONTROL AND LABORATORY ACCREDITATION SHOULD BE ASSURED BY ALL LABORATORIES

16.2.1 Implementation strategies

- (a) Minimum standards for quality control should be set and adhered to by all laboratories.

- (b) Laboratories must maintain internal quality control on an on-going basis.
- (c) In view of the need for the appropriate training of competent laboratory personnel, all training institutions should improve their quality of training.
- (d) An external quality control system should be established, to monitor the performance of laboratories independently. This system will ensure constant quality monitoring of the test repertoires of individual laboratories.
- (e) A laboratory audit should be undertaken, and linked to accreditation. This should be part of a process through which a laboratory's fitness to practice can be judged.

16.3 PROVISION OF LABORATORY SERVICES SHOULD BE CO-ORDINATED AT THE NATIONAL LEVEL BY A DIRECTORATE OF THE DEPARTMENT OF HEALTH. IN THE LONGER TERM, THE POSSIBILITY OF ESTABLISHING A STATUTORY, PARASTATAL CO-ORDINATING LABORATORY SERVICE SHOULD BE CONSIDERED

16.3.1 Implementation strategies

- (a) A directorate exists within the Department of Health to co-ordinate country-wide laboratory services and consider service delivery options.
- (b) The advantages and disadvantages of having a parastatal body co-ordinate laboratory services and other recommendations made to the Minister of Health, are being assessed.
- (c) Appropriate legislation will be introduced if a statutory body is required. The Minister of Health will appoint most of the body's members.

16.4 THE ACTIVITIES OF ACADEMIC AND NON-ACADEMIC LABORATORIES SHOULD BE CO-ORDINATED

16.4.1 Implementation strategies

- (a) Academic pathology departments should support provincial and other laboratory services. However, academic laboratories should have limited responsibility for routine service provision outside their academic complexes and satellite training sites.
- (b) An appropriately constituted provincial committee should be established to monitor and co-ordinate collaboration between academic and non-academic laboratory services.

16.5 PROVINCES WITHOUT MEDICAL FACULTIES SHOULD BENEFIT FROM INTER-PROVINCIAL "CATCHMENT AREAS"

16.5.1 Implementation strategy

The academic "catchment areas" adopted for clinical services should also be adopted by the academic laboratory services.

16.6 PRIVATE SECTOR LABORATORY SERVICES SHOULD SUPPORT PUBLIC SECTOR LABORATORIES

16.6.1 Implementation strategies

- (a) Areas for possible collaboration between public and private sector laboratories should be identified, with a view to improving services, cost-effectiveness, etc. (Possible areas include the transportation of specimens, services in remote areas, communications and assistance with excess service loads.)
- (b) Private pathology laboratories should confine themselves to providing services to the private sector, but they should also be available to tender via the NHLS.
- (c) The private sector's willingness to provide laboratory-based data for surveillance purposes (e.g. on communicable diseases) should be followed up by the public sector.

- (d) Existing co-operation between the public and private sectors in accreditation standards development should be extended to include a national external quality assurance system.
- (e) Possibilities for collaboration regarding the training of laboratory professionals should be explored.

16.7 INFORMATION GATHERING BY THE HEALTH LABORATORY SERVICES SHOULD BE IMPROVED

16.7.1 Implementation strategy

Laboratory services should be linked to the National Health Information System and information gathered by health laboratories should be processed and disseminated appropriately.

Chapter 17

The Role of Hospitals

Most public hospitals have been neglected for years. Major problems of inequity and inefficiency are apparent, quality of care varies widely and breakdowns in referrals to and from hospitals occur. Buildings and equipment have not been properly maintained, resources are poorly distributed, industrial relations and personnel management are often poor and highly trained staff are continually being lost to the private sector.

It is essential to find solutions to these problems. Hospitals have always been, and will remain central to the health care system. Adequate health care services cannot be provided without them. The PHC system cannot function efficiently without the support of the hospitals to which they refer patients. Therefore, substantial improvements to the PHC system are intimately connected with the functional efficiency of hospitals.

In the 1996-97 budget, expenditure on hospitals is estimated to account for 77% of total public sector health expenditure. Most additional resources for primary health care will have to be mobilised from existing allocations to the hospital sector. The prospects for such reallocation are, however, dependent on achieving substantial efficiency gains.

Principles

The role of hospitals will be redefined to be consistent with the primary health care approach.

Plans will be developed to rationalise hospital services, facilities, staffing and capital investment.

Decentralised hospital management will be introduced to promote efficiency and cost-effectiveness.

Hospital boards will be established to increase local accountability and power.

A targeted, efficient and equitable user fee system will be introduced and facilities will retain part of the revenue generated to encourage efficient collection and improved services.

Policy and regulations pertaining to private hospitals will be implemented to encourage cost containment in the private sector, and ensure that private hospitals contribute optimally to the National Health System.

Hospitals providing unique or highly specialised services will be treated as national resources.

17.1 THE ROLE OF HOSPITALS WILL BE REDEFINED TO BE CONSISTENT WITH THE PRIMARY HEALTH CARE APPROACH

Inadequate access to hospital care because of geographical and financial barriers is aggravated by fundamental problems in the referral system's structure and functioning. Referral problems have resulted in the under-development of PHC services and district and regional hospitals. Central hospitals have become overdeveloped and patients tend to be institutionalised. This, in turn, has led to inappropriate treatment of patients at

higher level hospitals, while lower level hospitals and PHC services are underutilised. The system lacks cohesion and gross inequity is apparent.

17.1.1 Implementation strategies

- (a) An appropriate hierarchy of hospital service provision will be clarified and the roles of the various hospitals in the referral chain (district, regional and central) clearly defined in terms of the level of care provided in each facility.
- (b) Appropriate referral mechanisms will be established to facilitate appropriate interaction between community, clinic and hospital-based care.
- (c) Appropriate clinical referral guidelines will be developed to improve the equity, efficiency and quality of care.
- (d) There will be clear differentiation between the primary, secondary and tertiary levels of care within the hospital system.
- (e) Financial incentives and disincentives, such as the use of by-pass fees, will be used to facilitate the above.
- (f) Existing hospital-based staff will be reorientated towards the PHC approach, and training will be upgraded to render hospital staff more community-orientated.

17.2 PLANS WILL BE DEVELOPED TO RATIONALISE HOSPITAL SERVICES, FACILITIES, STAFFING AND CAPITAL INVESTMENT

There is gross inequity in the distribution of hospital beds, and the physical state of the buildings in which they are housed varies widely. Many buildings are also poorly designed, contributing to inefficient patient care and high recurrent costs. Despite relatively higher levels of funding, many academic hospitals are also in need of extensive refurbishment or replacement. Redressing inequities and the past lack of investment in infrastructure and maintenance will require major capital investment in the hospital sector. It will also require the development of comprehensive capital investment plans.

There is also considerable variation, within and between hospitals, in the workloads of nurses, doctors and support staff. To improve both equity of provision and efficient

utilisation of personnel, an extensive parallel process of rationalisation and redistribution of staff is required. The skills mix of staff establishments should also be improved. Rationalisation of staff resources is the key to any real efficiency gains in the hospital system.

Realistic strategies must be developed to reallocate financial, human and physical resources from urban to rural centres, and from expensive to more cost-effective levels of care.

Hospitals attached to health science faculties consume a large proportion of the health budget. International experience suggests that academic functions increase unit costs by 30% to 40%. However, South African teaching hospitals have more generous staffing levels than regional hospitals and their unit costs are substantially more than 40% higher than those of other hospitals. The challenge with these hospitals is to maximise academic development and support of good clinical practice. This will attract and retain skilled personnel in teaching and research posts, and limit any excessive costs pertaining to academic activities.

Previous budgetary allowances to cover extra costs for academic involvement were based on historical expenditure data, and have included provision for the costs of Level III and highly specialised services. This has to be reviewed in view of the proposed shift towards greater utilisation at Level II and Level I facilities for teaching and training purposes.

17.2.1 Implementation strategies

- (a) In line with the recommendations of the National Health Facilities Audit, national and provincial priorities are being developed for upgrading or replacing existing facilities.
- (b) A comprehensive capital investment plan will be developed at the provincial level.
- (c) Guidelines for the licensing of facilities, equipment and certain procedures will be formulated.
- (d) National affordability guidelines for the staffing of all types of hospitals will be formulated and developed.

- (e) National policy on the location, size and financing of Level III services will be developed.
- (f) Level II care, which is offered mainly in regional hospitals accessible to potential patients, will be strengthened substantially. The quality and efficiency of Level I care, which is provided by district hospitals, will also be improved.
- (g) The concept of Academic Health Centres will be developed to place less emphasis on Level III care, ensure more academic staff availability at other levels and greater involvement by academics in teaching and research throughout regions.
- (h) Rational hospital reimbursement mechanisms for contributions to clinical training and research will be agreed upon and implemented.
- (i) Areas of underprovision, overprovision and inefficiency in referral patterns will be identified by comparing baseline data on resource allocation with national affordability guidelines.
- (j) Comprehensive plans for the rationalisation of hospital services will be developed to address the appropriateness and affordability of -
 - (i) levels of service provision;
 - (ii) teaching and research activities;
 - (iii) facilities planning; and
 - (iv) staff allocation.

17.3 DECENTRALISED HOSPITAL MANAGEMENT WILL BE INTRODUCED TO PROMOTE EFFICIENCY AND COST-EFFECTIVENESS

Most public hospitals are severely undermanaged, mainly due to -

- limited responsibility and authority accorded to hospital managers;
- ineffective and inappropriate structures and systems of management;
- limitations in the number and skills of managers;
- insufficient operational authority or incentives for managers to manage budgets efficiently; and
- the existing organisational culture within hospitals.

Hospital management must be strengthened fundamentally. Only then can health resources spent on hospitals be reduced significantly, without seriously compromising the quality and accessibility of hospital care.

17.3.1 General implementation strategies

(a) In order to overcome the problems outlined above, there will have to be substantial decentralisation of hospital management. This will allow managers of institutions to take responsibility for the provision of efficient and cost-effective services to the public. Hospital managers will also be involved in making longer term strategic decisions affecting the running of hospitals.

(b) The provincial health departments will delegate significant decision-making powers to hospital managers, giving them greater control and flexibility to manage daily operations. These delegations will include the authority to make decisions relating to personnel, procurement and financial management. The extent to which a province delegates powers will depend on the capacity of hospital management to take on additional responsibilities.

17.3.2 Management structures, systems and capacity

(a) A system of general management will be introduced to unify and integrate management, and facilitate decentralisation within a hospital.

(b) Management structures within hospitals will be based on cost centres and functional units. Each will have a single focus and significant managerial authority with regard to their budgets, staff and other resources. Details will vary to accommodate the hospitals' particular needs and circumstances.

