

CHAPTER 4

RIGHT TO HEALTH CARE

1. INTRODUCTION

The right to health is fundamental to the physical and mental well-being of all individuals and is a necessary condition for the exercise of other human rights¹ including the pursuit of an adequate standard of living. The right to health care services is provided for in three sections of the South African Constitution. These provide for access to health care services including reproductive health and emergency services; basic health care for children, and medical services for detained persons and prisoners.² Universal access is provided for in section 27(1)(a) which states that "Everyone has the right to have access to health care services, including reproductive health care..." Section 27(1)(b) provides for the State to "take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of the right." According to the Limburg Principles, progressive realisation does not imply that the state can defer indefinitely, efforts for the full realisation of the right. On the contrary, state parties are to "move as expeditiously as possible towards the full realisation of the right" and are required to take immediate steps to provide minimum core entitlements.³ Section 27(3) states that no one can be denied emergency medical treatment. Section 28(1)(c) provides for "basic health care services" for children, while section 35(2)(e) provides for "adequate medical treatment" for detainees and prisoners at the State's expense.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides for the "enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity".⁴ This means that health care facilities, goods and services have to be available in sufficient quantity; must be physically and economically accessible to everyone, must be ethically and culturally acceptable, and must be of a medically appropriate quality.⁵

According to section 7(2) of the Constitution⁶ the State is obliged to respect, protect, promote and fulfil all the rights in the Bill of Rights). In the case of the right to

¹ *General Comment No.14 (2000) The Right to the Highest Attainable Standard of Health*, (Article 12 of the International Covenant of Economic, Social and Cultural Rights). UN Committee on Economic, Social and Cultural Rights, 2000. para 1

² Sections 27 (1) (a), (b) &(c); Section 28 (1) (c) and Section 35 (2) (e) of the Constitution of the Republic of South Africa, Act 108 of 1996.

³ Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights Para 21 pp 63-78 in *Economic, Social and Cultural Rights: A Compilation of Essential Documents* International Commission of Jurists, 1977.

⁴ The steps to be taken by State Parties to the ICESCR to achieve the full realization of the right to health include those necessary for the provision of the reduction of the still-birth rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial health; the prevention, treatment and control of epidemics: endemic, occupational and other diseases; and the creation of conditions which would assure to all, medical services and medical attention in the event of sickness.

⁵ *General Comment No. 14 of Committee of ESCR*, 2000, para 12.

⁶ Section 27 (2) of the Constitution of the Republic of South Africa, Act 108 of 1996.

health, these fourfold obligations are defined in General Comment No.14⁷ and include the following: The obligation to respect the right, obliges the State to refrain from denying or limiting access to health care services to any one. These should be available to all on a non-discriminatory basis. The obligation to protect include, *inter alia*, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties; to ensure that privatisation does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties. The obligation to promote requires the State to disseminate appropriate information; foster research and support people to make informed choices. The obligation to fulfil requires that the State facilitates and implements legislative and other measures in recognition of the right to health and adopts a national health policy with detailed plans on how to realise the right. The State is also obliged to provide the right for people in disaster situations or in dire need when an individual or group is unable, for reasons beyond their control, to realise that right themselves with the means at their disposal.⁸

Since 1994 there have been several court cases which have served to add to the normative content of the right to health care. These have thrown light on the concepts of "available resources" and "reasonable measures" in terms of section 27 (1) (b) of the Constitution. In the *Soobramoney* case⁹ the Constitutional Court opined that the scarcity of resources available to the State were constraints to the enjoyment of the right by the appellants, given the socio-historical context of South Africa. In the *Grootboom* case,¹⁰ the Constitutional Court defined the parameters of what constitutes "reasonable measures". In addition to these, it concluded that measures that do not include meeting the needs of the most vulnerable groups in society, were unreasonable. Furthermore, it was stated that implementation plans that failed to be "reasonable" would not meet the State's obligations in terms of section 7(2) of the Constitution. Another important case dealt with the prevention of mother to child transmission of HIV in which the Treatment Action Campaign (TAC) requested that the anti-retroviral drug, Nevirapine be made available to all HIV positive pregnant women in the public health sector. In this case the Constitutional Court upheld the High Court order to make Nevirapine available to all HIV positive pregnant women.¹¹ This judgement is of great significance given the high prevalence of HIV/AIDS in the country and the growing number of AIDS orphans.

The objective of this chapter is to critically assess whether the measures taken by organs of State comply with constitutional obligations with respect to health care as outlined above. Responses to the SAHRC's protocols will be analysed and assessed. Where the information supplied by organs of state, is incomplete, it will be augmented

⁷ Katarina Tomasevski, "Health Rights" in Asbjorn Eide, Catarina Krause and Allan Rosas (eds.), in *Economic, Social and Cultural Rights: A Textbook*. Dordrecht, Kluwer Academic Press, 1995. p.125. See also Christof Heyns and Gina Bekker, Christof Heyns and Gina Bekker, "Introduction to the Rights Concerning Health Care in the South African Constitution," in Gina Bekker (ed.), *A Compilation of Essential Documents on the Right to Health*, Economic and Social Rights Series, Vol 4, Centre for Human Rights, 2000, p. 14-17.

⁸ *General Comment No. 14* of UN Committee of ESCR, 2000, para 34-37.

⁹ See *Soobramoney v Minister of Health, Kwa-Zulu Natal*, 1997 (12) BCLR 1696 (CC).

¹⁰ *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC)

¹¹ See Chapter 1 of this Report for a discussion of the *Grootboom* and *TAC* cases.

by information gathered from other reliable sources, such as academic institutions to facilitate an informed assessment.

The first part of this chapter endeavours to capture the responses from National and Provincial departments of Health. The second part is devoted to a critique of the measures instituted by organs of State, followed by recommendations to expedite access to the right to health care.

2. POLICIES, PROGRAMMES AND PROJECTS

Organs of state were requested to list and describe the policies, programmes and projects instituted during this reporting period and to outline how they respect, protect, promote and fulfil the right to health care. Responses from National Department of Health¹²(NDH) and the provincial departments are summarised below. Information gathered through independent research has been included to give a more comprehensive picture of instituted measures.

National Sphere

The National Department of Health (NDH) instituted the National Telemedicine Policy, the HIV/AIDS Strategic Plan for South Africa 2000-2005 and the National Policy on Quality of Care during 2000/2001. Policies, programmes and project are discussed below.¹³

The National Telemedicine Policy

The objective of this policy is to deliver health care and tele-education at a distance to health care workers in rural areas by connecting them to health centres which can provide these services. An amalgamation of medical schools provide a cost-effective service which include training and education of health care providers in remote areas. The system facilitates recruitment and retention of health care providers in rural communities. Images can be sent from the referring site to the provincial receiving site or the centre of excellence, which provides medical consultations. The consultations can be interactive and provide immediate advise to rural centres.

¹² The NDH is responsible for formulating national legislation, policy, guidelines and setting norms and standards. Implementation and delivery of public health care services are the responsibility of the nine provinces and local authorities. They may also formulate programmes and projects of their own to implement policy.

¹³ The NDH failed to report the HIV/AIDS Strategic Plan, the Human Genetics Policy and the Health Research Policy for South Africa. In addition, some of the titles of policies and programmes were inaccurate. e.g. the National Policy of Quality of Care. Additional information was obtained from the NDH's Annual Rreport and also its website.

