1 MISSION, VISION AND LEGISLATION

1.1 VISION

An accessible, caring and high quality health system

1.2. MISSION

To improve health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

1.3. HEALTH LEGISLATION

Legislation governing the functioning of the Department is outlined below, with a brief description of their provisions

1.3.1. LEGISLATION FALLING UNDER THE MINISTER'S PORTFOLIO

- **Constitution of the Republic of South Africa Act, 108 of 1996**
  Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.

- **National Health Act, 61 of 2003**
  Provides for a transformed national health system for the entire Republic

- **Medical Schemes Act, 131 of 1998**
  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

- **Medicines and Related Substances Act, 101 of 1965**
  Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy. The Act also provides for transparency in the pricing of medicines.

- **Mental Health Care Act, 17 of 2002**
  Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with emphasis on human rights for mentally ill patients.

- **Choice on Termination of Pregnancy Act, 92 of 1996 as amended**
  Provides a legal framework for termination of pregnancies based on choice under certain circumstances.

- **Sterilization Act, 44 of 1998**
  Provides a legal framework for sterilizations, also for persons with mental health challenges.

2 SITUATION ANALYSIS

2.1. DEMOGRAPHIC PROFILE

Mid-year estimates released by Statistics South Africa (StatsSSA) reflect that South Africa estimated total population grew from 46,586,607 in 2004 to 49, 320, 500 in 2009. Table 1 and Figure 1 below reflect the distribution of the population across the 9 Provinces.

The lowest rates of population growth occured in the North West (-9,7%) and Eastern Cape (-6,1%)

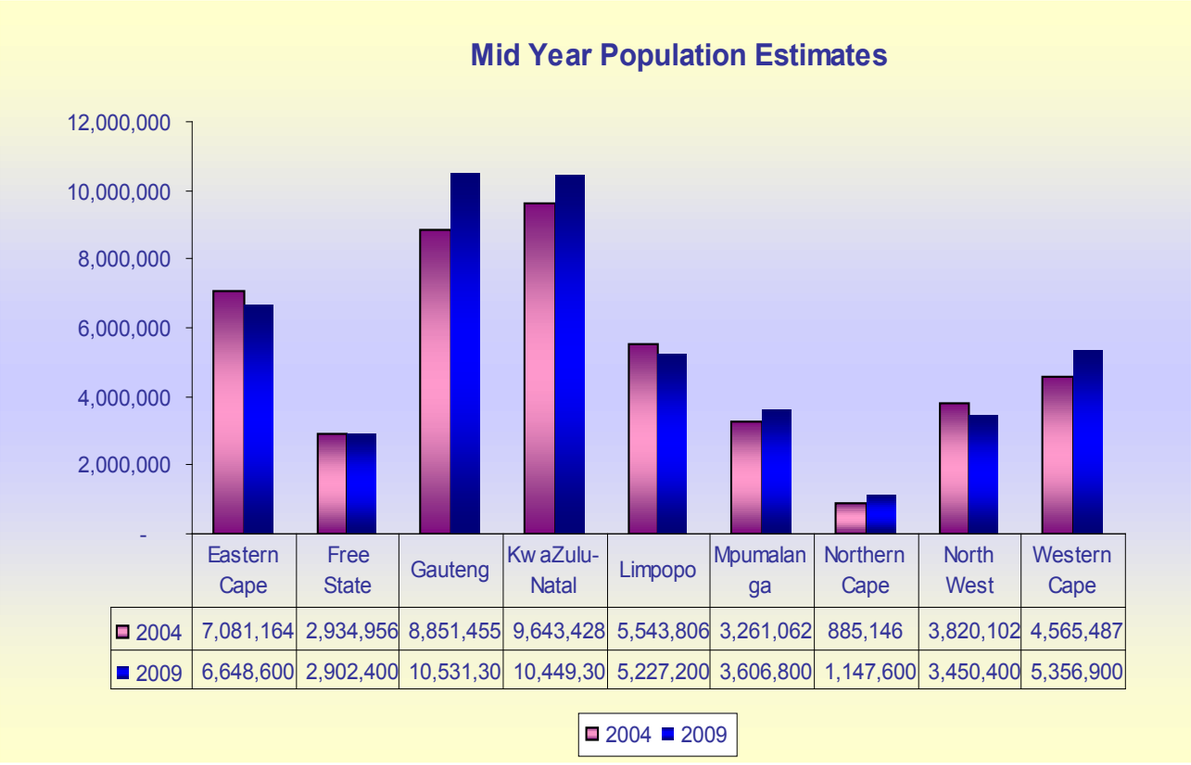
The Northern Cape experienced the highest rate of population growth of 29,7%, followed by Gauteng at 19,0% and the Western Cape Province at 17,3%.

Table 1: Mid-year populations Estimates 2004 and 2009

PROVINCE	2004	2009	% CHANGE
Eastern Cape	7,081,164	6, 648, 600	-6.1%
Free State	2,934,956	2,902,400	-1.1%
Gauteng	8,851,455	10,531,300	19.0%
KwaZulu-Natal	9,643,428	10,449,300	8.4%
Limpopo	5,543,806	5,227,200	-5.7%
Mpumalanga	3,261,062	3,606,800	10.6%
North West	3, 820, 102	3,450,400	-9.7%
Northern Cape	885,146	1, 147,600	29.7%
Western Cape	4,565,487	5,356,900	17.3%
Grand Total	46,586,607	49,320,500	5.9%

(Source: Statistics South Africa, mid-year population estimates, July 2009)

Figure 1: Mid-year populations Estimates 2004 and 2009



(Source: Statistics South Africa, mid-year population estimates, November 2009)

The key implications for planning are that access to health service must be expanded to ensure consistency with the population growth. This also has implications for resource allocations between Provinces, to consistently ensure equitable distribution.

2.2. DISTRIBUTION OF HEALTH FACILITIES

Population growth between 2004-2009 appears to have outstripped the availability of health facilities. For instance, the country's population per clinic is 13,718, which is inconsistent with the WHO norm of 10,000 people per clinic. This is reflected in Table 2 below. However, this analysis cannot be conclusive without reviewing the utilization rate of public health facilities. By the end of 2008/09, the PHC utilization rate in the country was 2,5 visits per person. The usable bed occupancy rates of hospital were: 65,2% at District Hospitals; 77,1% at Regional Hospital; 71,5% at Tertiary Hospitals and 69,2% at Central Hospitals. Except for Regional Hospitals, these utilisation rates were inconsistent with national targets.

Table 2: Distribution of Public Health Facilities in South Africa, 2009

SOUTH AFRICA	NUMBER OF FACILITIES (2009)	POPULATION PER HEALTH FACILITY
Clinic	3595	13,718
Community Health Centre	332	148,553
District Hospital	264	186,817
National Central Hospital	9	5,479,966
Provincial Tertiary Hospital	14	3,522,835
Regional Hospital	53	930,560
Specialised Psychiatric Hospital	25	1,972,788
Specialised TB Hospital	41	1,202,919
Grand Total	4, 333	

Sources: Statistics South Africa (StatsSA), Statistical Release P0302, Mid-Year Population Estimates, 2009 & District Health Information System (DHIS).

2.3 ECONOMIC PROFILE

South Africa is regarded as a middle income country with a Gross Domestic Product (GDP) of $277 billion. As reflected in Table 3, South Africa's GDP per capita was ranked third highest amongst 10 selected countries, following Brazil and Bostwana.