(c) There will be a shift from the culture of "rules and regulations" to one of accomplishing tasks, meeting needs and reaching targets. This will be accompanied by a strong emphasis on continually reorienting hospitals to patients' and other clients' needs. The quality of services, guided by the principle of total quality management, will also have to be improved.

(d) Existing systems will be revised and new ones developed to support decentralised management and promote efficiency and flexibility. This includes systems for financial and human resource management.

- (e) Management development and training for senior and mid-level managers will be strengthened. Such training and development will be immediately relevant to the work environment, and closely linked to the decentralisation process and the introduction of new methods and systems in hospitals.

17.3.3 Staffing and personnel management

- (a) In time, authority for almost all line personnel management functions will be delegated to the institutional level, subject to certain checks and balances. Hospital managers will decide on most appointments, performance appraisals and promotions, and will be responsible for disciplinary and grievance procedures.

They will also be able - within guidelines - to determine staff establishments and manage labour relations and human resource planning and training.

- (b) Central, national level bargaining on basic pay, increases and other basic conditions of service will continue. However, managers will have flexibility, within national guidelines, to determine competency grading, starting levels and performance-related rewards or bonuses.

- (c) Capacity to manage personnel and labour relations will be developed in all larger hospitals and groups of smaller hospitals which do not warrant full in-house capacity.

- (d) Labour relations management will be consistent with the Labour Relations Act's framework. Strategies will be aimed at ensuring justice in the workplace, the creation of workplace forums, opportunities for worker input to management decisions, and fair systems for grievances, dismissal, appeals and mediation or arbitration.

17.3.4 Procurement, public works and transport

- (a) The authority of hospital managers and hospital tender committees will be increased to enable them to purchase goods more efficiently and responsively. Spending bands will be widened, and modern systems and managerial skills developed to increase hospital procurement capacity. If hospitals have the capacity and are in a position to comply with the requisite financial regulations they will, in time, be able to decide whether to procure on their own, through government, or through other agencies.

(b) It is also envisaged that for minor works and maintenance, hospitals should be able to decide whether to make use of their own staff, the Department of Public Works or outside contractors. Large hospitals, or groups of smaller ones will develop the technical capacity to perform certain maintenance tasks themselves, and manage those services they contract out. Implementation of this concept will depend on agreement reached with the relevant Government departments.

(c) Hospital managements will have a greater role to play in the planning and design of major capital projects.

17.3.5 Financial management

(a) Each provincial health department will appoint a financial manager at a rank immediately below that of the Head of Department. Appointment of financial managers in large regional and district hospitals may also be considered.

(b) The departmental accounting officer will, in time, formally delegate the responsibility and accountability for financial performance to managers of large hospitals, and regional managers for smaller hospital groups. These delegations will include the power to shift funds between line items in the budget and retain and spend a portion of revenue generated. This will occur within a clearly defined framework of formal performance agreements.

(c) Such agreements will be reviewed and renegotiated annually. They will specify the expected range of outputs and standards to be achieved by the hospital, and link these to the budget and thus to financial performance objectives.

(d) Managers will be held fully accountable for the achievement of their defined objectives. All variances from budgets will have to be accounted for, and performance agreements will specify how accountability will be enforced.

(e) Departmental accounting officers will be able to delegate this level of authority to hospital managers, provided the following elements of a "safety net" are in existence:

- (i) A "performance agreement" between the hospital and province;
- (ii) an accurate and reliable system for reporting on hospital performance;
- (iii) adequate technical skills for financial management at hospital level; and

(iv) appropriate and respected sanctions for non-compliance with the performance agreement.

(f) A cost centre-based accounting system will be developed. This will account for all costs incurred on an accrual basis, allocate costs to the lowest appropriate level, ensure that the budget allocation can be accurately monitored, and assist in monitoring performance indicators and activities, so that costs can be linked to outputs. Key parameters of this system will be standardised nationally to encourage uniform standards and exchange of information. A national template will be developed, which can be modified by provinces or institutions to suit local requirements.

(g) The Department of Health will liaise with other departments to negotiate a revised accounting framework for the implementation of decentralised financial management in hospitals. This may involve the shift of public hospitals to the "transfer payment" accounting framework. This would allow them full management control over their budgets, and make provision for detailed internal and external auditing. An alternative option is the establishment of trading accounts at the provincial level, with negotiation of exemptions from key rules, regulations and instructions. Other frameworks may also be suited to this vision of financial management, and final decisions will be made on the basis of consultation between the Departments of Health, State Expenditure and Finance.

17.3.6 Phasing in decentralised management

(a) Each province will prepare a detailed implementation plan for a process of decentralising management. The provinces will receive support in the planning and implementation process from the national level.

(b) Plans will include detailed proposals for securing the necessary outside assistance and other resources that hospitals will require to implement decentralisation successfully. Hospitals will not be expected to fund their decentralisation process from their existing budgets alone.

(c) The decentralisation process will be tailored to address the specific conditions of each province and hospital. Decentralisation will be introduced progressively in three or more stages. For each stage, greater levels of managerial autonomy will be accompanied by increasingly stringent capacity and performance criteria. The

pace at which individual hospitals proceed through the stages of decentralisation will depend on the speed at which they develop their various capacities.

17.4 HOSPITAL BOARDS WILL BE ESTABLISHED TO INCREASE LOCAL ACCOUNTABILITY AND POWER

Most members of existing hospital boards were appointed before any vision of an integrated health care system existed. These boards exercise very little power and do not represent the community served by that hospital. Some do assist the hospital by raising funds for particular projects and/or providing hospital managers with advice, but most fulfill a largely ceremonial role. Few, if any, have structured mechanisms for listening or accounting to the local community. Despite close interaction with patients and their relatives, most hospital management is relatively isolated from representative community structures.

There is a great need to bring hospital managers closer to the communities they serve. This will include greater accountability of managers to the local communities, and greater understanding and support of them by communities.

The provincial health departments will retain overall powers of governance over hospital management, setting health service objectives and targets, monitoring hospital performance, providing support and capacity for hospital management, and performing functions governed by economies of scale. Hospital managers will remain accountable to their province for the use of public funds. However, hospital boards will also exercise real power, both in their dealings with hospital managers and their interaction with MECs for Health.

17.4.1 Implementation strategies

- (a) Hospital Boards will be established as statutory bodies with three primary objectives:
 - (i) To support hospital management in bearing the greater burden of responsibility attached to increased delegation of powers;
 - (ii) to ensure that hospital management meets its obligations in terms of its "performance agreement" with the province; and
 - (iii) to ensure that hospital management is responsive to community needs and views.

- (b) The Boards will have advisory, representative and oversight functions, and will be accorded appropriate powers to perform these.

17.5 A TARGETED, EFFICIENT AND EQUITABLE USER FEE SYSTEM WILL BE INTRODUCED AND FACILITIES WILL RETAIN PART OF THE REVENUE GENERATED TO ENCOURAGE EFFICIENT COLLECTION AND IMPROVED SERVICES

The existing user fee system in public hospitals is inequitable, inefficient and generates minimal revenues. It is inequitable, because it does not target the poor and often results in public subsidisation of better-off users of public hospitals. It is inefficient, because it fails to encourage use of the referral chain. The inability of hospitals to retain any of the revenue they generate also means that management and staff have no incentive either to attract paying patients or collect fees.

17.5.1 Implementation strategies

- (a) The current hospital user fee schedule will be redesigned to improve equity, collection efficiency and revenue generation. Changes will include:
- (i) A bypass fee to be paid by all patients not referred by a PHC clinic, except in cases of emergency or where no clinic is available;
 - (ii) different levels of payment at district, regional and central hospitals to encourage the appropriate use of facilities;
 - (iii) modification to income categories to ensure exemptions for the poor and full cost recovery from those who can afford to pay; and
 - (iv) simple fee schedules and adjustments reflecting underlying costs and inflation.
- (b) Application of the fee schedule in hospitals will be improved through incentives, the use of appropriate information technology and training of staff.
- (c) Regulations will be changed to allow hospitals to retain and use a portion of revenue generated. Redistribution mechanisms will also be developed. This will be accompanied by the increased authority of hospital managers, allowing them to manage budgets and reward staff for efficiency.
- (d) Efforts will be made to attract paying patients to public hospitals, and reverse the

current shift of these patients to private hospitals. Specific measures will include:

- (i) Reversal of the policy of referring insured patients to private facilities;
 - (ii) Improving services in public hospitals as part of a targeted strategy to attract paying patients; and
 - (iii) Regulatory measures to control the expansion of the private sector.
- (e) Arrangements with medical aid schemes, the Motor Vehicle Accident Fund and the Workmen's Compensation Commission will be improved to ensure higher levels of cost recovery by public hospitals.

17.6 POLICY AND REGULATIONS PERTAINING TO PRIVATE HOSPITALS WILL BE IMPLEMENTED TO ENCOURAGE COST CONTAINMENT IN THE PRIVATE SECTOR, AND ENSURE THAT PRIVATE HOSPITALS CONTRIBUTE OPTIMALLY TO THE NATIONAL HEALTH SYSTEM

Expanding the supply of private hospital beds has several negative effects on the national health care system. It leads to greater utilisation and increases in private sector costs and expenditures because of supplier induced demand. In addition, it undermines public hospital provision by enticing skilled staff away from public hospitals.

Several of the reasons for this expansion will be addressed through policy and regulations. Lack of uniform criteria for granting private hospital licenses has created a vacuum in which private hospital operators have found ways of obtaining permission to erect new facilities. The legal definition of a private hospital is rather vague, allowing some operators to open facilities which are not strictly defined in law as private hospitals. Finally, the inspection and regulation of private facilities has been sub-optimal in recent years, allowing unscrupulous operators to open hospital facilities without even applying for a license. Some even extend existing facilities without any permission.

Some of the demand for private facilities is legitimately based on perceived and, in some cases, real declines in the standards of public hospital care. As noted above, these issues will be addressed directly. However, it will remain necessary, in some circumstances, to satisfy the demand for private facilities. One possible mechanism may be collaboration between the public and private sectors in the use of these facilities. This approach was widely used in the past - particularly in small towns where no private facilities were available - to the mutual benefit of both sectors. Medical and nursing staff continued to work in public hospitals, while still serving certain private patients.

In recent years, the trend towards opening private hospitals in small towns has had a devastating effect on public hospitals. Efforts will, therefore, have to be made to explore mutually beneficial solutions.