Annual Report 2000, Pretoria, Department of Health, 201. http://www.196.36.153/Department_of_Health/norms/contents.html Accessed April 11, 2002

HIV/AIDS Strategic Plan for South Africa 2000-2005

The objective of the HIV/Strategic Plan is to reduce the number of new HIV infections and its impact on individuals, families and communities. Priority areas are prevention, treatment, care, human rights, monitoring and evaluation. The following programmes have been developed to prevent the spread of AIDS: Sexually Transmitted Diseases (STD) Management, Reducing Mother to Child Transmission (MTCT), Post-Exposure Prophylaxis (PEP), and Voluntary Testing and Counselling (VCT).

Sexually Transmitted Diseases Management

Interventions are clustered into various categories where programmes/projects may be developed around one or more policies, which have common goals. One of these interventions is the syndromic management of HIV/AIDS/STIs and TB, which is an opportunistic infection commonly found in people living with AIDS (PLWA). The objective is to train health workers to diagnose and to treat a given set of symptoms effectively. Health workers also contact sexual partners and provide counselling and education.

Reducing Mother to Child Transmission

MTCT is a pilot project designed to provide anti-retroviral drugs (ARVs) and breast milk substitutes (formula milk) to HIV-positive pregnant women in the public health sector in order to reduce the risk of transmitting the virus to the newborn child. Two pilot sites in each province have been established.

Voluntary Testing and Counselling

The VCT programme provides for confidential testing and counselling at public health facilities to ascertain a person's HIV status. The programme will enable patients to know their HIV status and make informed choices after counselling. The programme requires trained personnel and funding for rapid AIDS testing. It also requires a separate space which will ensure privacy and respect for the patient's right to confidentiality.

Post- Exposure Prophylaxis

The PEP programme is designed to provide ARVs to health workers who accidentally become infected with HIV in the workplace. This programme has now been extended to include all rape victims who can obtain ARVs free of charge at state hospitals.

Home and Community Based Care

Another intervention is the management and care of PLWA, AIDS orphans, as well as people living with physical or mental disabilities. Home based and community based care, programmes provide palliative care in the home or at the community level. These programmes require special training for health workers who visit patients in their homes and provide appropriate care which will result in the reduction of the

number of hospital beds occupied by chronic care patients for long periods of time and also in a reduction of hospital costs.

Life Skills Programme

This is a prevention programmes which includes the distributing of information and condoms at no cost to target groups who are most at risk of contracting AIDS. The Life Skills Programmes, which was introduced into the outcomes based curricula in schools, educates school children around issues surrounding AIDS and how to deal with them.

Psycho-social Rehabilitation of the Mentally Disabled

The programme for the psycho-social rehabilitation of mentally disabled persons is designed to de-institutionalise patients from psychiatric hospitals and to encourage community and home- based care as discussed above.

National Policy on Quality of Care

The NDH has developed a comprehensive set of guidelines to standardise the quality of primary health care delivery across all the provinces.¹⁴

Cervical Screening for Cancer (CS)

This programme is designed to reduce the high number of death from cervical cancer in women. Cervical cancer is one of the leading causes of death in women and can be treated if diagnosed early. Regular screening serves to detect early onset which can then be treated.

Maternal Death Notification (MDN)

The latter is designed to record all causes of maternal deaths in order to reduce the mortality rate and also for statistical purposes so as to improve monitoring.

The Human Genetics Policy

This policy is aimed at testing and counselling couples with genetic disorders, in order to reduce the incidence of birth defects. It is also aims at ameliorating the psychosocial and fiscal impact on the individual, the family and society in general. The objective is to provide a national, PHC-based, medical genetic service for the diagnosis, management and prevention of genetic disorders and birth defects. The target population are women of reproductive age, individuals and families at high risk for genetic disorders and birth defects.¹⁵

Health Research Policy in South Africa

¹⁴ http://www.Department_of_Health.gov.za/docs/policy/norms/contents.html Accessed February 19, 2002.

¹⁵ http://www.Department_of_Health.gov.za/docs/policy/humangenetics.pdf

This policy articulates the development of a national health research system which will contribute to equitable health development and promote innovation in service delivery. The objective is to advance knowledge that promotes quality health care through creating a national framework for research that would improve quality, impact, effectiveness and efficiency of the research.¹⁶

The table below summarises key policies/programmes/projects and their beneficiaries reported by the NDH.¹⁷

¹⁶ <http://www.Department of Health.gov.za/docs/policy/healthresearch-2001.pdf>

¹⁷ Note that some of these programmes and projects were instituted previously and are on-going.

Table 1 A summary of policies, programmes and projects instituted by the NDH

Policy on which programme/project is based	Programme/Project	Objectives	Beneficiaries	Achievements
HIV/AIDS	Prevention of Mother to Child Transmission (MTCT)	Reduce transmission of HIV from HIV positive mothers to new-borns	Babies of HIV-positive mothers	18 pilot sites established in four provinces
	Post-Exposure Prophylaxis (PEP)	Provide ARVs to rape victims	Victims of rape	–
	Voluntary Counselling & Testing (VCT)	Increase awareness of HIV status	Members of the public	Pilot sites provide VCT
	AIDS/DOTS	Combat AIDS related TB	HIV positive people with TB	All patients
	Beyond Awareness Campaign	Promote awareness and support prevention, HIV/AIDS	Youth and the public	250 million free condoms were distributed
	Home-based care	Move chronic care to families and communities	AIDS sufferers and orphans, elderly and mental health users	Staff trained to deliver home-based care
Stopping Violence against women & children	Victim Empowerment Programme	Reduce morbidity and mortality	Women and children, victims of rape	National guidelines on management of victims of violence being reviewed
Mental Health Policy	Deinstitutionalisation Rehabilitation	Move patients to community and home based care, treatment and rehabilitation	Mental health users	Increased number of beds available in hospitals
National Policy on Quality Care	Training of health workers to provide quality care	Improve standards of delivery at PHC	General public	Guidelines for all sectors established
Women's health and Reproductive Care	Screening for cervical cancer	To increase access screening services	Women	Pilot sites were set up in Gauteng Limpopo and the Western Cape
	Maternity Care	Decrease mortality	Pregnant women	
	Maternal Death Notification (MDN)	To establish reliable databases for monitoring maternal deaths		
National Strategy on Elder Abuse	Campaign held in 2001 & 2002	Raise awareness around abuse	Elder persons	1000 elders reached

Note: The dash (-) in all the tables denotes that the information requested was not provided.

Provincial Sphere

The provincial departments of Health reported similar policies and programmatic measures to those instituted by the NDH. A summary of these is provided in table 2 below. In addition to these, the Western Cape Department of Health (WC Department of Health) reported the *Kangaroo Mother Care Policy (KMC)*¹⁸ instituted in 2001. This was described as an intervention for low birth weight infants (LBW) which consists of four components- the kangaroo position, nutrition, support and discharge. This policy has proved to be a safe, effective, and affordable method for caring for LBW infants.

Table 2 A summary of programmes/projects reported by provincial departments of health¹⁹

Programme/project	Beneficiaries	Provinces which instituted programmes/projects
MTCT	Babies born to HIV positive women	Free State, Gauteng, Limpopo, North West, Western Cape
Voluntary Testing and Counselling	General Population	Free State, Limpopo, Western Cape
Post Exposure Prophylaxis	Survivors of rape and needle stick injuries	Free State, Western Cape
Home Based Care	Mental health clients, the elderly, the terminally ill, PLWAs and orphans	Eastern Cape, Free State, Limpopo, KwaZulu-Natal, North West, Northern Cape, Western Cape
Life Skills, Contraception	School children/Youth	Free State
Maternal Deaths Notification Register	Improved records to monitor and record causes of maternal deaths	Eastern Cape, Free State, Gauteng, North West, Northern Cape, Western Cape
Cervical Cancer Screening	Women	Free State, Gauteng
Stopping violence against women & children	Women, sexual assault victims, rape survivors	Gauteng, North West, Northern Cape
Training of nurses on Genetic Disorders-Haemophilia, Albinism	Patients	Free State

¹⁸ Independent research shows that this programme has been successfully adopted by other provinces but none of them reported it.