Table 3: Gross Domestic Product (GDP) of selected developing countries

COUNTRY	GDP ($) 2008[1]	GDP per capita ($) 2008[1]	
Brazil	$ 1.61 trillion	$ 8,400	1
Botswana	$ 13 billion	$ 6,808	2
SA	$ 277 billion	$ 5,685	3
Angola	$ 83.4 billion	$ 4,627	4
Namibia	$ 8.56 billion	$ 4,051	5
Swaziland	$ 2.62 billion	$2,242	6
India	$ 1.22 trillion	$ 1,068	7
Lesotho	$ 1.62 billion	$ 804	8
Afghanistan	$ 10.2 billion	$500[2]	9
Sierra Leone	$ 1.95 billion	$ 351	10

1. Source: World Bank: Development Indicator (2008)
2. Source: CIA World Factbook (2009 estimates)

2.4. HEALTH PROFILE

As reflected in Table 4 below, South Africa's GDP per capita is ranked third highest amongst the ten selected countries. However, South Africa's health outcomes are not always commensurate with this ranking.

In 2008, South Africa's GDP per capita was five times higher than that of India. However, the average life expetancy in India was much higher (64 years) than that of South Africa (53,5 years for males and

57,2 for females).

Table 4: GDP and Health Outcomes of selected countries

COUNTRY	GDP ($) 2008[1]		LIFE EXPECTANCY[2]		CMR 2007[2]		MMR 2005[2]	
Brazil	$ 8,400	1	72	1	21.7	1	110	1
Botswana	$ 6,808	2	50	5	39.7	2	380	3
SA	$ 5,685	3	50 53.5 Males** 57.2 Females**	4	59	3	400	5
Angola	$ 4,627	4	42	9	158	8	1400	8
Namibia	$ 4,051	5	53	3	68	4	210	2
Swaziland	$ 2,242	6	40	10	90.9	7	390	4
India	$ 1,068	7	64	2	71.8	5	450	6
Lesotho	$ 804	8	42	7	83.5	6	960	7
Afghanistan	$500[2]	9	44	6	257	9	1800	9
Sierra Leone	$ 351	10	42	8	261.8	10	2100	10

1. Source: World Bank: Development Indicators
2. Source: Unicef Statistics: http://www.unicef.org/infobycountry/index.html
****Source: StatsSA: Mid year population estimates 2009**

Three important reports from Ministerial Committees were submitted to the Minister of Health during 2009/10. These were: (i) the Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa, produced by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD); (ii) the First Report of the Committee on Morbidity and Mortality in Children under 5 Years (CoMMiC) and (iii) the National Perinatal Morbidity and Mortality Committee Report 2008.

The Saving Mothers' Report stated at the outset that CEMD systems are not epidemiological surveys such as the Demographic and Health Surveys or Burden of Disease Estimates, and could not report an accurate Maternal Mortality Ratio (MMR) for the country or Province. The Report also expressed concern that estimates of MMR in South Africa from different data sources varied from 150 per 100 000 live births; to 181-382 per 100 000 live births; to 240-400 per 100 000 live births and to 578 per 100 000 live births.

The Saving Mothers' Report indicated that the five major causes of maternal death had remained the same during 2005-2007 and 2003-2005, and these were: non-pregnancy related infections – mainly AIDS (43.7%), complications of hypertension (15.7%), obstetric haemorrhage (antepartum and postpartum haemorrhage; 12.4%), pregnancy related sepsis (9.0%) and pre-existing maternal disease (6.0%).
The Saving Mothers' Report also stated that 38,4% of the 4,077 maternal deaths reviewed were avoidable within the health care system. Key administrative weaknesses identified included poor transport facilities, lack of health care facilities and lack of appropriately trained staff. Avoidable factors associated with health care providers included failure to follow standard protocols and poor problem recognition and initial assessment.

The recommendations of the CEMD focused on four main areas of: knowledge development; quality of care and coverage of reproductive health services, establishing norms and standards and community involvement.

The First Report of the Committee on Morbidity and Mortality in Children under 5 Years (CoMMiC) estimated over 60,000 South African children between the ages of one month and five years

die each year. This translated into an under-five mortality rate for South Africa of between 57.6 and 94.7 deaths per 1,000 live births and an infant mortality rate of between 42.5 and 59.1 deaths per 1,000 live births. The CoMMiC indicated that these rates were highest in the Eastern Cape, KwaZulu-Natal, and Free State and lowest in the Western Cape, Gauteng and Northern Cape Province.

According to the CoMMIC, the major causes of childhood deaths were diarrhoeal disease, lower respiratory tract infections and perinatal conditions with HIV and AIDS and malnutrition contributing as both primary and underlying causes of child mortality. The CoMMiC recommended that clinical care be improved by strengthening the existing child survival programmes adopted by the National DOH including the Community Health Worker (CHW) programme, the Integrated Nutrition Programme; Expanded Programme on Immunisaiton; Prevention of Mother to Child Transmission (PMTCT); Integrated Management of Childhood Illnesses (IMCI); Essential Drug List (EDL); and 10 steps for the management of severe malnutrition. It further recommended that primary health care be strengthened by adopting and implementing the Household and Community component of IMCI (IMCI HHCC); introduction and roll out of standardized management and referral guidelines for general practitioners. Emergency referral and treatment capacity in all health facilities and districts should be strengthened through training in triage, assessment and resuscitation of critically ill children, and the development of suitable transport systems for the movement of critically ill children into and within the health system.

The National Perinatal Morbidity and Mortality Committee Report 2008 analsysed data on perinatal and neonatal deaths from the District Health Information System (DHIS) and the national Perinatal Problem Identifiifation Programme (PPIP). A perinatal death is that which occurs from 28 weeks of gestation (conception) to 7 days of life. A neonatal death is a death that occurs within the first 28 days (four weeks) of life. The Committee found that the PPIP database reflected 659,809 births and 25,060 perinatal deaths from 2244 sites, for the period 1st January 2006 to the 31st December 2007, which translated to 39,5% of all births in health institutions recorded in the DHIS. These were births and deaths that were recorded at all levels of health facilities, including PHC facilities namely Clinics and Community Health Centres; as well as District; Regional and Tertiary Hospitals.

The Committee found that the majority of births (59%) had occurred at CHC and district hospitals, and that most perinatal deaths had also occurred at these districts. The Committee classified circumstances surrounding mortality into non avoidable factors; possible avoidable factors and probable avoidable factors. 40% of deaths due to labour complications were classified as "probably avoidable" if appropriate action had been taken. The Committee found that the majority of recorded deaths had occurred at district hospitals; that the proportion of probably avoidable mortality was highest at these hospitals, and that the quality of intrapartum care was poorest at these hospitals.

The National Perinatal Morbidity and Mortality Committee Report 2008 made various recommendations, starting with the quality and comprehensiveness of DHIS data. The Committee stated that the DHIS must be supported to continue collecting data in healthcare facilities conducting births, as well as in its endeavours to improve quality of data collected.

The Committee also provided a set of 10 recommendations covering:

i. Clinical skills improvement (especially strengthening skills of interns; midwives; nurses);
ii. improving staffing, equipment and facilities;
iii. implementation of national maternal and neonatal guidelines;
iv. training and education;
v. transport and referral routes;
vi. normalization of HIV infection as a chronic disease;
vii. improving postnatal care;
viii. appointment of regional clinicians to establish, run and monitor evaluate outreach programmes for maternal and neonatal health;
ix. auditing, monitoring and evaluation and

x. constant health messages must be conveyed to all understand by all.