17.6.1 Implementation strategies

- (a) A national set of criteria and requirements for the granting of new private hospital licenses and extensions to current ones will be developed and implemented.
- (b) The legal definition of private hospital facilities, unattached operating theatres and associated facilities will be revised to eliminate current loopholes.
- (c) Inspection, implementation mechanisms and capacity will be considerably strengthened to ensure full compliance with all applicable laws and regulations governing private health facilities.
- (d) Mechanisms for collaboration between the public and private sectors in the use of public hospital facilities will be investigated and discussed with all interested stakeholders. This will form part of a process of developing creative solutions with benefits for both sectors.

17.7 HOSPITALS PROVIDING UNIQUE OR HIGHLY SPECIALISED SERVICES WILL BE TREATED AS NATIONAL RESOURCES

South Africa has a number of facilities offering unique services. The majority of these are linked to the Academic Health Centres. These facilities will be treated as national resources. Not only are the services they provide useful to this country, but they can also serve as an important resource for the Southern African region.

17.7.1 Implementation strategies

- (a) Agreement will be sought on definitions of unique and highly specialised services, and on a formula for their funding.
- (b) Clear guidelines for admission to these facilities will be formulated. The underlying principle will be ensuring access according to need and non-discrimination, especially for the poorest patients and for those outside the

immediate geographical location of the facilities.

- (c) Priority will be given to South African citizens in these facilities.
- (d) Similar facilities will only be opened or licenced on the basis of a clearly identified need, and within the context of available resources. Such decisions will be taken by the Minister of Health after consultation with the provincial MECs for Health. This way, due attention will be given to the equitable geographical spread of services.
- (e) A new policy on solid organ transplantation will be developed and implemented. This will include:
 - (i) Amendments to the Human Tissue Act, 1983 (Act No. 65 of 1983);
 - (ii) Co-ordination of donor organ harvesting and recognition that donor organs are a national resource; and
 - (iii) review of existing facilities in both the public and private sectors, with a view to their rationalisation.

Chapter 18

Health Promotion and Communication

The health status of the South African population must be viewed within a historical, social and economic framework. Poverty, and poor social and physical conditions, such as lack of adequate access to safe water and sanitation, and poor housing, have impacted negatively on health status. Whilst a minority population enjoyed fairly high standards of health and health care, a large proportion of the population was seriously disadvantaged through grossly inequitable access to health services and health-related information.

In addition, health programmes have been vertical, disease-focused and based on theoretical frameworks that are not always sympathetic of community perspectives. The struggle for health and development as promoted by the progressive school and progressive practitioners did, however, lay a unique foundation for health promotion based on community consultation, participation and control. The transition to democracy, reconstruction and development and the principles elaborated by the RDP are in themselves important cornerstones for developing necessary health promotion initiatives. The challenge facing health promotion is to support this policy framework through focused initiatives that highlight the relationship between health and development, and build capacity for a health-literate nation.

Communication strategies for health promotion have been restrictive and have favoured target audiences that are literate, urban based and who have easy access to print and audio-visual media. The language of health promotional messages and the ethnocentric nature of a majority of messages suggested that communication strategies were inadequate and narrow in their focus as health promotion tools.

Areas of principal activity identified for an effective health promotion and communication strategy are the development of public policies and legislation, community action, skills development, promoting healthy physical and social environments, empowerment of communities and individuals to promote their own health and a focused reorientation of the health services and service delivery.

The aim of health promotion is to improve the health of all South Africans through creating a social, political, economic and physical environment which helps to make healthy choices easy.

The following objectives will be pursued:

- To contribute to the development and achievement of a healthy nation, national health goals and targets;
- to promote standards of excellence in health promotion practice, drawing on both international and local experience;
- to promote and develop health promotion activity in government and civil society; and
- to develop a skilled cadre of health promoters.

Health promotion will be developed in accordance with the principles which underpin the WHO movement "Health for all by the year 2000".

- Equity: everyone should have similar opportunities to health and, therefore, certain target groups will have to be prioritised, e.g. low income families, rural people and women.
- Empowerment and respect: health promotion activities should be designed to increase and enhance the control that communities and individuals have over their own health; in the process, traditional values and beliefs will be respected.
- Participation: communities and individuals will be involved as respected partners in the planning and implementation of health promotion programmes.
- Intersectoral activity: multidisciplinary, inter-agency collaboration will be undertaken wherever relevant and possible.
- Standards of practice: the highest standards of practice, incorporating the above principles and based upon researched needs and adequate evaluation, will be encouraged.

Principles

Health promotion and communication will be established as an integral part of the National Health System.

The scope of health promotion activity will be in accordance with the five areas outlined by the Ottawa Charter.

Partnerships will be established with all stakeholders, especially with communities, in order to achieve optimum health for the nation.

Adequate capacity will be built into the health system, enabling it to provide South Africans with information on health policy, new health initiatives, their health-related rights and opportunities for gaining and maintaining good health.

18.1 HEALTH PROMOTION AND COMMUNICATION WILL BE ESTABLISHED AS AN INTEGRAL PART OF THE NATIONAL HEALTH SYSTEM

18.1.1 Implementation strategies

(a) Structures

Structures will be established at the national, provincial and district levels to facilitate the planning, implementation, co-ordination, monitoring and evaluation of health promotion and communication activities.

(i) National level

A Health Promotion and Communication Directorate will be established at the national level. This directorate will be responsible for co-ordinating and

supporting health promotion initiatives. Together with the provinces, it will also develop clear and transparent criteria for establishing national health promotion priorities, including training and capacity-building.

The Directorate will have the additional responsibility to ensure that all decisions, policies and laws emanating from other organs of state are health promoting. It will also ensure that opportunities for health promotion are maximised in all settings and in relation to all topics.

(ii) Provincial level

The health promotion team will be responsible for co-ordinating, facilitating and supporting health promotion activities at the provincial and district levels. This will include monitoring and evaluation and sharing of good practice within and between districts.

(iii) District level

An officer will be employed to initiate, support and co-ordinate health promotion activities at the district level. District health promotion activities will be based on a community development model, work closely with RDP initiatives and programmes, and involve local expertise (both statutory and non-statutory).

(b) Setting Priorities

Health priorities will be set in consultation with provincial departments of health, in order to respond to the needs of all South Africans in accordance with RDP goals. Among the priority groups are children, women, youth, the aged, the disabled and the poor. Priority health problems are violence, substance abuse, health problems related to lifestyle and HIV/AIDS.

18.2 THE SCOPE OF HEALTH PROMOTION ACTIVITY WILL BE IN ACCORDANCE WITH THE FIVE AREAS OUTLINED BY THE OTTAWA CHARTER

18.2.1 Implementation strategies

- (a) Promoting health public policy in all sectors of South African society, e.g. food labelling, taxation on the sale of tobacco and alcohol and fluoridation of water supplies.
- (b) Creating supportive environments, i.e. ensuring that the South African environment (social and physical) is healthy and that healthy behaviour is promoted, e.g. the creation of smoke free environments, safe workplaces and safe play areas for children.
- (c) Supporting community action by facilitating and encouraging communities to take action that will improve their health and resolve problems.
- (d) Developing personal skills in the formal and informal education sectors, including provision for basic health, personal and social education in schools.
- (e) Reorienting the health services to provide services which are relevant, appropriate and close to where people live. Users should also feel welcome and accepted.

18.3 PARTNERSHIPS WILL BE ESTABLISHED WITH ALL STAKEHOLDERS, ESPECIALLY WITH COMMUNITIES, IN ORDER TO ACHIEVE OPTIMUM HEALTH FOR THE NATION

18.3.1 Implementation strategy

All stakeholders will be mobilised to work in partnership towards achieving a nationwide impact on the major health problems.

The stakeholders will include all relevant Government departments, non-governmental and community-based organisations, the business community, education sector, the media and other mass communication bodies, professional associations, trade unions,

policy makers and the public.

18.4 ADEQUATE CAPACITY WILL BE BUILT INTO THE HEALTH SYSTEM, ENABLING IT TO PROVIDE SOUTH AFRICANS WITH INFORMATION ON HEALTH POLICY, NEW HEALTH INITIATIVES, THEIR HEALTH-RELATED RIGHTS AND OPPORTUNITIES FOR GAINING AND MAINTAINING GOOD HEALTH

18.4.1 Implementation Strategies

(a) Capacity-building and training

The training of all health personnel will be undertaken to improve their skills in health promotion and communication.

Undergraduate and postgraduate courses in health promotion will be established in suitable institutions, enabling skilled health promoters to work in all areas of the country. Provision should be made for both short and long courses.

(b) Research

Research capacity to support health promotion and communication will be developed. In this regard, the National Health Information System will be utilised to provide accurate and relevant baseline information. This will provide a basis for the planning and evaluation of health promotion activities.

(c) Communication

Effective communication underpins every health promotion activity. Communication will be participative, gender-sensitive and two-way. Innovative and culturally acceptable methods of communication methods will be utilised. Special communication methods will be developed for the disabled (blind and hearing impaired), illiterate and rural communities. All messages will be based on sound research, and tested on target audiences prior to their use.

Chapter 19

The Role of Donor Agencies and Non-Governmental Organisations

In its efforts to ensure the implementation of the RDP, South Africa is undergoing a process of profound transformation at all levels of Government and society. With the establishment of a democratic Government, international donor agencies are approaching the Department of Health in increasing numbers to offer aid in support of health services. Whilst international assistance is welcome and appreciated, it is the responsibility of the South African Government to ensure that the economy develops in such a manner that it can meet all the country's needs within its own means and resources.

International assistance should be used to support the process of transforming society, and to meet the health priorities of the country. Such assistance should not be seen as a substitute for investment in the country, but as an intervention that will facilitate such investment. The areas of support to which donor assistance will be channelled will be by agreement between the Government of South Africa and the donor(s) concerned.

19.1 POLICY GUIDELINES FOR DONORS IN THE HEALTH FIELD

International experience with regard to donor activities, especially in developing countries, indicates that without sound policy guidelines, various problems may be encountered, such as:

- (a) fragmented and unco-ordinated external financing of health services, leading to the implementation of conflicting health policies;
- (b) donations not necessarily addressing priority issues in the recipient country, thus diverting emphasis from real health needs;
- (c) conditions attached to donations having a negative impact on the economy and health services of the recipient country;
- (d) capital projects being undertaken, without ensuring that Government has the necessary resources to fund the recurrent costs;
- (e) donor programmes which fail to appreciate the importance of the multisectoral dimensions of health;
- (f) donations of equipment creating problems with appropriate utilisation and maintenance as a result of lack of skills, expertise and/or parts; and

- (g) donor assistance failing to strengthen the recipient nation's capacity to manage public policy and administration.

Assistance has, in some instances, undermined the recipient governments' policies to such an extent that these nations are wholly dependent on foreign assistance for service delivery.