¹⁹ Some of these programmes/projects were developed on policies instituted before this reporting period and are ongoing at the time of writing. The responses did not supply information on how these policies catered for specific vulnerable groups.

3. LEGISLATIVE MEASURES

Certain sections of the National Health Laboratory Services Act²⁰, Act 37 of 2000 came into operation in 2001. The Act provides for the establishment of a juristic person to be known as the National Health Laboratory Service. The Act will introduce a significant change to the way laboratory services are provided in the public sector. It creates a new service, as an autonomous body, bringing together the staff and assets of the South African Institute for Medical Research (SAIMR), the National Institute for Virology, the National Centre for Occupational Health, the forensic chemistry laboratories owned by the State (with the exception of those operated by the police and military) and all provincial health laboratories. A national laboratory service will regulate and standardise services.²¹

Since March 2000 two draft bills were tabled before Parliament for discussion providing a broad framework of the government's strategy on health. The National Health Bill and the Mental Health Bill.

The National Health Bill (2001)

The National Health Bill is a national framework legislation for the delivery of health care by creating closer cooperation between the three spheres of government. It is designed to improve access to health care facilities, improve quality of care by building capacity of health professionals. In the preamble, it is stated that the proposed law is pursuant to section 27(1) of the Constitution which provides for everyone to have access to health care services, including reproductive rights. The objective of the national framework legislation is to establish a national health system which encompasses public, private and non-governmental providers of health services; provides the population of the Republic with the best possible health services that available resources can afford and to set out the rights and duties of both health care providers and users.

Section 7 of the Bill provides that the Minister or the relevant MEC responsible for health, may prescribe that a private or public health establishment shall not deny any person seeking emergency medical treatment if such an establishment is open and able to provide such services. "Emergency treatment" is defined in the Bill as "treatment which is needed to treat a life-threatening but reversible deterioration in person's health status and it continues to be emergency treatment until the condition of the person has stabilised or has been reversed to a particular extent."

*The Mental Health Care Act (2002)*²²

The main purpose of the Act is to regulate, integrate, co-ordinate access to mental health care, treatment and rehabilitation services on a non-discriminatory basis. It also proposes to integrate mental health into Primary Health Care. Other areas of focus are the development of community, district and regional mental health services; de-institutionalization from psychiatric hospitals through the development of

²¹ *South African Year Book 2001/02*. Pretoria, Government Communication and Information System, 2001. p. 329.

²² The Mental Health Care Act No. 17 of 2002.

community support services (group homes; day programmes; rehabilitation groups and home based care).

The Act entitles mental health care users to legal representation and to be informed of his/her rights. It further provides, that a prisoner, who after an investigation by prison authorities, is considered mentally unfit may be transferred to a mental health institution on recommendation of a health practitioner. He or she may be released after the expiry of the term of imprisonment.

Provincial sphere²³

Eastern Cape

The Eastern Cape Provincial Health Act (Act 10 of 1999) was assented to on 24 January 2000. The objectives of the Act included the restructuring and provision for the implementation of Eastern Cape health service delivery in accordance with national and provincial health policies and procedures. It aims to provide for the management of a comprehensive provincial and district health system. The provincial health policy emphasises consultation and community participation. Consultation and co-operation between spheres of government (national, provincial and local) are the cornerstones of co-operative governance. Accordingly, provision is made for the relevant Member of the Executive Council (MEC) to consult with municipalities to coordinate service delivery.

Free State

The Free State Provincial Health Act (Act 8 of 1998) was assented to by the Premier on 15 February 2000. The Act lists the functions of the provincial sphere of government, which include the coordination of funding, financial management, technical and logistical support of District Health Authorities. However, the province is still responsible for rendering comprehensive primary health care services and community hospital services. All three governance options (provincial, local, statutory) expected to be included in the National Health Bill are provided for, with the functions of District Health Authorities (DHAs) being those determined by the Provincial Health Authority (PHA) and the MEC.

Gauteng

The Gauteng District Health System Act was passed during 2000 and the draft regulations developed. These provide for the delivery of primary health care services through a district system in the province, by creating a Provincial Health Authority as well as statutory District Health Authorities. However, the exact relationship between the DHAs and local government was not clearly stipulated and but makes provision for a framework for a phased approach of service delegations to Local Government; development of an Interim Memorandum of Agreement with the City of

²³ The following provinces reported that no new legislation had been passed during the reporting period: EC, FP, LP, NW, MP and the NC and they failed to provide information on constitutional obligations, vulnerable groups and implementation difficulties.

Johannesburg; functional integration of services; and the adoption of the PHC package of services.

KwaZulu-Natal

The most recently passed provincial Health Act was that emanating from the KwaZulu-Natal legislature in mid August 2000, after an initial delay in June. The objectives of the Act include to "structure and provide for the implementation of the district health system". In addition, the Act seeks to establish an integrated provincial health care network and health service delivery in accordance with provincial health policy. As the Act is the most recent to have been finalised, it does take into account the new local government demarcations resulting from the work of the Municipal Demarcation Board and indicates matters to be prescribed by Regulation.

Mpumalanga

The Mpumalanga Health Facilities and Services Bill of 2000 seeks to provide for the establishment, maintenance and management of health facilities and services and for nursing and emergency health services colleges in the province.

Northern Cape

The Northern Cape Nursing Education Bill will provide for the provision of nursing education, the establishment, maintenance and control of nursing colleges for the education and training of nurses and midwives. More expansive is the ambit of the Northern Cape Health Bill: this will consolidate the laws relating to health services facilities, and provide for the establishment, maintenance, organisation and management of health services and establishments in the province.

Northern Province

Regulations in terms of the Northern Province Health Services Act 5 of 1998 have been published for comment. These regulations deal with the following: the demarcation and variation of new health district boundaries; the naming and variation of health districts and facilities; appeals against these procedures; the abolition of the health facility board; membership of the district hospital board, the regional hospital board, the provincial tertiary hospital board and of District Health Authorities; and the establishment of a Provincial Consultative Health Forum.

North West Province

The Provincial Health Bill has been published for public comment and the Bill has provisions relating, to the following: the establishment of the Provincial Health Consultative Forum; the empowerment of the MEC to demarcate districts and the establishment of District Health Authorities; public-private partnerships; and the establishment of a Provincial Health Information Committee and a Provincial Health Research Committee.

Anticipated legislation includes amendments to the North West Health and Development and Social Welfare Hospital Governance Act. The amendments are

directed towards the separation of governance structures relating to health institutions from institutions relating to welfare. Furthermore, provision will also be made for elected representatives at local level to form a simple majority in forums and Health District Committees and will also permit hospital managers to be part of the governance structure.

Western Cape

The Western Cape Health Facility Boards Act 7 of 2001 provides for the establishment, functions, powers and procedures of private health facilities. The Act enables the inclusion of community organizations on the Boards. This means that communities can now participate in the running of health care institutions and influence the quality of care they receive.