Another key finding of significance to the public is that the National Perinatal Morbidity and Mortality Committee found that babies of pregnant women aged 17 years or less, and of pregnant women aged 35 years or more, had significantly higher perinatal mortality rates than women between the ages of 20 and 34 years. The Committee recommended that contraceptive use be promoted amongst the former age groups.

HIV and AIDS have played a major role in increasing the mortality rates of mothers and children. Avoidable factors within the health system are also a major contributor. A significant proportion of children died due to malnutrition, severe malnutrition and diarrhoeal diseases, which accentuates the imperative to address determinants of health that lie outside the health sector.

It is evident from the recommendations of the three committees that radical action is required from the health sector to strengthen the quality of maternal and child care.

3. OTHER KEY HEALTH INDICATORS

Table 5 below reflects other key health status indicators of the South African population.

Table 5: Key Health Status Indicators

INDICATOR	INDICATOR VALUE
Life Expectancy at Birth	• 53,5 years for males (StatsSSA, 2009)
	• 57,2 years for females (StatsSSA,2009)
Child Mortality	• 69 per 1,000
Maternal Mortality Ratio	• 400-625 per 100,000
HIV Prevalence (amongst 15-24 year old pregnant women)	• 21,7%
HIV Incidence	• 1,3%
Percentage of eligible HIV positive women initiated on ART	• 30%
TB cases notified	• 341, 165
TB Cure Rate	• 64%
Percentage of TB patients with MDR-TB	• 2%

Sources: Presidency (2010): Improving Government's Performance, Developing the MTSF into a set of key outcomes with measurable outputs and agreed interventions; Statistics South Africa, Statistical releases P0302, Mid-year Population Estimates 2009

Chapters 3 and 4 outline interventions that the health sector will implement in 2010/11-2012/13 to improve the profile of all South Africans.

- **SA Medical Research Council Act, 58 of 1991**
  Provides for the establishment of the SA Medical Research Council and its role in relation to health research.

- **Tobacco Products Control Amendment Act, 63 of 2008**
  Provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products as well as sponsoring of events by the tobacco industry.

- **National Health Laboratory Service Act, 37 of 2000**
  Provides for a statutory body that provides laboratory services to the public health sector.

- **Health Professions Act, 56 of 1974 as amended**
  Provides for the regulation of health professions, in particular, medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

- **Pharmacy Act, 53 of 1974 as amended**
  Provides for the regulation of the pharmacy profession, including community service by pharmacists.

- **Nursing Act, of 2005**
  Provides for the regulation of the nursing profession.

- **Allied Health Professions Act, 63 of 1982 as amended**
  Provides for the regulation of health practitioners like chiropractors, homeopaths and others, and for the establishment of a council to regulate these professions.

- **Dental Technicians Act, 19 of 1979**
  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

- **Hazardous Substances Act, 15 of 1973**
  Provides for the control of hazardous substances, in particular those emitting radiation.

- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 as amended**
  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular, setting quality and safety standards for the sale, manufacturing and importation thereof.

- **Occupational Diseases in Mines and Works Act, 78 of 1973**
  Provides for medical examinations on persons suspected of having contracted occupational diseases especially in mines and for compensation in respect of those diseases.

- **Council for Medical Schemes Levy Act, 58 of 2000**
  Provides for a legal framework for the Council to charge medical schemes certain fees.

- **Academic Health Centres Act, 86 of 1993**
  Provides for the establishment, management and operation of academic health centres.

- **Human Tissue Act, 65 of 1983**
  Provides for the administration of matters pertaining to human tissue.

1.3.2. OTHER LEGISLATION IN TERMS OF WHICH THE DEPARTMENT OPERATES

- **Public Service Act, Proclamation 103 of 1994**
  Provides for the administration of the public in its national and provincial spheres, as well as provides for the powers of ministers to hire and fire.

- **Promotion of Administrative Justice Act, 3 of 2000**
  Amplifies the constitutional provisions pertaining to Administrative law by codifying it.

- **Promotion of Access to Information Act, 2 of 2000**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

- **Labour Relations Act, 66 0f 1996**
  Regulates the rights of workers, employers and trade unions

- **Compensation for Occupational injuries and Diseases Act, 130 of 1993**
  Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, for death resulting from such injuries or disease.

- **Basic Conditions of Employment Act, 75 of 1997**
  Provides for the minimum conditions of employment that employers must comply with in their workplaces.

- **Occupational Health and Safety Act, 85 of 1993**
  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

- **The Division of Revenue Act, 7 of 2003**
  Provides for the manner in which revenue generated may be disbursed.

- **Skills Development Act, 97of 1998**
  Provides for the measures that employers are required to take improve the levels of skill of employees in workplaces.

- **Preferential Procurement Policy Framework Act, 5 of 2000**
  Provides for the implementation of the policy on preferential procurement pertaining to historically disadvantaged entrepreneurs.

- **Employment Equity Act, 55 of 1998**
  Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

- **State Information Technology Act, 88 of 1998**
  Provides for the creation and administration of an institution responsible for the State's information technology system.

- **Child Care Act, 74 of 1983**
  Provides for the protection of the rights and well being of children.

- **The Competition Act, 89 0f 1998**
  Provides for the regulation of permissible competitive behaviour, regulation of mergers of companies and matters related thereto.

- **The Copyright Act, 98 of 1998**
  Provides for the protection of intellectual property of a literary, artistic musical nature that is reduced to writing.

- **The Patents Act, 57 of 1978**
  Provides for the protection of inventions including the gadgets and chemical processes.

- **The Merchandise Marks Act, 17 of 1941**
  Provides for the covering and marking of merchandise, and incidental matters.

- **Trade Marks Act, 194 of 1993**
  Provides for the registration of, certification and collective trademarks and matters incidental thereto.

- **Designs Act, 195 of 1993**
  Provides for the registration of designs and matters incidental thereto.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**
  Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

- **State Liability Act, 20 of 1957**
  Provides for the circumstances under which the State attracts legal liability.

- **Broad Based Black Economic Empowerment Act, 53 of 2003**
  Provides for the promotion of black economic empowerment in the manner that the State awards contracts for services to be rendered, and incidental matters.

- **Unemployment Insurance Contributions Act, 4 of 2002**
  Provides for the statutory deduction that employers are required to make from the salaries of employees.

- **Public Finance Management Act, 1 of 1999**
  Provides for the administration of State funds by functionaries, their responsibilities and the incidental matters.

- **Protected Disclosures Act, 26 of 2000**
  Provides for the protection of whistle-blowers in the fight against corruption.

- **Control of Access to Public Premises and Vehicles Act, 53 of 1985**
  Provides for the regulation of individuals entering government premises, and incidental matters.

- **Conventional Penalties Act, 15 of 1962**
  Provides for the enforceability of penal provisions in contracts.

- **Intergovernmental Fiscal Relations Act, 97 of 1997**
  Provides for the manner of harmonisation of financial relations between the various spheres of government, and incidental matters.

- **Public Service Commission Act, 46 of 1997**
  Provides for the amplification of the constitutional principles of accountability governance, and incidental matters.