The aim of developing policy guidelines for donors is to ensure that donations dedicated to health in South Africa are managed in such a way that they optimise the benefits to local health services.

19.1.1 Principles and guidelines

- (a) All donations should be supportive of the RDP health priorities and those of the Department of Health.
- (b) Donor contributions should be used to support integrated programmes that meet the people's needs in a coherent manner, as opposed to the unco-ordinated vertical projects of the past. These contributions should help to develop sound health policies and create an enabling environment in which they will be realised, as well as giving rise to health systems reform.
- (c) Conditions attached to donations should
 - (i) be acceptable to both the donor agency and Government;
 - (ii) be in accordance with broad Government policies;
 - (iii) assist and support the sound planning and management of health services;
 - (iv) be aimed at making an impact on the health services;
 - (v) promote intersectoral collaboration and co-ordination; and
 - (vi) develop South Africa's capacity (at the national, provincial and/or local levels).

- (d) The principles that must be advanced by all donor projects or programmes include:

- (i) **Sustainability**

Donations which have recurrent cost implications for Government must be evaluated, to ensure that the required financial resources are available to

sustain such programmes or projects.

(ii) Equity

Donations must address -

- the shift to primary health care;
- inequalities between provinces, as well as unequal development within provinces;
- under-served areas, especially rural areas; and
- the needs of specific groups in society, such as women and children.

(iii) Accessibility

Donations should be directed at making health services accessible to all South Africans, irrespective of race, gender, income status or geographic location.

(iv) Efficiency

Donations should promote the efficiency of the health services through different mechanisms, e.g. training programmes for health workers, establishment of sound information systems, technical support initiatives and strengthening community involvement and participation in health services delivery.

(v) Acceptability

Donations should not only be acceptable to Government structures, but also to the communities for whom such donations are intended.

- (e) In view of the multidimensional nature of health, intersectoral collaboration among health, education, agriculture, housing, water provision and sanitation and other relevant Government department must be fostered by donations. Donations should be flexible enough to allow for the inclusion of those sectors which are major contributors to health.

- (f) Donations should be in accordance with South Africa's priority health needs.

Prospective donors and the South African Government must agree on the areas to which donations will be directed.

- (g) Donations should promote and encourage self-reliance and the development of communities, and not foster dependency.
- (h) The sustainability of donor support must be ensured in the short, medium and long term.

19.1.2 Categories of donations

(a) Financial donations

- (i) The acceptance of funds donated by external agencies must be in keeping with South Africa's fiscal policy and financial legislation.
- (ii) Subject to the general guidelines, the donation of funds should be focused initially on bridging finance for the reconstruction and rationalisation of the health services.
- (iii) Funding of recurrent expenditure for predetermined periods should focus initially on priority areas, as identified in the Government document titled "The Health Priorities of the Reconstruction and Development Programme" and other government policies.

(b) Donations of technical expertise

- (i) The Department will solicit and accept contributions of a technical nature from the donor community. This will only occur if there is a local shortage of such skills, or if such contributions are geared to enhancing local skills.
- (ii) Costs related to the provision of international expertise will be supported by the donor agency(ies), upon review and agreement with the Department.

(c) Other donations

- (i) Donations of equipment will be subject to the following principles:
 - appropriateness of and need for the particular equipment in South Africa; and

- adequate and readily available support structures, including -
 - expertise, potential for training and availability of suitable health personnel;
 - an adequate maintenance service, including the availability of service personnel and parts at a reasonable price; and
 - the necessary infrastructure, such as electrical power supply, adequate roads and telecommunications.

(ii) Donations of equipment which would replace existing equipment generally should take preference over the provision of new equipment, as the latter would result in an increase of recurrent costs.

(iii) Donations involving capital projects should facilitate job creation, capacity-building and community development, with particular emphasis on disadvantaged communities. In assessing such projects, one of the fundamental factors is their sustainability in the medium to long term.

19.1.3 Co-ordination

All offers of assistance to the Department of Health should be co-ordinated at the national level. This applies to both bilateral and multilateral agencies (UN agencies like UNICEF, the WHO, etc.). The provinces will be responsible for the co-ordination of offers of aid made to them, or to specific local communities. The national Department should be informed of all offers accepted. This will not only ensure equity between the provinces, but also that all offers are in keeping with Government priorities and needs.

9.2 RELATIONS BETWEEN THE DEPARTMENT OF HEALTH AND NON-GOVERNMENTAL ORGANISATIONS

The Department of Health, as a national authority, has the responsibility to determine the country's health priorities and policies. The Department is also ultimately responsible for the delivery of services to South Africa's people.

19.2.1 Community participation

Community participation is one of the key principles of the Department. This aspect is

clearly enunciated in the RDP, which states that "...apart from the strategic role of government in the RDP, mass participation in its elaboration and implementation is essential". NGOs, as part of civil society are, therefore, expected to contribute to the attainment of national priorities and programmes.

The Government and its departments are not responsible for the funding of NGOs. Such funding is a matter between donors and the NGOs concerned. Where the Department of Health commissions an NGO(s) to execute some of its programmes, the Department will be responsible for mobilising the financial resources for such a programme. It will sign a contract with the donor(s) concerned, and will be responsible for expenditure accounting.

Overall, the Department feels that NGOs can play a positive role. The Department of Health will thus, at all times, nurture relationships that impact positively on its national objectives.

19.2.2 Guidelines for the funding of NGOs by the Department of Health

(a) The NGO concerned should address national and/or provincial priorities.

(b) It must be non-racial and non-sexist.

(c) It should be non-profit-making.

(d) It must be accountable in terms of its -

(i) mission, i.e. serving the interests of the community;

(ii) organisational structure; and

(iii) finances.

(e) Preferred NGOs for funding are those which extend the Government's scope of activities. Examples include hospice care, advocacy organisations and certain forms of training.

(f) In the production of media messages, close attention should be given to content, literacy and language.

- (g) The NGO concerned must adhere to the RDP's principles, namely -
- (i) integration and sustainability;
 - (ii) nation-building;
 - (iii) peace and security;
 - (iv) linking of reconstruction to development; and
 - (v) democratisation of the country.
- (h) It must be a legally constituted body and, therefore, in law, a legal entity.
- (i) It should be duly constituted, have a functioning committee and be managed by a management committee.
- (j) It should have a potential or demonstrable capacity and proven track record for executing the proposed project.
- (k) The project should be evaluated against the criteria for the national health budget for the financial year concerned.
- (l) The NGO concerned should be able to provide evidence of its financial stability, together with a summary of its current financial situation. (Where applicable, audited balance sheets should be supplied). It should have no history of financial mismanagement.
- (m) It is preferable that an NGO request funding for a specific project, with defined outputs. This is easier to evaluate than the provision of global funding that provides for its continued functioning.
- (n) Other bodies involved in the provision of funding to the NGO, or those which have been approached, must be declared. The NGO concerned must demonstrate its ability to obtain external funds, as Government rarely subsidises a project in its entirety.

Chapter 20

International Health

Since the advent of a democratic government, the country has become an active and strategically relevant member of the international community. This also applies to South Africa's international health relations.

The primary responsibilities of Government include the following:

- leadership in the development of international health relations;
- guidance in setting priorities for development assistance utilisation;
- management to ensure the effective utilisation of these resources; and
- an effective link between the South African health sector and the international community.

The Department of Health will be a strong advocate for health improvements to be recognised as a developmental priority within South Africa and the international community.

Principles

An effective mechanism for international health liaison will be established and awareness of international issues and opportunities created

International health relations should serve the interests of South Africans, and contribute to the advancement of global health goals.

Development co-operation and donor assistance should support health reform.

International liaison activities should support regional health sector co-operation in Southern Africa.

South African participation in international health science development should be encouraged.

20.1 AN EFFECTIVE MECHANISM FOR INTERNATIONAL HEALTH LIAISON WILL BE ESTABLISHED AND AWARENESS OF INTERNATIONAL ISSUES AND OPPORTUNITIES CREATED

The Department of Health has a central role to play in co-ordinating, developing and managing South Africa's international health relations and providing support to the broader health sector in this field. A Directorate for International Health Liaison (IHL) was, therefore, established in 1994.

20.1.1 Implementation strategies

(a) Function and position of the International Health Liaison Directorate

This Directorate will be the focal point for the co-ordination and management of all international health and donor activities. It will be strategically positioned

within the organisational structure to bring knowledge, skills and experience to bear on departmental policies. It will also participate in all international relations-related activities of the Department. An effective service will be provided to Government decision-makers, the international community and other clients.

(b) Health Attaché Programme

The international health objectives of the Department of Health will be supported through the Health Attaché Programme.

The Department will fulfil its obligations towards health and development in the international environment, and seek to maximise its contribution to the focus, content and direction of international policy. Using its international networks, opportunities for health development in South Africa will be maximised. For this purpose, health attachés will be deployed in several key positions.

Mechanisms will be developed to accommodate attachés between placements, to ensure the retention and optimal utilisation of their acquired skills within the public sector.

(c) Consultation mechanisms and services

The Department of Health must have the capacity to consult with, and for, other Government departments, the provinces, service, academic and research institutions, and the private sector on international health affairs.

(d) Increasing awareness of international health issues and opportunities

Government, the provincial health departments and the health sector at large will be kept informed of current developments in international health, their influence on South Africa and potential opportunities arising.

The performance of this task requires an effective information and communication system. This will necessitate not only improved communication and co-ordination of activities within and between the national and provincial departments of health, but also dissemination of relevant information through all available communication channels.

(e) Provincial health departments

In many respects, it is the provinces and districts which will benefit most from opportunities realised through the IHL and the acquisition of donor assistance. Close co-ordination is required, if the mobilisation of resources is to match needs and the IHL Programme is to identify resources capable of fulfilling these requirements. The provinces also have to be kept informed about their responsibilities under international treaties and resolutions. A strategy will be developed to improve communication with provincial authorities.

(f) Intersectoral collaboration

Collaboration with other departments is essential for effective IHL. An interdepartmental international affairs liaison committee will be established.

(i) Department of Foreign Affairs

The implementation of international health policy will have a bearing on international relations, which is the responsibility of the Department of Foreign Affairs (DFA). Close co-ordination on health and development issues is crucial for a coherent approach to foreign governments and international agencies. It will be ensured that all bilateral agreements on development co-operation with other countries reflect health sector requirements. The Health Attaché Programme adds value to the work of the DFA in foreign health missions, but co-ordination of effort and agreement on responsibilities is essential.

Response to humanitarian situations of conflict, famine and natural disaster require liaison with the DFA for both policy formulation and intervention, and with the South African Medical Services.