4. BUDGETARY MEASURES

National Sphere

The national department did not provide any information on budgetary allocations which was the case for the two previous Economic and Social Rights reports. Figures obtained from the National Department of Health's Annual Report are summarised in the table below:

Table 3 National allocations for the Department of Health

Year	Total Revenue in Rands	Total Allocation in Rands	Total Expenditure in Rands	Under-expenditure in Rands
2000/2001	6 773 823 000	6 765 145 000	6 666 810 000	107 013 000
2001/2002	-	-	-	-

The under-expenditure of R107 013 000 was not accounted for.

According to figures published by the National Treasury²⁴ the total expenditure estimates for the National Department of Health are as follows:

AIDS Prevention

The total allocation for 2001/2002 was R243 081 000, and the actual expenditure was R245 417 037. There was an over-expenditure of R2 336 037, the NDH gave no reasons for this.

AIDS Treatment

The total allocation for HIV/AIDS treatment for 2001/2002 was R17 858 000 of which the actual expenditure was R10 450 248. An unspent amount of R7 397 752 was not accounted for.

²⁴ *Estimates of National Expenditure 2002*, National Treasury of the Republic of South Africa, p 349.

Table 4 Total revenue and allocations

Province	Year	Amount received from other sources in Rands	Total allocation in Rands	Allocation as a % of GGP in Rands	Per capita allocation after inflation adjustment in Rands	Actual Expenditures in Rands
Eastern Cape	2000/2001	30 433 000	-	-	583	3 650 636
	2001/2002	29 395 000	-	-	720	3 892 198
Free State	2000/2001	48 667 223	1 833 067 000	0.020	-	1 777 203 000
	2001/2002	67 058 519	1 970 476 000	0.020	721.75	2 035 536 068
Gauteng	2000/2001	5 562 252 000	5 562 252 000	2	786	5 942 208 000
	2001/2002	6 771 374 000	6 771 374 000	3	868	6 805 610 000
KwaZulu-Natal	2000/2001	110 010 000	5 832 108 000	-	593.47	5 775 995 000
	2001/2002	118 226 000	6 743 749 000	-	691.44	7 032 951 000
Limpopo	2000/2001	2 368 169	2 368 169	6.28	450.36	2 565 894
	2001/2002	2 634 907	2 634 907	6.62	470.49	2 674 094
North West	2000/2001	-	1 576 29 000	-	-	1 561 485 000
	2001/2002	-	1 734 817 000	-	-	1 698 928 000
Western Cape	2000/2001	98 781 000	3 391 224 000	-	-	3 366 689

Variance, Adequacy and Remedies

The Eastern Cape reported the under-spending of R328 468 890 due to lack of capacity to spend in areas such as infrastructure and equipment. This figure cannot be reconciled with the figures provided. No annual breakdown was provided. The budget was reported to be inadequate resulting in curtailment of services and deterioration of infrastructure. More efficient management of funds had been introduced to address these problems.

The Free State did not account for variances in its budget and claimed that it was inadequate even though it under-spent for 2000/2001. The issue of under-spending and its impact on service delivery were not addressed. The department considered over-spending by less than 2 percent for 2001/2002 to be a small deviation. To address budgetary problems the department intended improving control measures and realigning the budget.

The Gauteng Department of Health reported that inflation adjustments, additional allocations for capital expenditure and HIV/AIDs accounted for variances. The budget was inadequate and referred to the appropriate authorities

The KwaZulu Department of Health reported that variances were due largely to personnel budgets which could not be effectively managed at the district level. In 2000/2001, the department overspent its budget by some R158 million. In 2001/2002, an over-expenditure of R289 202 000 was reported to be mainly due to the cholera outbreak in KwaZulu-Natal.

The department also reported that the budget was inadequate since the weaker Rand resulted in increased costs of fuel, imported medicines and equipment. In order to address budget inadequacy enforced saving took place at all levels, with intended expansion of PHC services being limited to the absolute essentials.

The Limpopo Department of Health reported a negative variance for R220 178 000 for 2000/2001 due to insufficient funding. This was a result of the increased costs of additional infrastructure, purchase of medicines, and appointment of personnel and also for debts which had to be settled from the previous year. The budget had not been adequate for the past four years and the department experienced over-spending.

The Western Cape Department of Health reported that under-spending in the 2000/2001 financial year was mainly due to claims received after 31 March 2001 which were paid in the following financial year.

The Eastern Cape, Limpopo, and the Northern Cape Departments of Health gave no budgets for PHC. The Mpumalanga Department of Health gave irrelevant figures. The Gauteng Department of Health and the Western Cape Departments of Health provided figures but no other information.

Table 5 Provincial budgets for Primary Health Care

Province	Year	Total allocation in Rands	Allocation as % of total revenue in Rands	Per capita allocation after inflation adjustment in Rands	Actual expenditure in Rands
Free State	2000/2001	657 030 000	-	-	183 753 490
	2001/2002	700 123 000	-	-	763 712 317
Gauteng	2000/2001	1 410 217 000	24	181	1 458 755 000
	2001/2002	1 513 249 000	22	194	1 582 598 000
KwaZulu-Natal	2000/2001	2 750 031 000	-	-	2 892 473 000
	2001/2002	3 244 479 000	-	-	3 487 391 000
North West	2000/2001	920 571 000	59	-	951 739 000
	2001/2002	989 947 000	57	-	989 945 000
Western Cape	2000/2001	870 789 000	-	-	874 256 000
	2001/2002	939 774 000	-	-	-

Variance, Adequacy and Remedies

The Free State Department of Health reported that the budget allocation has increased annually. Some of the reasons for the increase include, improvement in the provision of new services such as Health Promotion and the Occupational Health Unit. The department reported that the budget was adequate.

The KwaZulu-Natal Department of Health reported that in 2000/2001 an over-expenditure of R142 442 000 was mainly due to rank upgrading, the re-introduction of personal profiles, which were suspended from 1997/1998, as well as the cholera epidemic. In 2001/2002 a shortfall of R242 912 000 was mainly due to the cholera epidemic, and inflation related to foreign exchange rates resulting in increased costs of medicines and fuels.

The North West Department of Health reported variances for 2000/2001, which were due to an increased demand for drugs for the treatment of AIDS and related illnesses. Under-expenditure in 2001/2002 was due to late submission of invoices by suppliers. The department considered the budget inadequate for PHC which is not calculated according to needs. The department had to reprioritise services to fit into the available resources and reported no negative impact on the realisation of the right to health.

The following tables summarise provincial AIDS budgets

Table 6 Prevention of HIV/AIDS

Province	Year	Total allocation in Rands	Per capita allocation in after inflation in Rands	Projected expenditure in Rands	Actual expenditure in Rands
Free State	2000/2001	4 810 412	-	-	3 107 336
	2001/2002	4 455 783	-	-	-
Gauteng	2000/2001	12 881 000	-	-	-
	2001/2002	15 533 000	-	-	-
KwaZulu Natal	2000/2001	-	3 437 9	34 437 9	30 403 000
	2001/2002	-	52 576 728	52 576 728	49 363 497
Limpopo	2000/2001	6 900 000	-	-	3 452 814
	2001/2002	8 013 000	-	-	5 664 456
North West	2000/2001	2 006 000	-	2 006 000	2 006 057
	2001/2002	4 641 000	-	4 641 000	2006 000
Western Cape	2000/2001	7 300000	-	-	-
	2001/2002	14 825000	-	-	-

Variance, Adequacy and Remedies

Provincial Sphere

The Eastern Cape and Northern Cape Departments of Health did not provide any information. The Gauteng Department of Health reported that there was no dedicated

budget for the prevention of AIDS which is included in the total Public Health Directorate budget.