3 HEALTH SECTOR STRATEGIC FRAMEWORK: THE 10 POINT PLAN

3.1. THE 10 POINT PLAN

The health sector has adopted a 10 Point Plan for 2009-2014, which consists of the following priorities:

i. Provision of Strategic leadership and creation of a Social Compact for better health outcomes;
ii. Implementation of a National Health Insurance Plan (NHI);
iii. Improving Quality of Health Services;
iv. Overhauling the health care system and improve its management;
v. Improving Human Resources Planning, Development and Management;
vi. Revitalization of physical infrastructure;
vii. Accelerated implementation of HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase focus on TB and other communicable diseases;
viii. Mass mobilisation for better health for the population;
ix. Review of the Drug Policy;
x. Strengthening Research and Development

Table 6 below provides the key activities that will be undertaken for each of the priority areas of the 10 Point Plan:

TABLE 6: KEY PRIORITIES AND ACTIVITIES, 2009-2014

PRIORITY	KEY ACTIVITIES
1. Provision of Strategic leadership and creation of Social compact for better health outcomes	• Ensure unified action across the health sector in pursuit of common goals • Mobilize leadership structures of society and communities • Communicate to promote policy and buy in to support government programs • Review of policies to achieve goals • Impact assessment and program evaluation • Development and implementation of a social compact • Grassroots mobilization campaign
2. Implementation of National Health Insurance (NHI)	• Finalisation of NHI policies and implementation plan • Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation
3. Improving the Quality of Health Services	• Improve service delivery in all 52 districts, with a special ephasis on 18 priority districts • Refine and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation • Consolidate and expand the implementation of the Health Facilities Improvement Plans • Establish a National Quality Management and Accreditation Body

PRIORITY	KEY ACTIVITIES
4. Overhauling the health care system and improving its management	
4.1 Refocus the Health System on Primary Health Care (PHC)	• Develop and implement a national model for the delivery of health services based on the PHC approach • Scale up community-based promotive and preventive health service, and massively expand immunisation programmes: antenatal care; postnatal care; nutrition and school health services
4.2 Improve the functionality and management of the Health System	• Assess the qualification, skills and competencies of Hospital CEOs; Hospital Senior Managers and District Managers • Training managers in leadership, management and governance • Decentralization of management • Development and implementation of an accountability framework for the public and private sectors • Establish a management and leadership academy for health managers
5. Improved Human Resources Planning, Development and Management	• Refinement of the HR plan for health • Re-opening of nursing schools and colleges • Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals • Focus on training of PHC personnel and mid-level health workers • Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG) • Manage the coherent integration and standardisation of all categories of Community Health Workers
6. Revitalization of physical infrastructure	
6.1 Accelerate the delivery of health infrastructure through Public Private Partnerships (PPPs)	• Establish Public Private Partnerships, particularly for the construction and refurbishment of Tertiary Hospitals • Accept 13 new projects annually for delivery through the revised Hospital Revitalisation Project • Implement refurbishment and preventative maintenance of all hospitals
6.2 Revitalise Primary level facilities	• Complete the Audit of PHC infrastructure and services • Accelerate the delivery of infrastructure for primary level facilities • Implement refurbishment and preventative maintenance of all hospitals
6.3 Accelerate the delivery of Health Technology and Information Communication Technology (ICT) Infrastructure	• Finalise and implement the Health Technology Strategy • Finalise and implement the ICT Strategy for the Health Sector
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	• Implement new HIV and AIDS policies and strategies announced on World AIDS Day, 01 December 2009 • Urgently strengthen programs against TB, MDR-TB and XDR-TB • Implement new PMTCT Guidelines

PRIORITY	KEY ACTIVITIES
8. Mass mobilisation for the better health for the population	• Intensify health promotion programs • Place more focus on Maternal, Child and Women's Health • Place more focus on the programs to attain the Millennium Development Goals (MDGs) • Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
9. Review of drug policy:	• Complete and submit proposals and a strategy, with the involvement of various stakeholders • Draft plans for the establishment of a State-owned drug manufacturing entity
10. Strengthen Research and Development	• Commission research to accurately quantify Infant mortality • Commission research into the impact of social determinants of health and nutrition • Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

3.2. KEY OUTPUTS FROM THE OUTCOME-BASED MTSF 2009-2014

In keeping with the revised, outcome-based Medium Term Strategic Framework (MTSF) for 2009-2014, adopted by Cabinet in January 2010, the health sector will produce 20 key outputs and outcomes, which are outlined below:

i. Increased Life Expectancy at Birth;
ii. Reduced Child Mortality
iii. Decreased Maternal Mortality Ratio;
iv. Managing HIV Prevalence;
v. Reduced HIV Incidence;
vi. Expanded PMTCT Programme;
vii. Improved TB Case Finding;
viii. Improved TB outcomes;
ix. Improved access to Antiretroviral Treatment for HIV-TB co-infected patients;
x. Decreased prevalence of MDR-TB;
xi. Revitalisation of Primary Health Care;
xii. Improved Physical Infra-structure for Healthcare Delivery;
xiii. Improved Patient Care and Satisfaction;
xiv. Accreditation of health facilities for quality;
xv. Enhanced Operational Management of Health Facilities;
xvi. Improved access to Human Resources for Health;
xvii. Improved Health Care Financing;
xviii. Strengthened Health Information Systems (HIS);
xix. Improved health services for the Youth
xx. Expanded access to Home Based Care and Community Health Workers

These outcomes are consistent with the 10 Point Plan for 2010-2014

As reflected in Table 7, The 10 Point of the Health Sector for 2009-2014 incorporates the 20 priority areas of the outcome-based MTSF, as well as the Millennium Development Goals (MDGs). The 10 Point Plan remains the strategic framework of the health sector for producing the outcomes desired by all three sets of mandates. Other key interventions to improve health status include intersectoral collaboration with government departments responsible for key determinants of health such as education; water and sanitation and housing, as well as community participation.

Table 7: 10 Point Plan 2009-2014 and the outcome-based MTSF 2009-2014

10 POINT PLAN 2009-2014		DELIVERABLES FROM THE OUTCOME-BASED MTSF 2009-2014
PRIORITIES	**KEY ACTIVITIES**	
1. Provision of Strategic leadership and creation of Social compact for better health outcomes	• Ensure unified action across the health sector in pursuit of common goals • Mobilize leadership structures of society and communities • Communicate to promote policy and buy in to support government programs • Review of policies to achieve goals • Impact assessment and program evaluation • Development of a social compact • Grassroots mobilization campaign	• Revitalisation of the Primary Health Care approach • Enhanced Operational Management of Health Facilities
2. Implementation of National Health Insurance (NHI)	• Finalisation of NHI policies and implementation plan • Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation • Finilise and implement an Information and Communication Technology (ICT) Strategy	• Improved Health Care Financing • Implementation of NHI • StrengthenedHealth Information Systems (HIS)
3. Improving the Quality of Health Services	• Improve service delivery in all 52 districts, with a special ephasis on 18 priority districts • Refine and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation • Consolidate and expand the implementation of the Health Facilities Improvement Plans • Establish a National Quality Management and Accreditation Body	• Improved Patient Care and Satisfaction • Accreditation of health facilities for quality
4. Overhauling the health care system and improving its management		
4.1 Refocus the Health System on Primary Health Care (PHC)	• Develop and implement a national model for the delivery of health services based on the PHC approach • Scale up community-based promotive and preventive health service, and massively expand immunisation programmes: antenatal care post	• Revitalisation of the Primary Health Care approach • Enhanced Operational Management of Health Facilities