(ii) Department of Welfare and Population Development

By definition, the overlap in responsibility for social affairs with the Department of Welfare and Population Development - particularly with respect to disabled, elderly, mentally and chronically ill persons - necessitates the synchronisation of international efforts toward people-

centred social development.

(iii) Department of Arts, Culture, Science and Technology

Due to a shared responsibility for health sciences, close collaboration on international resources, meetings and committees is necessary with the Department of Arts, Culture, Science and Technology (DACST). The absence of science advisors or attachés abroad has, in some instances, resulted in health attachés' bearing responsibility for these functions on behalf of the DACST. Continued dialogue is required to direct the Department's efforts and responsibilities in this regard, and ensure they are in harmony with the objectives of the DACST's international programme.

(iv) Reconstruction and Development Programme

Donor assistance requires collaboration with the authority responsible for the RDP, whereas programme implementation requires co-ordination with the Department of Finance.

(v) Other departments

Numerous other departments are affected by factors falling within the scope of international health. The strategy for marketing health services and products will be developed in close conjunction with e.g. the Department of Trade and Industry.

(vi) Marketing strategy for South African health services and products

Expansion of the client base and customer orientation will improve service and increase the likelihood of effective exploitation of the Programme's opportunities.

A strategic partnership will be established with appropriate Government departments and industry. This will be done to explore mechanisms for utilising the strategic contacts of the Department in support of international market expansion.

(vii) Research and development capacity

Research and development capacity will be developed in IHL to refine policies, mount rapid and efficient responses to new opportunities and develop projects. This will require the use of non-governmental and parastatal institutions for health and development. The Directorate must offer an advisory and consultancy service in these instances.

Consistent with the diversion of resources for capacity development in previously underfunded institutions, the Department will establish a research database and development units in Government, non-governmental and private institutions capable of responding to project development and implementation.

(viii) Employment of South Africans in the international health community

A system will be established for the identification, promotion, selection and recruitment of South Africans to serve on international expert advisory committees of the UN and other agencies. A policy for the placement of our nationals in international agencies must ensure that precious human resources are not lost to the international community.

20.2 INTERNATIONAL HEALTH RELATIONS SHOULD SERVE THE INTERESTS OF SOUTH AFRICANS, AND CONTRIBUTE TO THE ADVANCEMENT OF GLOBAL HEALTH GOALS

This objective will be achieved through focusing the Department's liaison activities on advancing the public health interests of developing countries in the international public health community, promoting good governance in international organisations, developing strategic international alliances, contacts and agreements, and promoting the South African health sector's international interests.

20.2.1 Implementation strategies**(a) Promoting the public health interests of developing countries**

The Department of Health will promote developing countries' public health

interests by -

- (i) actively raising awareness of developing countries' particular health needs in the international community through active bilateral and multilateral diplomacy;
- (ii) influencing United Nations Agencies' agendas with health-related concerns through participation in and membership of governing bodies;
- (iii) ensuring that emerging public health issues are brought to the attention of international organisations, and through developing joint initiatives; and
- (iv) promoting the inclusion of South African experts in advisory and technical committees of international agencies.

(b) Promotion of good governance within the World Health Organisation, UNAIDS and other international health organisations

The Department of Health has the primary responsibility for conducting government relations with certain international organisations. It will fulfil its obligation as a responsible member state by ensuring that all aspects of this relationship advance good governance in these organisations. In pursuit of this goal, the Department will use diplomacy and participation in governing bodies to promote -

- (i) responsible, accountable and transparent management practices; and
- (ii) principle-based employment practices that will take into account representation of gender, race and people with disabilities.

(c) Development of strategic international alliances, contacts and agreements

To ensure optimal advantages from international relations, mutually beneficial bilateral agreements relating to co-operation on health issues will be developed. This will be in accordance with foreign policy guidelines. A proactive approach will be followed in establishing and maintaining strategic contacts with:

- (i) all United Nations Agencies involved with health or related activities including: WHO, UNICEF, FAO, UNESCO, UNFPA, ILO, the World Bank, UNFPA, IAEA, UNDCP, UNDP, UNEP and other relevant UN headquarters programmes;
- (ii) the European Union;
- (iii) the Commonwealth;
- (iv) regional organisations, with particular emphasis on organisations in the

African region, and those representing developing countries; and

(v) relevant bilateral development agencies and foundations.

(d) Promotion of the international interests of the South African health sector

Collaboration with the broader health sector (private, provincial and academic) will be undertaken to ensure that their interests are promoted internationally. This will include:

- (i) Support through consultancy and information services on international issues; and
- (ii) direct support from the IHL Directorate and health attachés.

(e) Representation of government at international meetings

The interests of the health sector will be promoted by the participation of Government delegations at international meetings where issues relevant to health are on the agenda.

(f) International obligations

Health-related obligations resulting from South Africa's membership of international organisations, bilateral agreements or international conventions will be identified and incorporated with health policies and strategies. Implementation of such obligations will be monitored on a regular basis.

20.3 DEVELOPMENT CO-OPERATION AND DONOR ASSISTANCE SHOULD SUPPORT HEALTH REFORM

International resources will be utilised in support of health and development. As the long-term sustainability of such resources (technical and financial) cannot be guaranteed due to declining development assistance, such offers of support will be carefully managed to ensure compatibility with national priorities and programmes, and ensure the long-term sustainability of projects.

International resources will also be utilised to fast-track programme development and promote intersectoral collaboration.

20.3.1 Implementation strategies

(a) Identification of international resources for health and development

The Department will network with foreign governments and international agencies to identify opportunities for health and development within RDP health priorities. For this purpose, it will use its own international networks and liaise closely with representatives of these governments in South Africa.

(b) Mobilisation of resources

The Department encourages donors to provide programme support in a way which strengthens systems. Interventions should increase capacity to collect and analyse health and related data, monitor trends and evaluate the impact of interventions. They should assist policy development and planning for health, as well as development of the necessary human resources to fulfil the above objectives and deliver PHC services at the district level.

Because of concerns about sustainability and recurrent costs, there is a preference for horizontal programmes which are integrated with the Department's objectives for health. This will facilitate improved co-ordination and make for smoother programme management. Donors can, thus, relate to priority areas and be confident that their investments are fully congruent with the most pressing needs of the Department. Certain activities of the Department readily lend themselves to technical or budgetary support. Conversely, a multiplicity of projects are a burden, and this form of assistance is best directed to NGO's or other publicly funded institutions.

Instruments of support include support for research and evaluation, technical assistance and direct budgetary support.

The IHL Directorate will advise on project development for donor support including design, preparation of business plans, budgets, operationalisation and implementation.

(c) Co-ordination

Whilst all managers in the Department (national and provincial) should explore the use of international resources, co-ordination of these activities is essential for their rational use and South Africa's relations with foreign governments and agencies. Nationally, the Chairperson of the Departmental Donor Committee bears overall responsibility for all donor affairs. The focal point of first contact, however, is the IHL Directorate.

(d) Universities, NGO'S, research-based and other institutions

International resources will be directed to universities, NGOs, research-based bodies and other institutions. There will be particular emphasis on strengthening capacity amongst historically Black and under-resourced institutions.

20.4 INTERNATIONAL LIAISON ACTIVITIES SHOULD SUPPORT REGIONAL HEALTH SECTOR CO-OPERATION IN SOUTHERN AFRICA

Given the agreement between SADC Health Ministers on the need for and terms of reference of a health sector, the most urgent needs are mobilisation of all potentially available resources within member states and the acquisition of resources from the international community. This will support capacity development for regional health initiatives and programme development.

The development of health programmes will be consistent with the need for greater regional co-operation in health, within the framework of the resolutions adopted by the Health Ministers focusing on -

- communicable disease control;
- human resource development and management;
- regional health information and communication systems;
- procurement and distribution of pharmaceuticals;
- harmonisation of legislation on public health, pharmaceuticals, environmental health and food; and
- health research relevant to SADC issues.

20.4.1 Implementation strategies

(a) Establishment of an active liaison capacity for co-operation with SADC countries

A health attaché post in the IHL Directorate will be dedicated to this objective. This will provide the South African health sector with an implementation capacity for developing activities in the context of SADC health sector co-operation.

(b) Mobilisation of resources

International liaison activities of the Department in general, and of health attachés in particular, will be utilised to identify and mobilise resources (technical and financial) for SADC health sector projects.

20.5 SOUTH AFRICAN PARTICIPATION IN INTERNATIONAL HEALTH SCIENCE DEVELOPMENT SHOULD BE ENCOURAGED

In matters affecting health science policy and intergovernmental agreements, there is shared interest and responsibility, and a need for co-operation with the Department of Arts, Culture, Science and Technology. The Department will work with universities and other institutions for health science research actively to encourage international agencies, organisations, foundations and trusts to support "essential national health research" in South Africa.

20.5.1 Implementation strategies

(a) Increasing funding for health research in South Africa

Efforts will be directed toward international resources for research programme support, capacity development, and identification and activation of international scholarships and fellowships.

(b) Increasing access to international research programmes

Numerous international research programmes have the capacity for third country participation. Knowledge about these opportunities will be disseminated

throughout the research community.

In some instances, entry to these programmes require government-to-government agreements, where close collaboration with the Department of Arts, Culture, Science and Technology and the Department of Foreign Affairs is required.

(c) Promoting South African expertise

Promoting the participation of South African experts and scientists in international scientific, technical and advisory committees will be utilised for this purpose. The programme will raise awareness of South Africa's strengths across the range of health science research activities.

(d) Facilitating contact with the international research community

Opportunities identified during liaison activities will be brought to the attention of the research community. Active assistance can be provided to the research community, on request.

(e) Initiating and developing collaborative research projects

Based on experience and knowledge of the content, work programmes, networks and application procedures of international research programmes, the Programme will, in certain circumstances, initiate, advise and develop collaborative research projects with partners in research-based institutions.

Chapter 21

Year 2000 Health Goals, Objectives and Indicators for South Africa

The mission of the Department of Health is to provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all South Africans, and provide caring and effective services through a primary health care approach.

This chapter, compiled by the National Health Information System Committee, presents the health goals, objectives, strategies and indicators based on the RDP's priorities, the recommendations of the health committees convened by the Minister of Health, and provincial goals, objectives and indicators. The goals and objectives presented here are not the product of one organisation only, but of many individuals and organisations. They represent high priority national goals and objectives for the year 2000, unless otherwise indicated. Provincial and district health authorities will have additional goals and objectives, based on local health conditions.

The goals contained here offer a vision of improved health status, and are based on several principles. These include the need to provide comprehensive and integrated services at all levels of health service delivery, and a commitment to primary health care principles. Some objectives in this chapter have specific, measurable outcomes, based on recommendations submitted to the Department of Health. These are not final outcomes, but should initiate discussion to achieve consensus on measurable outcomes.