The Free State Department of Health reported that the budget increased every year. Conditional grants for HIV/ AIDS increased in line with implementation of various programmes such as the Home Based Care programme, MTCT pilot projects and others. The allocation for 2001/2002 includes VCT R3 455 783 and NGO transfers of R1 000 000 no inadequacies in the budget were reported. For the fiscal year 2000/2001 an under-expenditure of R1 703 078 was reported. The department gave the following reasons for this under-expenditure which include allocations for specific projects, late receipt of conditional grants, and in some cases, there were delays in processing funding.

The measures the department put in place to address under-spending included efficient management of programmes and projects. The budget provided was enough to realise the goals of the unit.

The KwaZulu-Natal Department of Health reported that in 2000/2001, an under-expenditure of R6 897 000 was mainly due to difficulty in finalising acceptable contracts/agreements on special projects. In 2001/2002, the under-expenditure of R6 928 503 was due mainly to difficulties in finalising contracts with lay counsellors.

The Limpopo Department of Health provided the following variances: for 2000/2001, there was an under-expenditure of R3 447 186. for 2001/2002, the variance was R1 642 115. The fund was stagnant for a long time due to delays in appointing managers for the HIV/AIDS/STIs and TB Programme.

The North West Department of Health does not have a specific budget for AIDS prevention except for a conditional grant for MTCT which was implemented in 2001/2002. Under-expenditures were due to delays in tender procedures and finalisation of NGO funding. The department reported that the budget was insufficient to cover needs, so a revision of targets and re-prioritisation of programmes and projects had to be made based on available resources. The impact of under-funding and under-spending resulted in delay of service delivery. It hoped that pre-planning and a revision of the procurement process would alleviate some of the problems related to under-spending.

The Western Cape Department of Health reported that the budget for AIDS was inadequate. To address this the department increased the total allocation in 2000/2001 from R7.3 million to R14 825 million in 2001/2002 and to R43 138 million in 2002/2003 in an attempt to prevent the disease from spreading. This allocation includes national conditional grant funding for VCT as well as home based care. Only the conditional grant funds were under-spent because of the late transferral of funds and delays in the approval of business plans. These funds have been rolled over to the next financial years. Under-spending resulted in optimal delivery of services being impeded. A lack of spending capacity by NGOs also hampered service delivery which might have compromised the right in some ways.

To address these problems the department improved the monthly reporting system as well as its cash flow projection mechanisms. The department also created specific

objective codes for some of the conditional grants, which will improve the monitoring of spending. This will improve the chances of the department being aware of possible over/under spending well in advance.

5. OUTCOMES AND INDICATORS

National Sphere

The National Department of Health reported that much of the information requested was not available in the format required by the SAHRC. Much of the information requested was not provided even such important statistics such as the infant and maternal mortality rate and the general life expectancy. The following tables are a summary of the information provided. It must be noted that no breakdown for the two fiscal years was provided.

Table 7 Public health care clinics

	Year	Number of Patients
	2000	83 352 903 ²⁵
	2001	68 301 226 ²⁶

Table 8 Public hospitals

	Total	Urban	Rural
Patient/ doctor ratio	-	-	-
Patient/nurse ratio	-	-	-
Number of hospitals	376	143	233
Number of patients for the year (headcount)	3 901 350	1 599 554	2 301 797
Number of available beds	101 829	39 713	62 116
Average number of days in hospital stayed per patient	6.1%	5.3%	6.8%

The figures provided by the NDH do not indicate the patient/doctor ratio nor the patient/nurse ratio which are important indicators of the level of care received. The figures provided for the total number of patients per year using public hospitals seems low. A breakdown for the two fiscal years requested was not provided.

Table 9 Private hospitals

	Total	Urban	Rural
Patient/ doctor ratio	-	-	-
Patient/nurse ratio	-	-	-
Number of hospitals	238	188	50
Number of patients for the year (headcounts)	-	-	-
Number of available beds	31 937	27 775	4 162
Average number of days in hospital stayed per patient	6.6%	6.6%	6.6%

Information for private hospitals was not provided by the NDH This is especially disturbing since they are to be regulated by the NDH under the National Health Act.

²⁵ The NDH reported that data for Gauteng is from April 2000 – December 2000.

²⁶ The NDH reported that data for Gauteng is from Jan 2001 - March 2001.

Table 10 Access to Health Care Clinics

Distance	Total Number of Cl
(a) 5km radius	3 382 710
(b) greater than 5km radius	2 419 815

The NDH reported that the average distance to a clinic was 12.5 kms but no breakdown by province was reported nor access to clinics in rural areas.

Table 11 Disease indicators

		Total
Percentage of population with HIV/AIDS		-
Percentage of population with Tuberculosis		-
Percentage of population with STDs		64
Percentage of population with Hepatitis B		-
Incidence of population with Malaria		392/100 000
Incidence of population with water-borne diseases	Cholera Incidence	242/100 000 population
	Total Typhoid Fever Incidence	8 000 000

The incidence for malaria was based on the three provinces where malaria is endemic, which are KwaZulu-Natal, Mpumalanga and Limpopo. The numerator includes both active and passive cases. Malaria incidence for the whole RSA population is: 161/100 000.

The NDH reported that the only data available for water borne diseases is for cholera and typhoid fever, and this data is not broken down in terms of the demographics as requested.

Table 12 Primary Health Care indicators

	Total
Percentage Clinics with STDs Services every day	73.5 ²⁷
Percentage Clinics with Cervical Cancer Screening Service	15 144 ²⁸
Percentage Clinics with Family Planning Services	206 1955
Percentage Clinics with Antenatal Care Services	10 254 222

The figures provided by the NDH are not percentages of clinics that provide these services, except for clinics which provide STD services every day.

²⁷ The figure excludes Gauteng as they are currently using the old version of the software.

²⁸ Only Gauteng province collects data on cervical smear. As they are currently using the old version of the software the figure cannot be calculated. The total reflected is the number of smears for the period April 2000 – March 2001.

Provincial Sphere

Table 13 Number of public health care personnel

Type of Personnel	EC Total	FS Total	GP Total	KZN Total	LP Total	MP Total	NC Total	NW Total	WC Total
Nurses & midwives	14 796	5 499	18 141	23 091	10 781	45 000	1 737	3 550	8 289
Doctors	709	427	2 198	1 290	586	375	221	254	870
Specialists	220	119	1 708	294	39	16	15	27	910
Dentists	55	-	241	72	36	43	13	37	63
Pharmacists	116	58	341	326	128	42	25	57	173
Other Allied Medical Personnel	586		1384 ²⁹	700	398	95	82	221	98
Ambulance Drivers	851	599		1 514	-	490	217	222	-

The figure for Gauteng includes nurses, matrons and midwives. Matrons are now known as Chief Professional Nurses (CPNs) and ambulance drivers are included in category of allied medical personnel.

Table 14 Public Health Care Personnel: Provinces showing urban/rural breakdown

Type of Personnel	KZN Urban	KZN Rural	LP Urban	LP Rural	NW Urban	NW Rural	WC Urban	WC Rural
Nurses (includes midwives)	17 644	5 437	1 454	9 327	1 823	1 727	6 779	1 510
Matrons	85	58			25	12	1,960	626
Doctors	1 143	147	151	435	162	92	727	143
Specialists	288	6	38	1	27	0	883	27
Dentists	56	16	10	26	17	20	43	20
Pharmacists	285	41	33	95	35	22	173	56
Allied Medical personnel	615	85	103	295	113	108	1 234	98
Ambulance drivers	1 403	111			86	136		

The Eastern Cape, Free State, Gauteng, Mpumalanga and the Northern Cape did not provide a breakdown of urban and rural figures.