10 POINT PLAN 2009-2014		DELIVERABLES FROM THE OUTCOME-BASED MTSF 2009-2014
PRIORITIES	**KEY ACTIVITIES**	
4.2 Improve the functionality and management of the Health System	• Assess the qualification, skills and competencies of Hospital CEOs; Hospital Senior Managers and District Managers • Training managers in leadership, management and governance • Decentralization of management • Development and implementation of an accountability framework for the public and private sectors • Establish a management and leadership academy for health managers	• Revitalisation of the Primary Health Care approach • Enhanced Operational Management of Health Facilities
5. Improved Human Resources Planning, Development and Management	• Refinement of the HR plan for health • Re-opening of nursing schools and colleges • Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals • Focus on training of PHC personnel and mid-level health workers • Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG) • Manage the coherent integration and standardisation of all categories of Community Health Workers	• Improved access to Human Resources for Health
6. Revitalization of physical infrastructure		• Improved Physical Infra-structure for Healthcare Delivery
6.1 Accelerate the delivery of health infrastructure through Public Private Partnerships (PPPs)	• Establish Public Private Partnerships, particularly for the construction and refurbishment of Tertiary Hospitals • Accept 13 new projects annually for delivery through the revised Hospital Revitalisation Project • Implement refurbishment and preventative maintenance of all hospitals	
6.2 Revitalise Primary level facilities	• Complete the Audit of PHC infrastructure and services • Accelerate the delivery of infrastructure for primary level facilities • Implement refurbishment and preventative maintenance of all hospitals	
6.3 Accelerate the delivery of Health Technology and Information Communication Technology (ICT) Infrastructure	• Finalise and implement the Health Technology Strategy • Finalise and implement the ICT Strategy for the Health Sector	

10 POINT PLAN 2009-2014		DELIVERABLES FROM THE OUTCOME-BASED MTSF 2009-2014
PRIORITIES	**KEY ACTIVITIES**	
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	• Implement new HIV and AIDS policies and strategies announced on World AIDS Day, 01 December 2009 • Urgently strengthen programs against TB, MDR-TB and XDR-TB • Implement new PMTCT Guidelines	• Managing HIV Prevalence; • Reduced HIV Incidence; • Expanded PMTCT Programme; • Improved TB Case Finding; • Improved TB outcomes; • Improved access to Antiretroviral Treatment for HIV-TB co-infected patients; • Decreased prevalence of MDR-TB • Expanded access to Home Based Care and Community Health Workers
8. Mass mobilisation for the better health for the population	• Place more focus on the programs to attain the Millennium Development Goals (MDGs) • Intensify health promotion programs • Place more focus on Maternal, Child and Women's Health • Place more focus on non-communicable diseases and patients' rights, quality and provide accountability	• Increased Life Expectancy at Birth • Reduced Child Mortality • Decreased Maternal Mortality Ratio • Improved health services for the Youth • Expanded access to Home Based Care and Community Health Workers
9. Review of drug policy:	• Complete and submit proposals and a strategy, with the involvement of various stakeholders • Draft plans for the establishment of a State-owned drug manufacturing entity	• Improved Patient Care and Satisfaction • Accreditation of health facilities for quality • EnhancedOperational Management of Health Facilities
10. Strengthen Research and Development	• Commission research to accurately quantify Infant mortality • Commission research into the impact of social determinants of health and nutrition • Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines	• Enhanced Operational Management of Health Facilities • Strengthened Health Information Systems (HIS)

Table 8 below reflects the 2009 baselines and 2014/15 targets for the 20 outputs entailed in the outcome-based MTSF.

TABLE 8: HEALTH SECTOR OUTPUTS 2009-2014: INDICATORS; BASELINES AND OUTPUTS

INDICATOR	BASELINE 2009	TARGET 2014/15
Life Expectancy at Birth	• 53.5 years for males (StatsSSA, 2009) • 57,2 years for females (StatsSSA, 2009)	• 58-60 years
Child Mortality	• 69 per 1,000 live births	• 30-45 per 1,000 live births
Maternal Mortality Ratio	• 400-625 per 100,000 live births	• 100 per 100,00 live births
HIV Prevalence (amongst 15-24 year old pregnant women)	• 21,7%	• Not Applicable
HIV Incidence	• 1,3%	• 0,6%
Mother to child transmission rate of HIV	• 10%	• 0% - < 5%
Percentage of eligible HIV positive women initiated on ART	• 37%	• All eligible pregnant women to be initiated on ART at a CD4 count of <350 or WHO stage III or IV
TB cases notified	• 341, 165	• 175,000
TB Cure Rate	• 64%	• 85%
Percentage of HIV-TB co-infected patients who are on ART	• 30%	• 100%
PHC service delivery model completed	• Strategy for accelerating progress towards health related MDGs through strengthening PHC developed	• Health service delivery model based on the PHC approach developed
Percentage of health facilities accredited for quality	• None	• 25% of health facilities accredited annually
Patient Care and Satisfaction	• 87,5%	• 90%
Improved access to Human Resources for Health	• Human Resources for Health (HRH) Plan produced	• Revised HRH Plan produced, which reflects an appropriate balance between health professionals and administrative personnel; re-introduces key PHC workers such as Infection Control Officers; Environmental Health Practitioners. • Monitor vacancy rates in the public sector on a quarterly basis
Improved Health Care Financing	• Creation of national Health Insurance comenced	• NHI policy finalised and implemented
Strengthened Health information systems (HIS);	• Draft e-Health Strategy produced	• Finalise e-Health Strategy finalised and implemented
	• National Indicator Dataset (NIDS) revised	• Finalise new NIDS
Improved health services for the Youth and	• Strategy to improve health levels of the youth population segments developed	• Strategy finalised • 70% of PHC facilities implementing Youth Friendly Services by 2014/15

INDICATOR	BASELINE 2009	TARGET 2014/15
Expanded access to Home Based Care and Community Health Workers	• Draft policy on Community Health Workers produced	• Strategy for Home and Community-based Care (HCBC) developed • Policy on Community Health Workers finalised

4 OUTLINE OF THE IMPLEMENTATION OF THE TEN POINT PLAN

4.1. PRIORITY 1: PROVISION OF STRATEGIC LEADERSHIP AND CREATION OF SOCIAL COMPACT FOR BETTER HEALTH OUTCOMES

(a) Ensure unified action across the health sector in pursuit of common goals

The Ministry of Health will assert stewardship over the entire National Health System (NHS), both the public and private sectors. The National Health Amendment Bill will be produced during 2010/11, which will achieve three objectives namely: the review of the powers and functions of both the National and Provincial Departments of Health; facilitate the establishment of an independent accreditation body for health facilities; and enable the review of the current position on the licensing of blood transfusion services. This Bill will be tabled before Parliament by September 2010. The Health Laws Amendment Bill will also be developed and tabled in Parliament in 2011. The Bill will cover all important amendments to all Acts administered by the National DoH, to ensure that existing legislation reflect the government's priorities, where they are found to be inconsistent with these.

Key reforms are required to transform the current health system into well oiled machinery that produces the desired health outcomes. The first is a return to Primary Health Care (PHC) as a fundamental approach to the delivery of health services. The White Paper for the Transformation of the Health System in South Africa, released by the democratic government in April 1997, espoused the PHC approach implemented through the District Health System (DHS). The second reform is to chart a new discourse on HIV and AIDS, which reflects an added sense of urgency in dealing with this pandemic, through a coherent and sustained programme of response.

To ensure coherence in health sector planning, an integrated national health plan will be produced annually, which outlines strategies for the implementation of the 10 Point Plan across the three levels of the health system. The Annual National Health Plan (ANHP) has been produced annually since 2007, in terms of the National Health Act of 2003. The key challenge that lies ahead is to complete the ANHP prior to commencement of the budget cycle, to inform resource allocation to the health sector. The priorities entailed in the integrated national health plan must provide the basis for the budget bid to National Treasury.