For many of the objectives, additional information is required to determine baseline data and develop specific outcomes. Outcomes listed in this document may be modified, based on information collected in future years. Improvements to the National Health Information System will require addressing deficiencies in vital statistics, health facility records, and existing surveillance systems. The development of new surveys and data collection systems will be required to supplement existing information.

The legacy of apartheid has created marked differences in health status, based on race. The creation of a healthier South Africa depends on narrowing the difference in mortality and morbidity, and improving access to comprehensive health services for all population groups. Outcomes for these population groups, as well as South Africans as a whole, will be developed. Although not specified here, it is understood that data will be collected for variables that will facilitate health promotion and disease prevention and control.

Although health priority areas are listed separately, many are related to one another. In particular, many health objectives from maternal, reproductive and women's health, child health and nutrition are complementary.

The Department of Health acknowledges the importance of a national consultative process involving the health and other sectors to achieve these objectives and improve the health status of all South Africans.

1.1 Organising, planning and financing health services

Problem Statement: Health services are fragmented and unevenly distributed, resulting in inefficiency and ineffectiveness. In particular, many people in rural and peri-urban areas have inadequate access to health care services.

GOALS	OBJECTIVES	INDICATORS
To develop a comprehensive and integrated National Health System (NHS) which provides accessible services to all South Africans	Combine fragmented structures into a unified NHS.	Development of a unified NHS
	Define comprehensive services which are to be delivered at all levels of health service delivery.	Proportion of facilities offering comprehensive services at all levels. (At the primary health care level, this will include maternal child and women's health; adolescent and elderly care; mental health; screening and treatment for priority diseases, such as tuberculosis and sexually transmitted diseases; and oral health care.) Proportion of health facilities offering the minimum package of recommended comprehensive health services
	Improve planning, implementation and evaluation of health services at the national, provincial and district levels.	Proportion of management personnel who have received formal training in management and planning
	Establish structures to promote community participation at the national, provincial and district levels.	Number of structures to promote community participation at the national, provincial and district levels

GOALS	OBJECTIVES	INDICATORS
	<p>Provide community health centres (CHCs) with appropriate staff in rural, peri-urban and urban areas to improve access to health facilities. (Access is defined as the distance from, or the time required to reach a CHC.)</p> <p>Develop and implement a criterion for equitable resource allocation, to be applied at the national, provincial and local levels.</p>	<p>Proportion of the population, including rural areas, with access to health facilities</p> <p>Proportion of provinces, regions and districts which equitably allocate resources (using set criteria).</p>

21.2 Maternal, reproductive and women's health

Problem Statement: Women often do not have access to comprehensive health services, including antenatal, delivery, postnatal and reproductive health services.

GOAL	OBJECTIVES	INDICATORS
To reduce mortality and morbidity	Reduce the maternal mortality rate by 50%.	Maternal Mortality Rate
	Ensure that 75% of all maternity facilities are "mother and baby-friendly".	Proportion of all hospitals and maternity facilities which are "baby-friendly", according to the global Baby-Friendly Hospital Initiative
	Increase the proportion of deliveries in institutions with trained birth attendants to 90%.	Proportion of deliveries in institutions attended by trained personnel
	Increase the proportion of pregnant women who receive antenatal care to 90%.	Proportion of pregnant women who receive antenatal care within the first, second and third trimesters of pregnancy
	Increase clinic attendance for contraceptive and family planning services.	Clinic attendance rate for contraceptive and family planning services
	Implement a plan for cervical cancer health education, screening and treatment.	Number of people exposed to cervical cancer education, screening and treatment.
	Increase the proportion of pregnant women who are immunised against tetanus to 80%	Proportion of pregnant women immunised against tetanus

21.3 Child health

Problem Statement: There is poor access to quality preventive health care services, resulting in significant mortality and morbidity.

GOALS	OBJECTIVES	INDICATORS
To reduce infant and child mortality and morbidity	Reduce the infant and under-5 child mortality rate by 30%, and reduce disparities in mortality between population groups.	Cause-specific neonatal, post-neonatal, infant and <5 mortality rate; mortality rates in different population groups.
	Reduce the prevalence of low birth weight to 10% of all live births.	Proportion of infants with birth weight <2 500 gms
	Reduce mortality due to diarrhoea, measles and acute respiratory infections in children by 50%, 70%, and 30% respectively.	Cause-specific neonatal, post-neonatal, infant and <5 mortality rate
	Increase immunisation coverage among children up to one year of age against diphtheria, pertussis, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 80% in all districts, and to 90% nationally.	Proportion of children immunised against diphtheria, pertussis, tetanus, polio, hepatitis, tuberculosis and measles before their first birthday
	Eradicate poliomyelitis by 1998.	Annual number of reported cases of acute flaccid paralysis
	Reduce neonatal tetanus to fewer than one case per 1 000 live births in all districts by 1997.	Annual number of reported cases of neonatal tetanus

GOALS	OBJECTIVES	INDICATORS
	<p>Increase regular growth monitoring to reach 75% of children <2 years.</p> <p>Increase the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months.</p> <p>Reduce the prevalence of underweight-for-age among children <5 to 10%.</p> <p>Reduce the prevalence of stunting among children <5 to 20%.</p> <p>Reduce the prevalence of severe malnutrition among children <5 to 1%.</p>	<p>Growth promotion and its regular monitoring among children up to 2 years</p> <p>Breast-feeding rate at 4-6 and 12 months</p> <p>Proportion of children under five years of age below one SD from the median weight/height for age</p> <p>Proportion of children under five years of age below two SDs from the median weight/height for age</p> <p>Proportion of children under five years of age below three SDs from the median weight/height for age</p>

21.4 Adolescent health

Problem Statement: There is a need to increase access to health care services for adolescents, with the emphasis on reducing substance abuse, depression, teenage pregnancies and sexually transmitted diseases.

GOALS	OBJECTIVES	INDICATORS
To improve the health status of adolescents and the youth	Reduce intentional and unintentional injuries among adolescents, including teenage suicide.	Age-specific intentional and unintentional morbidity and mortality
	Reduce substance abuse among adolescents.	Age-specific substance abuse prevalence (especially tobacco, alcohol, marijuana and mandrax)
	Reduce the proportion of births among girls aged <16 and 16-18 to five and 10% respectively.	Proportion of total births among girls aged <16 and 16-18

21.5 Care of older persons

Problem Statement: There is a need to improve knowledge of the health status of the elderly and their access to health services.

GOALS	OBJECTIVES	INDICATORS
To improve the quality of life of older persons	Increase accessibility to and availability of health services.	Percentage of health services accessible and available to older persons.
		Proportion geriatric services integrated with PHC

21.6 Nutrition

Problem Statement: There is a need to eliminate micronutrient disorders and monitor mortality related to disease of lifestyle.
[Note that nutrition objectives related to children are listed under child health]

GOALS	OBJECTIVES	INDICATORS
To improve nutritional status	Eliminate micronutrient deficiency disorders.	Micronutrient deficiency disorder rate
	Maintain mortality rate for diseases of lifestyle related to nutrition to <28,5% of all adult mortality.	Mortality for disease of lifestyle related to nutrition

21.7 Oral health

Problem Statement: Oral diseases are common in South Africa, and there has been an insufficient focus on preventive strategies.

GOALS	OBJECTIVES	INDICATORS
To reduce oral diseases in children and adults	Increase the percentage of children <6 who are free of caries to 50%, and reduce the number of decayed, missing or filled teeth at age 12 to 1,5%.	Percentage of children <6 who are free of caries, and the number of decayed, missing or filled teeth at age 12
	Reduce the proportion of persons aged 35 to 44 and 60 to 64 who are edentulous by 6% and 10% respectively.	Percentage edentulousness in the 35-44 and 60-64 age groups
	Ensure that 40% of the population on piped water systems receive optimally fluoridated water.	Percentage of the population on piped water systems who receive fluoridated water

21.8 Environmental health

Problem Statement: The prevalence of environmental health-related risks are important causes of mortality and morbidity. In certain geographic areas, environmental health services coverage is inadequate. The majority of South Africans have no access to basic housing and amenities.

GOALS	OBJECTIVES	INDICATORS
To reduce environmental health related risks	Increase to 80% the population which has access to basic environmental health needs (i.e water, sanitation, shelter and safe food).	Percentage of the population - - with adequate, safe drinking water - with access to adequate sanitation - occupying dwellings which do not have a detrimental effect on the health of inhabitants
	Reduce to <10% the environmental health risks relating to food hygiene, water and sanitation, labelling and importation of consumer goods, hazardous substances and port health.	Percentage of evaluated facilities or products relating to food hygiene, water and sanitation, labelling and importation of consumer goods, hazardous substances and port health, which do not pose health risks
	Improve the accessibility of all South Africans to a comprehensive environmental health service.	Number and distribution of environmental health officers/assistants; number of districts rendering a comprehensive environmental health service; number of EHOs completing the advanced In- service training course
	Ensure the rendering of a community development-orientated environmental health service.	Number of environmental health-related community development projects
	Develop uniform legislation, to be applied by all relevant authorities. Conduct public information campaigns to promote environmental health.	Availability of appropriate uniform environmental health services-related legislation Coverage of Public information campaigns to promote environmental health

21.9 Occupational health

Problem Statement: Occupational mortality, morbidity and disability are a major problem in South Africa. There is a need to place greater emphasis on prevention.

GOALS	OBJECTIVES	INDICATORS
To improve the health of the workforce	Establish an interdepartmental agency to manage national occupational health and safety.	Functional national occupational health and safety agency
	Reduce occupation-related mortality, morbidity and disability.	Work-related mortality, morbidity and disability rates
	Promote the convergence of occupational health and safety legislation, standards and enforcement.	Uniform legislation, standards and enforcement

21.10 Emergency health services

Problem Statement: There are inadequate emergency health services, especially in rural and peri-urban areas. Emergency health standards and training for emergency health personnel are required.

GOALS	OBJECTIVES	INDICATORS
To improve response to emergencies, with special emphasis on women and children	Increase the proportion of health regions which have a 24 hour dispatching centre, communication system, vehicle maintenance programme and human resource development programme.	Proportion of health regions which have a 24 hour dispatching centre, communication system, vehicle maintenance programme and human resource development programme
	Increase the proportion of emergency health service staff who have basic ambulance assistance qualifications, and are able to provide emergency care to victims of poisoning, injuries and maternal emergencies.	Proportion of emergency health service staff who hold basic ambulance assistant qualifications

21.11 Human resource development

Problem Statement: There is a need to improve the distribution of health personnel and provide training programmes and re-orientation towards integrated health services, especially primary health care.