²⁹ This figure includes ambulance drivers

Table 15 Private health care personnel

Type of Personnel	Eastern Cape Total	Free State Total	Western Cape Total	Western Cape Urban	Western Cape Rural
Nurses	1 545	892	2275	2067	208
Matrons	12	33	70	60	10
Midwives		-	104	84	20
Doctors	-	14	-	-	-
Specialists	-	120	-	-	-
Dentists	-	3	-	-	-
Pharmacists	26	15	86	71	15
Allied medical personnel	-	84	31	21	10
Ambulance drivers	-	4	116	98	18

EC reported that the data was collected from 7 out of 27 private facilities. The NDH, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape and the North West provincial departments of Health reported that they were not responsible for collecting statistics.

Table 16 Access to health care clinics

	Eastern Cape	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	North West	Western Cape
Patient/doctor ratio	-	-	-	-	-	-	57 598
Patient nurse ratio	-	-	-	-	-	-	15 561
Number of Clinics per 1000 population	716	0.6	-	43	359	1	-
Number of Patients for the year 2000/2001	4.6 mil ³⁰	10.2 mil	28.9 mil	1.8 mil	5.1 mil	17.1mil	11.9 mil
Number of PHC patient visit per capita	-	-	-	-	-	-	36
Number of available beds	-	16 744	-	8 939	-	1 358	-

The Northern Cape and the Free State Department of Health provided no information.

³⁰ Note that mil denotes million as in R1 000 000

Table 17 Public hospitals

	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	North West	Western Cape
Patients/Doctor ratio	7 830:1. 666 in-patients:1	-	950;1	-	-	302;1	7686:1	-
Patients per nurse	66 in-patients: 1	-	-	-	-	-	550:1	-
No. of Hospitals	98	31	32	60	43	24	32	58
No. of Patients for the year	In-patients 1 379 526 Out-patients 396 103	205 000	3.8 mil	9.5 mil	1.8 mil	1.2 mil	1.9 mil	3.1 ³¹ mil
Available beds	19 953	5 492	16 744	22 563	8 939	2 226	7 701	10 400
Average No. of days in hospital per patient	District hospitals: 6 Regional hospitals: 7 Specialised hospitals: 55	4.5	6	6.3	7	-		7.2

The Northern Cape failed to provide any information.

Table 18 Access to health care clinics

	Eastern Cape	Limpopo
Average distance to PHC clinics	11	20
% of persons who reside Within 5kms radius	75	-
Greater than 5kms radius	22	-
Greater than 25kms radius	3	-
Greater than 50kms radius	-	-

The other provinces provided no statistics and indicated that mobile clinics provide services to remote areas. None of the provinces provided information on access to hospitals.

³¹ April 2000 to March 2001

Table 19 Disease indicators

	EC	FS	KZN	LP	MP	NC	NW
	Total	Total	Total	Total	Total	Total	Total
Percentage of population with HIV/AIDS	-	-	-	13	40	11	23 ³²
Percentage of population with Tuberculosis	0.4	0.49	0.4	0.12	-	1.2	0.34
Percentage of population with STDs	15	6.	3.8	5	-	3	10
Percentage of population with Hepatitis B	-	0.0008		0.003	-	0.005	30 cases
Incidence of population with Malaria	-	0.0034	0.34	0.22	18	0.6	0.03
Incidence of population with water-borne diseases e.g. cholera, typhoid etc.	-	0.7	0.81	-	-	0	-

No breakdown of figures for urban, rural, and females was provided. Gauteng did not provide any figures at all while the Eastern Cape, Free State and Kwa-Zulu Natal failed to provide figures for HIV/AIDS in spite of the fact that antenatal surveys are established in all the provinces especially in Kwa-Zulu Natal which has one of the highest incidence of AIDS in the country.

Table 20 Primary Health Care indicators

	EC	FS	LO	NW	NC	WC
% of clinics with TB services every day	85	86	100	79	100	-
% of clinics with STD services every day	91	100	100	100	100	-
% of clinics with cervical cancer screening services	49	71	6	90	-	-
% of clinics with family planning services	97	100	100	60	100	100
% of clinics with antenatal care services	80	100	100	80	100	100
% of clinics where condoms are freely available	85	100	100	100	100	100

In view of the fact that some of the provinces did not respond, while others failed to provide figures for the outcomes of PHC package is unacceptable, given that delivery of quality care is a priority of government.

Table 21 General Indicators

	EC	FS	NC
Infant Mortality Rate per 1000 live births	62	12 (1,2%)	5.8
Maternal Mortality Rate per 100, 000 live births	135	100 (0,1%)	1,4
Life Expectancy (years)	60,7	56,1	-

No urban/rural and "racial" breakdown was provided as requested. Some of the provinces reported that such data is not kept. Most of the provinces did not provide any information at all. This is difficult to understand since they reported that recording notification of maternal mortality as one of the programmes which has been implemented. The figures for life expectancy should easily be available to the NDH and to the provinces.

³² The percentage of the population testing positive for HIV is extrapolated from antenatal surveys of pregnant women.

6. NATIONAL ACTION PLAN (NAP)

National Sphere

Table 22 Public Clinics

	Total
Number and % of clinics reporting	4 497 & 95%
Number and % of population without a medical clinic within a 5km	1041514
Number and % of clinics with inadequate supply of medication	-

Table 23 Public hospitals

	Total	Urban	Rural
Number of hospitals	376	143	233
Bed occupancy rate	65%	58%	69%
Number and % of overcrowded hospitals	31/8%	10/7%	21/9%

Table 24 Private hospitals

	Total	Urban	Urban %	Rural	Rural %
Number and % of hospitals	238	188	79%	50	21%
Bed occupancy rate	40%	39%	-	46%	-

Provincial Sphere

Table 25 Public clinics

	Free State*	North West	Northern Cape	Western Cape
Number	330	344	140	519
Number of clinics with inadequate supply of medication for patients	0	0	-	-
Number of clinics with inadequate staff provision	73*	-	-	-
Number of the population without a medical clinic within a 5 km radius	-	-	-	-
Number of overcrowded clinics	68	0	-	-
Number of population denied access to medical services because of fees	0	0	0	-

*The FS reported that some facilities did not provide data.

Table 26 Public hospitals

	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Western Cape
Number and % Hospitals	98 of which 66% are urban & 33% rural	31	32	60	58/100 of which 22 (38%) are urban and 36 (62%) are rural
Bed Occupancy Rate %	District hospitals: 6 Regional hosp: 90 Specialised hosp: 90	54.8	89	68	80
Number and % hosp with inadequate supply medicine	Unknown	Nil	-	Nil	-
Number and % hosp with inadequate staff provision	-	Nil	-	-	-
Number and % hosp with inadequate supply beds	Nil	Nil	-	Nil	-
Number and % hosp with inadequate supply linen	Unknown	Nil	4%	-	-
Number and % hosp with inadequate supply clothes for patients	Unknown	Nil	-	-	-
Number & % of over crowded Hospitals	-	-	-	-	-

The Eastern Cape reported that hospitals in the Kokstad, Umtata and PE area short staffed while those in the East London area generally have sufficient or excess staff.