The health sector must also produce long-term plans, with a planning horizon of 10 years or longer, and which are aligned to the 10-Point Plan for 2009-2014.

As the health sector revises its HR Plans for 2010-2012, there will be a return to prominence of frontline cadres of health workers such as Community Health Workers; Environmental Health Officers, Infection control nurses; and other categories of mid-level workers.

(b) Mobilise leadership structures of society and communities

To strengthen consultation with leadership structures of society and communities, a National Consultative Health Forum (NCHF) will be held during the course of 2010, at which a social compact with South Africans to improve health outcomes will be adopted. The NCHF will include representatives from

Public Health Sector; the Private Health Sector; other Government Departments; Academic institutions; Research institutions; Community-based Organisations (CBOs); Non-Government Organisations (NGOs); Organised labour; and Faith based Organisations; International Development Partners, amongst others. Beyond 2010, the NCHF will be convened every 12 months, in keeping with the National Health Act of 2003. Amongst other objectives, the NCHF will monitor the implementation of the social compact. Provincial DoHs will also convene Provincial Health Consultative Fora.

Leadership structures of society and communities will also be strengthened. Training will also be provided to hospital board members to create capacity and enabling environment for them to perform their duties.

(c) Communicate to promote policy and buy in to support government programs

The Communication Strategy of the Ministry of Health will be finalised and disseminated to all key stakeholders. These will outline the mechanisms for regular interaction with the health leadership.

Opportunities will be provided to communities to articulate compliments and concerns, as well as their recommendations for improving health service delivery. This process will also assist in reviving grassroots participation in health service delivery, which was pervasive at the advent of democracy in 1994, but which subsequently subsided over time.

(d) Review of policies to achieve goals

Through the National Health Council (NHC), which is the highest decision making structure in the National Health System, health policies will continuously be reviewed to assess their impact on health care delivery. NHC will steadfastly monitor the performance of the health system at all levels, and investigate deviations from nationally adopted policies and programmes, and act swiftly to address these.

(e) Impact assessment and programme evaluation

External reviews of the implementation of health sector policies, plans and programmes will be commissioned at periodic intervals, and undertaken by academic institutions and independent a research organisations. This will generate useful findings to inform planning and implementation. Internally, the impact of policy implementation will be reviewed through regular analysis of data from the District Health Information System (DHIS). The South African Demographic and Health Survey (SADHS) will be completed in 2010, and the survey report released in 2011. The SADHS 2010 will provide an assessment of the health status of South Africans, and draw comparisons with the SADHS 2003. During the current term of office of government, the SADHS 2013 will also be undertaken.

(f) Develop a Social Compact and Grassroots mobilization campaigns

The Department will also strengthen its relations with all its stakeholders, including grassroots structures. A policy framework on Community Health Workers (CHWs), as well as guidelines for the implementation of Home and Community-based Care (HCBC) will be finalised by the end of 2010/11.

4.2. PRIORITY 2: IMPLEMENTATION OF NATIONAL HEALTH INSURANCE

(a) Finalisation of NHI Policies and implementation plans

The South African health system is characterized by a dichotomy between the public and private health sectors. This is a paradigm of inequity. In 2008/09, expenditure in the public sector, which

serves about 86% of the population (41,9 million uninsured people) was estimated at R84 589 billion. Expenditure in the private sector, which serves 14,9% insured South Africans (7,3million people) was R113 181 billion. This figure included R77, 7 billion which was expenditure from medical schemes; medical insurance and employer private contributions, and R35 468 billion from out -of -pocket expenditure. A solid foundation is being laid for the introduction of National Health Insurance (NHI). Extensive technical work on the NHI was conducted during 2009/10. The NHI policy document was presented to Cabinet.

During 2010/11, the Department will submit to Cabinet the proposed NHI legislation. Continuous efforts will be made to render public health facilities NHI-ready, amongst others, through improving the quality of our health services, Health Information Systems and our Information and Communication Technology (ICT).

(b) Implementation of Immediate implementation of steps to prepare for the introduction of the NHI (e.g. Budgeting, Initiation of the drafting of legislation)

Creation of the necessary institutional and organisational structures to start implementing NHI have commenced. A dedicated NHI technical support unit was also established within the Department to steer the implementation of NHI. A 27-member Ministerial Advisory Committee on NHI was established in terms of the National Health Act of 2003 in September 2009.

4.3. PRIORITY 3: IMPROVING THE QUALITY OF HEALTH SERVICES

(a) Stregthen service delivery in all districts starting with 18 Priority Districts

Programmes of support for the 18 priority health districts, as well as an implementation plan were produced. An analysis of the District Health Plans of the 18 priority districts reflected adverse performance on key coverage; health systems performance; as well as outcome indicators. Concerted effort will be devoted to providing systematic support in all 52 health districts to improve service delivery in all health districts, starting with the 18 priority districts.

(b) Refine and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation

Several measures will be implemented to improve Quality of Care. A revised set of core standards was produced in 2009, building on the initial version produced in 2008 and used to assess the functioning of 27 hospitals. The revised core standards will be finalized in 2010/11, and implemented over the next 3 years. Health facilities will produce Quality Improvement Plans (QIPs) focusing on six priority areas: patient safety; infection prevention and control; availability of medicines; waiting times and positive and caring attitudes. Annual patient satisfaction surveys will also be conducted in public sector hospitals.

(c) Consolidate and expand the implementation of the Health Facilities Improvement Plans

The production of Health Facility Improvement Plans which commenced in 2008/09 will be sustained over the next three years.

(d) Establish a National Quality Management and Accreditation Body

The legislative framework for the establishment of the National Quality Management and Accreditation Body has been developed, and will be finalised in 2010/11. The National Health Act of 2003 will be amended to provide for an independent accreditation body.

About 25% of health facilities will be assessed annually, and accreditation will be granted to those that meet required quality standards.

4.4. PRIORITY 4: OVERHAULING THE HEALTH CARE SYSTEM AND IMPROVING ITS MANAGEMENT

(a) Refocusing the Health System on Primary Health Care

The Primary Health Care (PHC) approach is endorsed in key policy documents of the health sector as the strategic approach for ensuring an accessible, affordable, acceptable, equitable and efficient health system, with full community participation and intersectoral collaboration. However, uneven progress has been made with the implementation of PHC across the country.

An urgent need exists to revitalize PHC and to develop a model for the delivery of health services based on the PHC approach in South Africa. In 2009, the National DoH commissioned the development of a strategy for accelerating progress towards health related MDGs through strengthening PHC and DHS, which was produced. Key interventions to be implemented during 2010/11-2012/13 to revitalise PHC include: (i) producing a PHC-oriented service delivery model for South Africa; (ii) establishing PHC Teams in each District to improve access to health care; (iii) completing the audit of Primary Level Services and infrastructure (iv) establishing Governance structures for all health facilities; (v) improving the resource allocations for Primary Level health services; and (vi) finalising Provincial legislation governing the functioning of the District Health System.

To strengthen the decentralised management of health districts for local accountability, the health sector will ensure that District Management Teams (DMTs) are established in all 52 Districts, and that all Districts establish District Health Councils. Delegations for District Health Managers will also be finalised.

(b) Improving the functionality and management of the Health System

The health system will be overhauled to ensure that it is managed by appropriately trained and qualified managers. Initial focus will be on hospital Chief Executive Officers (CEOs); senior hospital managers and District Health Managers. The Development Bank of Southern Africa (DBSA) has been commissioned to assess their skills and competencies. Where skills gaps are identified, appropriate training will be provided. Appropriate delegations will also be given to eligible hospital managers.