GOALS	OBJECTIVES	INDICATORS
To provide appropriate human resources for policy, planning, management and service delivery	Train 25% of district health managers by December 1996, and 50% by June 1997 in the PHC approach, and provide career opportunities for existing personnel.	Percentage of district health personnel trained.
	Increase the number of health personnel in PHC facilities and the number trained in public health, epidemiology and research	Number of personnel in public PHC facilities
		Number of personnel trained in public health, epidemiology and research

21.12 Substance abuse

Problem Statement: Substance abuse, including tobacco, is an important and increasing cause of mortality and morbidity. There is also a need to increase access to prevention and treatment programmes.

GOALS	OBJECTIVES	INDICATORS
To reduce legal (including alcohol and tobacco) and illegal (including cocaine, mandrax, heroin and marijuana) substance abuse	Reduce the prevalence of substance abuse. Establish tobacco-free environments in public places. Reduce alcohol-related motor vehicle mortality and morbidity.	Prevalence rate of legal and illegal substance abuse Tobacco-free environments in public places Alcohol-related motor vehicle morbidity and mortality .

21.13 Mental health

Problem Statement: Mental health services are often inaccessible, and are not integrated with primary health care services. There is a need to improve knowledge and treatment of mental disorders.

GOALS	OBJECTIVES	INDICATORS
To improve the mental health and social well-being of individuals and communities	Improve counselling services for, and management of victims of attempted suicide, violence and rape.	Number of Improved counselling services
	Develop community-based mental health care services.	Proportion of patients managed for attempted suicide, violence and rape.
	Improve mental health services in prisons.	Number of communities/facilities providing community-based mental health care services
	Develop comprehensive mental health services for children in provinces.	Status of mental health services in prisons Number of comprehensive mental health services provided for children in hospitals per province

21.14 Disability

Problem Statement: Ineffective legislation, lack of policy and inadequate health care programmes deprive people with disabilities of opportunities to function independently in the community of their own choice.

GOALS	OBJECTIVES	INDICATORS
To enable people with disabilities to become less dependent and reach their potential for achieving a socially and economically productive life	<p>Improve access to comprehensive health services for the disabled.</p> <p>Diagnose disabilities as early as possible, and develop a system of referral.</p>	<p>Proportion of people with disabilities with access to health services.</p> <p>System of diagnosis and referral of people with disabilities</p>

21.15 Sexually transmitted diseases (STDs) and HIV/AIDS

Problem Statement: The prevalence of STDs and HIV is a critical health and social problem which requires increased emphasis on prevention and treatment.

GOALS	OBJECTIVES	INDICATORS
To reduce STD and HIV prevalence.	<p>Introduce age-appropriate STD/HIV-prevention education curricula as part of quality school health education.</p> <p>Reduce incidence of STDs.</p> <p>Reduce HIV transmission.</p>	<p>Number of children/teenagers receiving STD/HIV education</p> <p>Prevalence rate of STDs</p> <p>HIV incidence rates</p>
To reduce the personal and social impact of HIV/AIDS	<p>Improve accessibility to male and female condoms.</p> <p>Increase STD clinic attendance of males and females.</p> <p>Promote voluntary and confidential HIV counselling and testing.</p>	<p>Number and coverage of condoms distributed</p> <p>STD clinic attendance rates</p> <p>Percentage of health facilities where voluntary HIV testing and counselling is available and accessible</p> <p>Number of individuals receiving voluntary HIV testing and counselling.</p>

21.16 Chronic diseases

Problem Statement: Selected Chronic diseases (Cancer, hypertension, smoking-related diseases, diabetes, tuberculosis, and malaria,) are important causes of mortality and morbidity. Increased emphasis should be placed on prevention, early detection and treatment. [Note that objectives relating to immunisation are listed under child and maternal, women's and reproductive health]

GOALS	OBJECTIVES	INDICATORS
To reduce morbidity and mortality associated with chronic diseases and improve treatment and care for chronic disease patients.	Increase by 50% the proportion of facilities that provide comprehensive services for persons with chronic diseases.	Proportion of facilities that provide comprehensive services for chronic disease patients
	Ensure the early diagnosis and effective treatment of stroke, heart disease, renal disease and smoking related cancers, hypertension and diabetes.	Mortality rates due to stroke, heart disease, renal disease, hypertension, diabetes and smoking- related cancers
	Cure 85% of new smear positive TB cases at the first attempt.	Percentage of new smear positive TB cases cured at the first attempt through a cohort analysis of treatment outcomes
	Reduce the risk of TB infection by 5% per year.	Annual risk of infection studies conducted
	Reduce the number of reported cases of indigenous malaria by 10% per year.	Number of reported cases of malaria
	Reduce mortality due to malaria by 0,3% of noted cases per year.	Number of reported deaths due to malaria

21.17 Technology policies

Problem Statement: There is a need to guide the purchase and distribution of health technologies.

GOALS	OBJECTIVES	INDICATORS
To ensure the appropriate use of health technologies	<p>Develop a national essential technology policy and guidelines.</p> <p>Develop a system of quality control and regulation of expensive technology.</p>	<p>National essential technology policy and guidelines</p> <p>System of quality control and regulation of expensive technology</p>

21.18 Drug policy

Problem Statement: There is an inefficient and inadequate drug distribution system which results in poor access to and availability of essential drugs.

GOALS	OBJECTIVES	INDICATORS
(a) To improve the availability of essential drugs	<p>Establish essential drugs lists and standard treatment guidelines for all levels of health service delivery.</p> <p>Develop systems for improved stock control and security.</p>	<p>Existence of an essential drugs list at all levels of health service delivery</p> <p>Systems for improved stock control, security and storage</p>
(b) To improve the safety and efficacy of drugs	<p>Ensure the safety and efficacy of drugs supply to the public.</p> <p>Improve accessibility of drugs.</p>	<p>Safety and efficacy of drugs</p> <p>Availability and affordability of drugs</p>
(c) To ensure the affordability and promote the rational use of drugs	Provide training to improve the rational use of drugs and ensure sound dispensing practice.	Number of training sessions on drug use for dispensers

21.19 Health information system

Problem Statement: Health information is unco-ordinated, fragmented and poorly utilised.

GOALS	OBJECTIVES	INDICATORS
To provide information for the planning, management and evaluation of the health services.	Develop a comprehensive national health information system.	<p>National health status/ vital statistics data sets</p> <p>National health care management data sets</p> <p>Notifiable and non notifiable disease surveillance data</p> <p>Demographic and population statistics</p> <p>Management information data sets (financial management, pharmaceutical, facilities, equipment etc)</p>
	Provide training at the provincial level, so that information is optimally used.	<p>Number of training programmes in information management, data analysis and epidemiology at various levels of the health system.</p>
	Identify and create, where necessary, national data sources to measure progress towards the national health objectives.	<p>Number of health indicators that are available to assess progress of the health system per year.</p>

21.20 Health research

Problem Statement: Research is fragmented, unco-ordinated and there is no essential research strategy. Research has not been used to develop the health system. fragmented and unco-ordinated.

GOALS	OBJECTIVES	INDICATORS
To integrate and ensure links among research, policy and action.	Develop health system research at the national, provincial and district levels.	Number of health systems research projects completed or ongoing at national, provincial and district levels
	Co-ordinate health research and policy implementation.	Existence of health system research at the national, provincial and district levels
	Develop an Essential National Research Strategy and policy	Procedures to co-ordinate health research and policy implementation
	Networking of research within and between provinces/regions	Establishment of a functional ENHR co-ordinating committee Number of provinces/regions with functional research committees

Glossary

Child (under 5) Mortality Rate

The number of deaths among children before the age of 5 years per 1 000 live births.

Maternal Mortality Rate (MMR)

The number of female deaths that occur as a result of complications of pregnancy and child birth per 100 000 live births.

Infant Mortality Rate (IMR)

The number of deaths among children before the age of one year per 1 000 live births.

Neonatal Mortality Rate

The number of deaths before one month of age per 1 000 live births.

Perinatal Mortality Rate

The number of stillbirths and early neonatal deaths per 1 000 live and still births.

Comprehensive

The fullest possible range of, for example, primary health services; the provision of preventive, promotive, curative and rehabilitative care by a health care facility or authority.

Decentralisation

The process of shifting responsibility, authority and accountability for planning, management and allocation (and raising) of resources to those who are implementing policy at the lowest level; the transfer of appropriate authority from central government to provinces, regional offices, district health authorities, local governments and/or non-governmental organisations.

Delegation

The process of shifting authority and responsibility for specific issues and defined functions to other administrative structures or individuals; responsibility remains with the delegating authority.

Devolution

The creation or strengthening of sub-national levels of government (such as local authorities) that are substantially independent of the national level with respect to a defined set of functions; normally there is geographic responsibility for a range of services and the power to raise revenue; accountability is usually to the electorate.

District Council Area

An area which is managed by a district council; may be larger than a health region; may contain a Transitional Rural Council and Transitional Local Councils.

District Health Authority

Governance structure which is responsible for ensuring the delivery of all primary health care in a health district.

District hospital

First level non-specialist hospital to which patients from clinics or health centres may be referred.

Economies of scale

Achieving the correct scale of operations so that the unit cost of each production or purchase is reduced to a minimum, e.g. it may be cheaper for a provincial department of health to purchase medicines than for a district health authority.

Effectiveness

The best possible outcome or result.

Efficiency

The attainment of the best outcome or result at the lowest possible cost.

Ensure

To make happen; to co-ordinate.

Equity

The universal provision of services on the basis of need rather than any other criterion.

Governance

The processes used by governing structures to make and implement laws and provide services.

Health district

Geographic area that is small enough to allow maximal involvement of the community so that local health needs are met, but also large enough to effect economies of scale.

Health region

Geographic area into which a province is divided and within which secondary hospital services are available within the health districts that fall within its boundaries.

Local authority

Administrative structure that is responsible for the provision of services within a local government.

Local government

Third tier of government; most suitable for a village, rural setting, town or city.

National Health Service

Health services provided by a country for all its citizens.

National Health System

The organisation of a country's health service (including services provided by central government, provincial government, local government, NGOs/CBOs and the private sector).

Prevention

Ensuring that diseases or illnesses do not occur.

Primary Health Care approach

The underlying philosophy for the provision of health care services that is based on the Alma Ata Declaration, i.e. comprehensive care that includes curative, preventive, promotive and rehabilitative care within the context of, amongst others, community participation and intersectoral collaboration.

Public sector

Services provided by and through government structures (national or provincial departments of health or local government), for the benefit of all citizens.

Quality assurance

A management system designed to ensure the provision of services that are of the highest possible standard.

Rationalise

A process whereby resources are used most effectively and efficiently; often used to mean, especially in the civil service, a cutting back or reduction of resources.