7. CRITIQUE

National Sphere

The information provided by the NDH lacked clarity, accuracy and was incomplete. Descriptions of policies were either very brief or omitted. The NDH failed to mention a major policy developed by the Department: the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. It also failed to mention policies developed in 2001/2002 which were identified through independent research. Furthermore, the NDH's failed to distinguish policies from programmes or projects.

The NDH erroneously reported the launch of the Primary Health Care Package which had occurred in 1996. Independent research shows that a comprehensive set of norms and standards for improved quality of delivery standards was developed, namely, the Standard Package of Primary Health Care Services. A comprehensive list of guidelines to promote quality care, for both public health clinics and for community based initiated services was distributed.³³ These guidelines do not constitute new

³³ See the NDH's website, [http://196.36.153/Department of Health/policy/norms/contents.html](http://196.36.153/Department%20of%20Health/policy/norms/contents.html). Accessed April 11, 2002.

policies or programmes as reported by the NDH and many of the provinces, but are in keeping with the NDH's strategic five-year goal of improving service delivery.

The information provided did not include a comprehensive account of the outcomes and achievements of the measures instituted. Similarly, the information provided on budgets and indicators suffered the same poor treatment.

Provincial Sphere

The North West Department of Health must be commended for its comprehensive coverage of policies and for providing a description of each. The Western Cape Department of Health's report was more comprehensive than the other provinces. Many of the policies and programmes reported were consistent with national policies on improved service delivery and care.

The Eastern Cape, Northern Cape, Mpumalanga and Kwa-Zulu Natal Departments of Health provided no information on policy and programmatic measures while the other provinces provided only cursory information. Many of the departments did not state the goals of the programmes/projects, nor their achievements. Only three provinces reported new legislation and instances of corruption. The Eastern Cape and Northern Cape Departments of Health failed to provide any information on budgetary measures.

It is not possible to make an assessment of the progressive realisation of the right to health care based only on the information provided by organs of State because of the inaccuracies and gaps in the information. For this it was necessary to consult other sources.

Constitutional Obligations

Organs of State were requested to show how the instituted measures met their constitutional obligations to respect, protect, promote and fulfil the right to health. The responses are discussed in the section below.

National Sphere

Respect

The NDH stated that policy and programmatic measures instituted respect the right by making health care services available to all on a non-discriminatory basis as provided for in the Patients' Rights Charter which prohibits denial of services on the basis of age, disability, race, gender, sexual orientation, marital status, religion, educational level, colour, beliefs, values, culture, and health status.

Promote

The NDH promoted the right by disseminating information regarding availability and quality of services to the public. Education is also provided to groups such as the elderly and women to inform them of their rights and assist them against abuse.

Fulfil

The PHC package is available to all at health care facilities. Special programmes for women, children, previously disadvantaged groups, the elderly, rural communities and other vulnerable groups ensure that health care is accessible to all.

Provincial Sphere

Respect

The North West Department of Health reported that a range of quality services are offered to all who need them without any discrimination in accordance with the Patient's Rights Charter and the Batho Pele Principles. Programmes that ensure appropriate services for safe pregnancy and childbirth, taken together with the TOPS programme respects women's reproductive rights. The Free State Department of Health made a similar statement regarding the obligation to respect the right. The Western Cape Department of Health reported that by recognising and implementing all policy and programmatic measures to which all citizens have a right ensures respect for the right. Other departments did not respond to this part of the protocol.

Protect

The North West and Free State Departments of Health, respectively have put a mechanism in place to protect against violation of patients' rights in the form of a complaints register available at all service delivery points. This enables patients to register their complaints and have them addressed through the Clinical Investigation Committee.

Promote and Fulfil

The North West Department of Health has instituted intensive awareness campaigns especially around AIDS prevention. It has also instituted a large number of measures ranging from building new hospitals and clinics, infrastructure upgrading, and ensuring availability of basic amenities at clinics, such as water and electricity. The allocation of community service pharmacists to outlying districts has increased the availability of medicines to rural communities. Implementation of the national HIV/AIDS/TB syndromic intervention programme, provides services to youth and women. The expansion of services through the use of mobile clinics has promoted the right to health care especially in the rural areas.

The Western Cape Department of Health reported that the training of health workers raises awareness regarding the standards to be employed in the delivery of quality care as well as the rights of beneficiaries to access services. Strong health promotion interventions have been developed in such areas as HIV/AIDS, TB, maternal and child health, chronic diseases and nutrition. Education of clients creates an awareness of their rights to access available services. Implementation of health policies and programmes ensures access to primary, secondary and tertiary health care.

The Free State Department of Health reported conducting numerous awareness campaigns including the dissemination of information regarding HIV/AIDS, women and elder abuse.

Vulnerable and Marginalized Groups

National Sphere

The NDH made a general statement that the PHC Package provides "a range of services arranged according to life cycle." It identified programmes for older persons and people with disabilities but failed to report on the efficacy of these. The National Telemedicine policy was erroneously reported to benefit women and children in rural areas. Similarly, the PEP programme was reported to provide for women and children and not rape survivors and the MTC programme was reported to "provide for people infected with HIV" rather than for neonates born of HIV positive mothers.

Provincial Sphere

Women

The Western Cape and Free State Departments of Health, identified the following policies and programmes which make provision for the women and children. Prevention of MTCT programme according to the WC Department of Health will save more than a thousand babies. The VCT, PEP will benefit *women* and health workers against HIV infection, while the KMC programme will benefit *infants*. The EC Department of Health, and NW Department of Health, identified TOPs, Maternal Care and Maternal Death Notification programmes to benefit *women*. The EC Department of Health and the NW Department of Health reported early detection of cancer through cervical screening to reduce the risk of cancer in women.

Older Persons

The Eastern Cape, KwaZulu-Natal and Western Cape Departments of Health identified Chronic Care, the Elder Abuse Programme, and the Cataract Removal Programmes to benefit older persons.

Girl-children

The Eastern Cape, Western Cape and Northern Cape Departments of Health identified child health programmes and the policy on the Management of Rape Survivors to benefit and *girl-children*. The Gauteng Department of Health stated that 97 per cent of the province is urbanized and that children in rural areas have mobile clinic services and that all children have access to PHC services at no charge, and terminally ill children have home based care and hospices.

Previously Disadvantaged Racial Groups and Refugees and Asylum Seekers

The Western Cape and Eastern Cape Departments of Health reported that these groups had equal access to PHC services.

People Living in Rural Areas

The North West Department of Health reported that *people living in rural areas* had access to health care through mobile clinics. None of the provinces mentioned telemedicine services.

People with Disabilities

The Free State and Western Cape Departments of Health listed the Assistive Device Policy and the National Rehabilitation Policy to benefit *people with disabilities*. The Gauteng Department of Health stated that wheel chairs are made available for children with disabilities.

People Infected and Affected by HIV/AIDS

The Eastern Cape, North West, and Western Cape Departments of Health identified the HIV/AIDS policy and related programmes and projects, the home-based care programme, the establishment of youth centres to specifically cater for this group. The North West Department of Health has established 5 regional teams totalling 280 health workers to provide home-based care. and to provide voluntary testing and counselling.

The NDH's, as most of the provincial responses did not respond to satisfactorily to the question and did not show a clear understanding of how programmatic measures respect, protect, promote and fulfil the right to health care, including reproductive health.

Responses from the Eastern Cape, Gauteng, KZN, Northern Cape demonstrate a lack of understanding on the meaning of these constitutional obligations. Mpumalanga did not respond at all.