In the last three years, more than 220 Hospital CEOs have enrolled in Hospital Management Training Programmes at the Universities of the Witwatersrand (WITS) and KwaZulu-Natal (KZN). These training programmes will be expanded to senior managers in all 400 hospitals in the next 3 years.

(c) Development of an accountability framework for the public and private sectors

The Department will collaborate with various stakeholders to develop an accountability framework for the health sector.

The Department will also enforce compliance of private and public establishments and agencies with national legislation and regulations. The National Core Standard for Quality will be applicable to both the public and private health sectors, and measures will be implemented to ensure compliance.

(d) Identify existing constitutional and legal provisions to unify the public health service; and draft proposals for legal reform

The National Health Amendment Bill will be produced to review the powers and functions of both the

National and Provincial Departments of Health. This legislation will be submitted to Cabinet in 2010. The National Department will also implement measures to reduce a proclivity towards 'federalism' in the public health sector and ensure that it functions coherently and in unison, as a single national health system envisaged in the National Health Act of 2003.

A process of organisational review and design will also be implemented, to ensure that structures of the public sector reflect the new mandate and priorities, particularly the 10 Point Plan for 2009-2014.

4.5. PRIORITY 5: IMPROVED HUMAN RESOURCES PLANNING, DEVELOPMENT AND MANAGEMENT

(a) Refinement of the Human Resources Plan for Health

A framework for the development of the revised National HRH Plan was produced in 2009. A Ministerial Committee or Working Group will be established during 2010 to guide the development of a new HRH Plan for South Africa. The revised HRH Plan to be produced by the end of 2010/11 will quantify the country's needs for health care workers, and specify training targets for the future.

(b) Re-opening of Nursing Schools and Colleges

The health sector will finalise the Audit of Nursing Schools and Colleges conducted in 2009, including costing of resources for recapitalisation. The sector will also strive to mobilise the resources required for recapitalising nursing schools and colleges for expanded production of nurses.

(c) Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals

The revised Human Resource Health Plan which will be produced during 2010/11 will also reflect comprehensive strategies for the recruitment and retention of health professionals; including urgent collaboration with countries that have excess of these professionals, as well as strategies to strengthening the training platform.

Following on the implementation of an Occupational Specific Dispensation (OSD) for nurses in the Public Service, an agreement was signed in the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) on 7 August 2009 to give effect to the implementation of an OSD for medical doctors, dentists, medical and dental specialists, pharmacist assistants, pharmacists and emergency medical services personnel. A proposal for the establishment of an OSD for diagnostic, therapeutic and related allied health professionals was also tabled by the Employer in the PHSDSBC for implementation with effect from 1 July 2009 once an agreement has been reached with the labour unions.

A new policy for the recruitment and employment of foreign health professionals in view of various international recruitment protocols and SADC and AU agreements, and also to ensure that the employment of foreign health professionals do not prejudice health services in developing countries, was approved by the NHC in February 2010.

(d) Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG)

In 2009, a Health Sciences Review Committee established by the DoH and Department of Higher Education examined the utility of the Health Professions Training and Development Grant (HPTD) and

completed a series of investigations into the costs of maintaining current trends in the system, along with scenarios and costs of enrolment growth, using medicine as a tracer profession. Preliminary results of the study were released. Over the next planning cycle, a policy and funding mechanisms for the development of health professionals and delivery of tertiary hospital services will be presented to the National Health Council for adoption and implementation across Provinces.

(e) Manage the coherent integration and standardisation of all categories of Community Health Workers

A Draft Community Health Worker (CHW) Policy was produced in collaboration with National Departments of Social Development and Treasury. This policy will be finalized in 2010/11. Training curriculum and conditions of service of 60,000 CHWs should be standardized across the 9 Provinces during the next MTEF period.

4.6. PRIORITY 6: REVITALIZATION OF INFRASTRUCTURE

(a) Accelerate the delivery of health infrastructure through Public Private Partnerships (PPPs)

The National DoH will accept 2 projects per province per year (18 projects) for inclusion in the Hospital Revitalisation Programme (HRP). Thirteen of these will be implemented through the revised HRP and five through Public Private Partnerships (PPPs). The National Infrastructure Plan will be used as a database as it will contain data on the backlogs of primary to tertiary health facilities, to inform the funding needs.

(b) Revitalise Primary Level Facilities

The development of a National Infrastructure Plan started in 2009/10. This plan will be completed in 2010/11, and implemented to fast-track the delivery of new health facilities with emphasis on primary level facilities. This process will be informed by the outcomes of the audit of primary health care infrastructure and services.

(c) Accelerate the delivery of Heath Technology and Information Communication Technology

The Department will develop and implement a National Health Technology Strategy. Improvement of health technology maintenance as a means to ensure safety will be prioritized. An audit of Essential Equipment will be completed in all 9 Provinces, and an Audit Report produced. Findings of this audit will inform the finalization of the National Health Technology Strategy.

An Information Communication Technology strategy will also be finalised and implemented.

(d) Urgent implementation of refurbishment and preventative maintenance of all health facilities

A process of data collection commenced in 2009/10 to determine the health facilities maintenance baseline. The aim is to achieve a 3-5% expenditure on preventative health facility maintenance. The health sector will also complete the audit of the capacity of Provinces to deliver infrastructure, with a view to further enhance capacity.

4.7. PRIORITY 7: ACCELERATED IMPLEMENTATION OF THE HIV AND AIDS AND SEXUALLY TRANSMITTED INFECTIONS NATIONAL STRATEGIC PLAN AND THE INCREASED FOCUS ON TB AND OTHER COMMUNICABLE DISEASES

(a) Implementation of new HIV and AIDS and TB policies and strategies announced on World AIDS Day, 01 December 2009

HIV/AIDS and Tuberculosis continue to account for a significant burden of diseases in South Africa. WHO (2009) estimates that HIV and AIDS account for 41% of the Disability Adjusted Life Years (DALYs) in South Africa. The results of the National Antenatal HIV and Syphilis Survey for 2008 reflects a national HIV prevalence rate of 29,3%. While this figure reflects a stabilising epidemic, when viewed together with the 29,4% recorded in 2007, and the 29,1% prevalence recorded in 2006, the reality is that HIV prevalence in South Africa is still too high.

New policies and strategies will be implemented during 2010/11-2012/13 to combat the scourges of HIV and AIDS and Tuberculosis. All children less than 1 year of age who test positive for HIV will be initiated on treatment, irrespective of their CD4 count. Antiretroviral Treatment (ART) will be provided to pregnant women at CD4 count of 350 or less, to enhance maternal survival. ART will also be provided to people co-infected with TB and HIV at a CD4 count of 350 or less. Pregnant women who do not qualify for full HAART will receive dual therapy for PMTCT from 14 weeks of pregnancy until post delivery. This will contribute significantly to reducing morbidity and mortality associated with TB and HIV and AIDS. Most importantly, HIV and AIDS and TB will be treated under one roof. The health sector with SANAC will lead a massive campaign to mobilise all South Africans to get tested for HIV and AIDS, and put in place measures are to expand our response. This integration of services will also extend to the delivery of Antenatal Care and the Prevention of Mother to Child Transmission (PMTCT) of HIV.

In keeping with the National Strategic Plan for HIV and AIDS, and STIs, the health sector will strive to contribute to the efforts of SANAC to reduce the incidence of HIV by 50%, from 1,3% in 2008 to 0,6% in 2014/15. HIV prevalence will also be monitored, but no specific targets will be set given that the large numbers of patients on ARVs, prevalence will increase (due to people living longer). The key objective is to improve the quality of life and life expectancy of people living with AIDS.