Regional hospital

Usually a secondary hospital to which patients are referred from the district hospital (i.e. a hospital which serves many districts and at which more specialised services are available).

Revenue

Monies earned; income; usually refers to income earned by a government or authority, e.g. from taxes, or from user fees collected by a hospital.

Wellness approach

An approach to the provision of services that places the emphasis on creating all the conditions (i.e. not just health services) that enable people to become, and remain, healthy and that contribute to the well-being of all.

Academic Health Complex

Functional unit consisting of one or more faculties and/or departments of health sciences and associated health care facilities at the primary, secondary and tertiary levels.

Hospital**Level 1**

Patients requiring treatment which may be adequately and appropriately provided at the first level of referral (e.g. a community hospital) by a generalist with access to basic diagnostic and therapeutic facilities.

Level 2

Hospitals providing specialist services at the provincial level. Such hospital would be equipped with an intensive care unit.

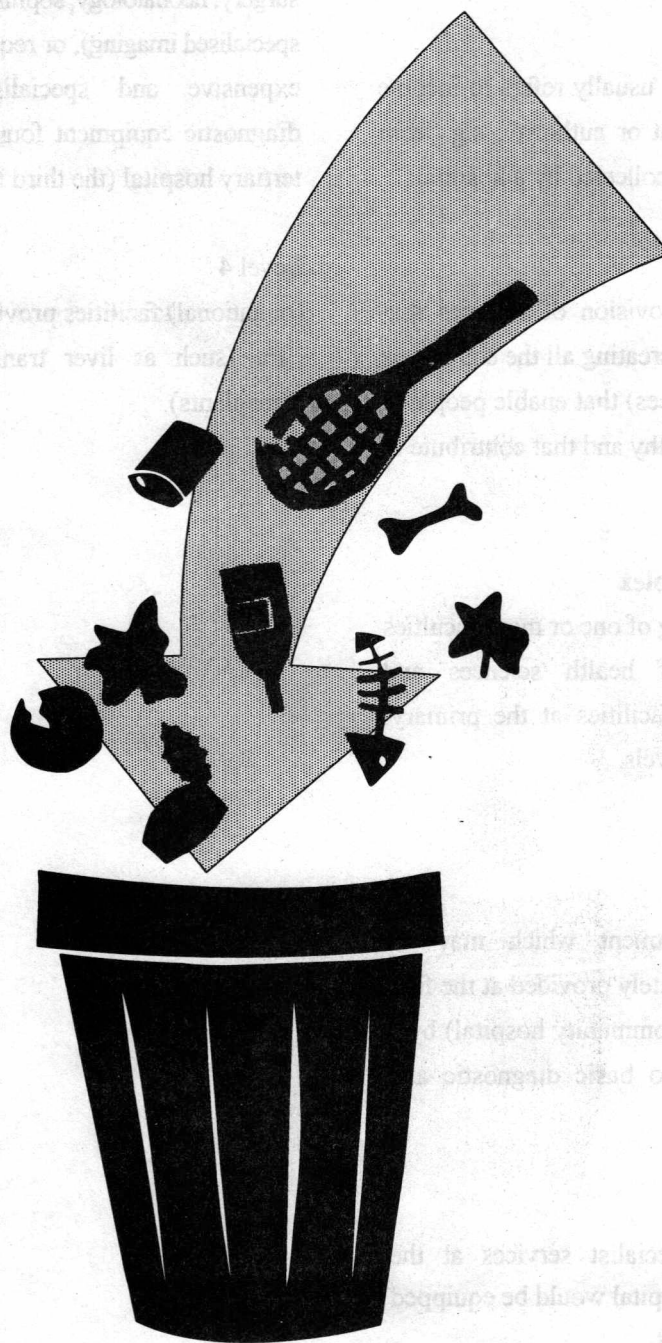
Level 3

Patients requiring the expertise and care associated with the specialties, sub-specialties and less common specialties (such as cardiology, endocrinology, oncology, plastic and trauma surgery, neonatology, sophisticated paediatrics and specialised imaging), or requiring access to scarce, expensive and specialised therapeutic and diagnostic equipment found only at a central or tertiary hospital (the third level of referral)

Level 4

(or national) facilities providing quaternary health care (such as liver transplantation and heart transplants).

Keep South Africa Clean



Throw trash where it belongs

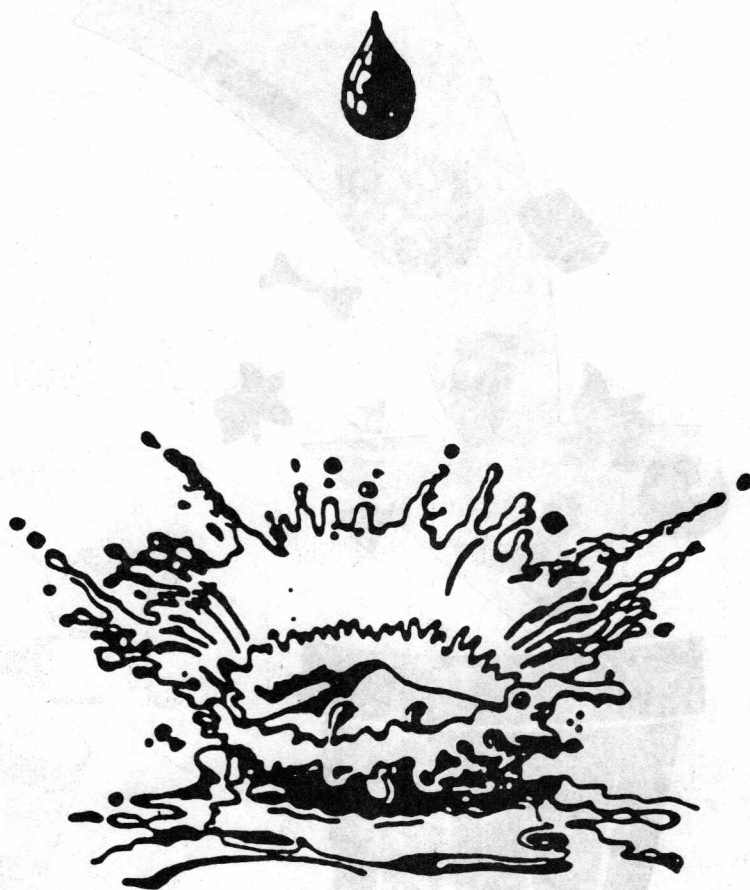
Hou Suid-Afrika Skoon



Gooi rommel waar dit hoort

Save a drop — and save a million

Water conservation is very important to the community and industry to ensure their survival. So save water!



Spaar 'n druppel — en vul die dam

Indien almal van ons besparingsbewus optree, besnoei ons nie slegs uitgawes nie maar wen ook ten opsigte van ons kosbare water- en elektrisiteitsvoorraad

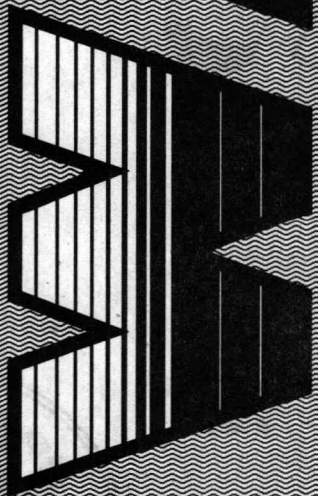
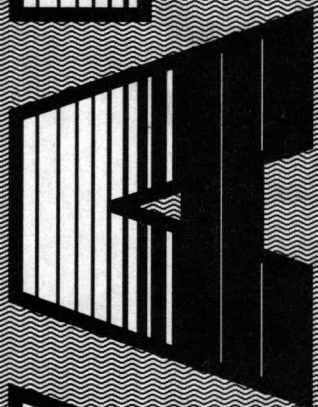
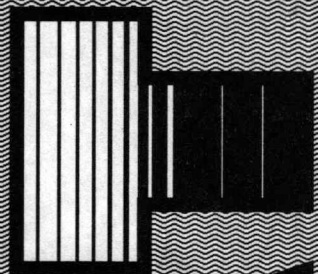
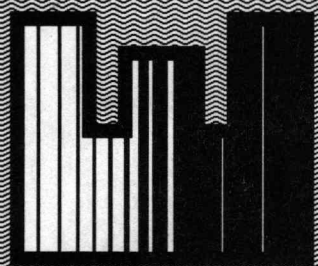


RECYCLE HERGEBRUIK



Department of Environmental Affairs
Departement van Omgewingsake



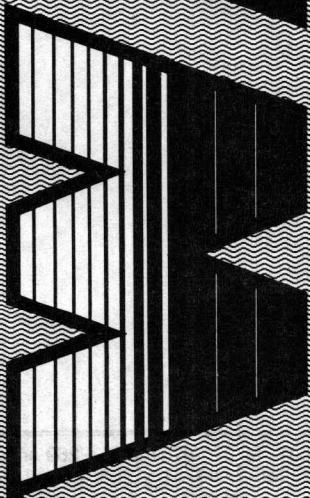
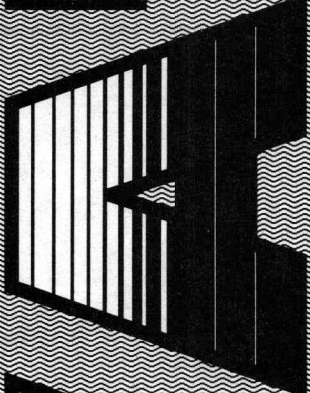
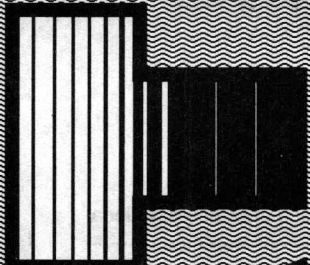
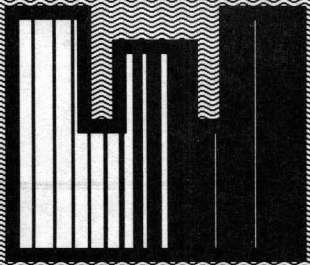
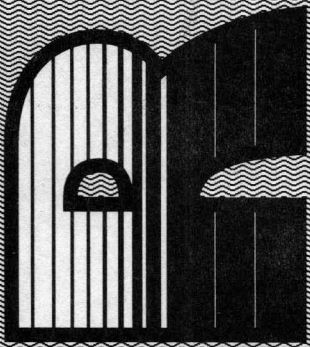


DON'T

WASTE

IT!

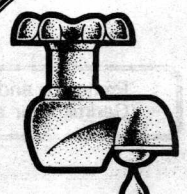




WERK

SPAARSAAM

DAARMEE !



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