The health sector will continue to implement the Comprehensive Plan for HIV and AIDS Care, Management and Treatment (CCMT). By October 2009, 939, 722 patients were on ART treatment. Of these, 856,265 were adults and 83,454 were child patients. The health sector aims to place a total of between 400 000 and 550,000 South Africans living with AIDS on ART annually from 2010/11 to 2012/13. Most importantly, primary prevention will remain the mainstay of all efforts to combat HIV and AIDS.

(b) Urgently strengthen programs against TB, MDR-TB; XDR-TB and Malaria

The management of TB will be strengthened. A total of 3,000 health professionals will be trained annually in the management of TB. 2,500 non-health professionals (Community Care-Givers) will also be will be trained annually to support TB patients and to facilitate successful treatment completion.

In keeping with the outcome-based approach, the health sector will strive to achieve 5 key outcomes in TB management and control. These include: decreasing the number of TB from 341, 165 in 2008/09 to 175,000 in 2012/13; decreasing the TB defaulter rate from 7.9% in 2009 to $\leq$5% in 2012/13; increasing the TB cure rate from 64% in 2007 to 80% in 2012/13; and decreasing the percentage of TB patients with MDR-TB.

The health sector will strive to reduce the incidence of local malaria transmission from 0.7 cases per 1000 population at risk in 2009 to 0.56 by 2012/13, by implementing diverse strategies such as ensuring optimal indoor spraying; definitive diagnosis of malaria cases; as well as effective malaria case management.

4.8. PRIORITY 8: MASS MOBILISATION FOR THE BETTER HEALTH FOR THE POPULATION

(a) Intensify Health Promotion Programmes

A draft National Integrated Health Promotion Strategy was produced in 2009, which aims to identify priorities for health promotion in the country, and to provide a mechanism for enhancing existing health promotion strategies and initiatives. Key elements of the strategy include creating supportive environments; developing personal skills on health promotion; building health public policies strengthening community participation securing infrastructure for health promotion; and mobilizing appropriate resources. The Health Promotion Strategy will be incorporated into all 9 Provincial Health Strategies, and implemented in all 52 Districts going forward.

The National Implementation Guidelines for promoting Healthy Lifestyles Programmes were also produced and disseminated. These guidelines identify 5 priority lifestyle programmes namely: tobacco control; physical activity, nutrition; preventing alcohol and substance abuse, and safer sexual practices. 52 districts across the country started implementing the guidelines.

(b) Strengthen programmes focusing on Maternal, Child and Women's Health

In keeping with the outcome-based approach, the set target is to reduce the Maternal Mortality Ratio from the estimated 400-625 per 100,000 in 2009 to 100 or less per 100,000 live births. Key interventions to achieve this include: (i) increasing access to health care facilities; (ii) increasing the percentage of pregnant women who book for antenatal care before 20 weeks gestation; (iii) increasing the percentage of mothers and babies who receive post-natal care within 3 days of delivery; (iv) increasing the percentage of maternity care facilities which review maternal and perinatal deaths and address identified deficiencies; and (v) enhancing the clinical skills of health workers and improve the use of clinical guidelines and protocols.

With regard to improving child health, the set target is to reduce child mortality from 69 per 1,000 in 2009 to 30-45 per 1,000 by 2014/15. Key interventions to achieve this include (i) increasing the percentage of infants requiring dual therapy for PMTCT who actually receive it; (ii) increasing the percentage of mothers and babies who receive post-natal care within 3 days of delivery; (iii) increasing the percentage of maternity care facilities which review maternal and perinatal deaths and address identified deficiencies; (iv) ensuring that 90% of children under 1 year of age are vaccinated with pneumococcal and rotavirus vaccines; (v) increasing the percentage of districts in which 90% of children are fully immunized at one year of age; (vi) increasing the proportion of Nurse Training institutions who teach the Integrated Management of Childhood Illnesses (IMCI); (vii) increasing the proportion schools which are visited by a School Health Nurse at least once a year; (viii) conducting health screening of learners in Grade 1 in Quintile schools for eyes, ears and teeth; (ix) and providing penicillin for prevention of rheumatic heart disease.

(c) Place more focus on the programs to attain the Millennium Development Goals (MDGs)

The health sector will continue with the implementation of the National Strategic Plan (NSP) for HIV and AIDS and Sexually Transmitted Infections (STIs) 2007-2011, which was adopted by the South African National AIDS Council (SANAC) in 2007, the NSP for Tuberculosis Management 2007-2011, also adopted in 2007. In addition the 5-year NSP for Maternal, Child and Women's Health (MCWH), will be finalised in 2009.

Successful implementation of these Strategic Plans three NSPs provide an important vehicle to steer the public health sector in South Africa towards attainment of the outcomes outlined above, namely reduction of childhood mortality by two-thirds by 2015, which is consistent with MDG4; reduction of maternal mortality by three-quarters (75%), which is consistent with MDG 5; as well as halting the

incidence of HIV and managing HIV prevalence, which is consistent with MDG 6.

A major challenge that faces the health sector is to increase life expectancy, from the 53,3 years males and 57,2 years for females in 2009/10 to 58-60 in 2014/15. To accelerate progress towards this goal, the health sector will implement diverse interventions including: (i) increasing the number of new patients initiated on Antiretroviral Therapy (ART); (ii) initiating people with HIV and AIDS and Tuberculosis (TB) co-morbidity at a CD 4 count of 350 on ART (iii) strengthening the integrated TB Control Programme (iii) increasing the national average TB cure rate (iv) Implement co-ordinated intersectoral interventions to reduce intentional and unintentional injury (iv) Halting malaria transmission nationwide and prevent re-introduction of malaria in non-endemic areas (v) conducting ARV drug resistance baseline study; (vi) enhancing the implementation of the National Epidemic Preparedness and Response Plan in line with International Health Regulations.

(d) Place more focus on Non-Communicable Diseases

The increased contribution of Non-Communicable Diseases (NCDs) to the Burden of Disease (BoD) is being recognised globally. In South Africa, emerging evidence from empirical studies estimates that NCDs account for 11-13% of our BoD. The health sector will therefore implement enhanced programmes for prevention and treatment of diseases of lifestyle, as well co-ordinated intersectoral interventions to reduce intentional and unintentional injury.

To improve the management of Non-Communicable Diseases (NCDs), the Department will implement a long-term care model. The primary focus will be on hypertension and diabetes, but not to the exclusion of other NCDs. Particular focus will be placed on the implementation of the Diabetes Declaration and Strategy for Africa of 2006.

Co-ordinated intersectoral interventions will be implemented to reduce intentional and unintentional injury.

4.9. PRIORITY 9: REVIEW OF DRUG POLICY

The Review of the Drug Policy was completed in 2009/10. Over the next 3 years, the health sector aims to improve monitoring systems for drug supply and management, and ensure a zero stock out rate for essential medicines, including TB drugs and Anti-retroviral Treatment (ART).

4.10. PRIORITY 10: RESEARCH AND DEVELOPMENT

Two key objectives of the health sector for the next 3 years are to complete the South African Demographic and Health Survey (SADHS) 2010, as well as the SADHS 2013. These national surveys which will provide reliable data on the health status of South Africans. Infant and maternal mortality will be more accurately quantified. The Department will also conduct the Annual National HIV and Syphilis Prevalence Surveys.

The health sector will also commission research studies and surveys to generate key information for health planning, health service delivery and monitoring.