Legislative measures

National Sphere

The National Department stated that new legislation effected changes to prior legislation that obstructed the promotion and fulfilment of the right. In response to how the legislation caters for vulnerable groups, the NDH's response was that the legislation caters for all vulnerable groups.

Provincial Sphere

The Gauteng Department of Health stated that preventative, promotive, curative and rehabilitative health care is accessible to all. This meant that all vulnerable groups are

catered for. The other provinces did not respond to this section of the protocol or provided irrelevant information.

Although the responses from government show that the policies and programmatic measures do not follow a human rights based approach, the PHC package does however provide universal access which grants free access to mothers and children. Some of these measures also provide for the needs of some of the vulnerable groups such as the elderly, children, the disabled, women, and youth. However, there are either few or no specific programmes in place to cater for the needs of the rural populations where 75 percent of the people are poor and access to clinics and hospitals is made difficult by distance and lack of transport and money, refugees and asylum seekers, girl-children, people infected or affected by AIDS and AIDS orphans.

Where measures are in place they are either inadequate or do not have sufficient trained health workers to implement them effectively and efficiently. Insufficient funding or the inability to spend available resources also compounds the problem and impedes delivery of quality services.

Policy and programmatic measures

In this section key policies, and programmatic measures will be examined in the light of the NDH's stated goals. In this reporting period there are few new policy measures. The most notable one is the one on AIDS. Most of the programmes and projects are aimed at accelerating or improving quality of care at the primary level. This is in line with NDH's five year strategic plan, *The Health Strategic Framework 1999-2004: Accelerating Quality Health Service Delivery* which proposes that the next five years will be devoted to the implementation of efficient service delivery. The Strategic Plan outlines a ten point programme which identifies the areas in which quality service is to be delivered over the next five years:

The Health Strategic Framework 1999-2004: Accelerating Quality Health Service Delivery.³⁴

1. Decreasing morbidity and mortality through strategic interventions
2. Revitalisation of public hospitals
3. Accelerating delivery of an essential package of Primary Health Care (PHC) services through the District Health System (DHS)
4. Improving mobilization and management of resources
5. Improving human resource development and management
6. Improving quality of care
7. Enhancing communication and consultation in the health system and with communities
8. Initiating legislative reform
9. Reorganisation of certain support services
10. Strengthening co-operation with international partners

³⁴For the full report see [http://196.36.153.56/Department of Health/docs/policy/framework/index.html](http://196.36.153.56/Department%20of%20Health/docs/policy/framework/index.html). Accessed March 2002.

While it is too early to assess the overall success of the ten point plan, it is possible to make a preliminary assessment on the progress made to date by examining key developments. With regards to *decreasing morbidity and mortality through strategic interventions* the following observations can be made.

The Cholera Outbreak

According to the NDH's Annual Report,³⁵ the worst recorded outbreak of cholera began in August 2000, by the end of March 2001, 81 265 cases had been recorded. The outbreak 'underscored the extent to which poverty and underdevelopment still blight our society is the NDH's view. The low rate of fatalities of 0,22 percent is attributed to the effective response by the KwaZulu-Natal authorities and to the NDH's supportive role.

No mention is made in the NDH's Report of the unavailability of clean drinking water and proper sanitation in the rural areas of KZN and in Alexander township in Gauteng and in other informal settlements where cholera outbreaks occurred. However, the Department of Water Affairs has since undertaken to supply sanitation facilities to under serviced areas.

As a result of the cholera outbreak, emergency medical services have become a provincial responsibility. Formally, local authorities were contracted to deliver on their behalf. This will ensure uniformity of response across provinces. All the provinces had training programmes in place except for Mpumalanga and the North West who were in the process of establishing training colleges.

At the time of writing there were reports of more cholera outbreaks. This indicates that sanitation facilities are still lacking in many areas and that education on prevention has to be stepped up.

Tuberculosis

There were 119 638 reported TB cases. The DOTS programme was being expanded, and by March 2001 there were 134 Demonstration and Training Districts established with cure rate of 60 percent in 2000. Ten districts reported a cure rate of 85 percent while further thirty-one reported a cure rate of between 75 percent and 84 percent. While these are significant gains, the NDH Annual Report does not give any statistics to show the overall reduction of the incidence and infection rate. Since TB is one of the most common opportunistic diseases associated with AIDS it is important to disaggregate cure rates and mortality rates due to TB alone and TB associated with AIDS.

Malaria Control

In 2000 there were 61 934 recorded cases of malaria. Co-Artem, DDT and bed nets sprayed with insecticide have been introduced in the malaria endemic areas of KwaZulu-Natal, the Northern Province and Mpumalanga. In spite of these

³⁵ Statistics are quoted from the National *Department of Health Annual Report 2000/2002*.

interventions, the disease is on the increase and fatalities rose to 423 in 2000. According to the NDH, about R93 million was spent on control in 2000.

Women's Health

The NDH's Report list interventions targeted at the improvement of women's health to include the reduction of maternal mortality rates, expansion of the awareness for screening for cervical and breast cancer. It highlights the fact that trends in maternal deaths pointed to HIV/AIDS being the leading contributor to maternal deaths and inadequate referral systems at primary care level.

TOPS

Safe abortions are legalized but many rural women are effectively without such a service.

Mental Health and Substance Abuse

In accordance with the policy on mental health, de-institutionalisation of persons from psychiatric institutions into the community was initiated but this requires, adequate funding and training for community involvement. A pilot programme at Tower Hospital Eastern Cape is underway and a formal evaluation was scheduled to begin in 2001. No information of the evaluation is currently available from government sources.

Violence prevention and surveillance systems are also being piloted in the Eastern Cape, KwaZulu Natal and Mpumalanga. Violence prevention programmes were being run at nine schools in three provinces and efforts to promote mental health through parent-child bonding in high risk families.

Reducing substance abuse is an intersectoral responsibility. A Central Drug Authority was formed to co-ordinate all activities which include the incorporation of prevention programmes into the Life Skills strategy in secondary schools, research into campaigns to reduce foetal alcohol syndrome and advertising of alcohol-linked sponsorships was being planned. A ten percent reduction of substance abuse was reported.

The department's performance in relation to the ten point programme has been assessed by Erich Buch³⁶ and some of the salient features are discussed below:

According to Buch, the diseases focussed upon are relevant to the health needs of South Africa. While progress is being made in most areas adequate funding, effective resource allocation stakeholder participation is required to scale up targets which start from a low baseline.

As far as the needs of the disabled are concerned there is a huge backlog in the supply of assistive devices . Only 324 wheelchairs, 140 hearing aids and 430 spectacles were

³⁶ For a comprehensive review of the ten point Strategic Framework see Eric Buch, "The Health Sector Strategic Framework: A review" in *South African Health Review* 2000. Also [http:// www.hst.org.za](http://www.hst.org.za) Accessed March 2002.

supplied to provinces to assist their efforts. It is clearly unacceptable that paraplegics have no wheelchairs and the hearing impaired have no hearing aids.

Much planning has gone into the revitalisation of public hospital services but implementation is still not a reality. A uniform patient billing system has been introduced across all provinces. There are approximately 2.8 000 000 public hospital beds per 1 000 population but there is no objective set of criteria in place to guide the suggested number of between 1 million and 3 million per 1 000 population. Overcrowding in hospitals and reports of patients sleeping in corridors and on the floor are common in spite of the introduction of home based care chronically ill patients. Addressing the imbalances of the past by making health care available to all has stretched the resources of the health system which is now facing the additional burden of the AIDS pandemic.

The Acceleration of Delivery of an Essential Package of PHC Services

The establishment of the DHS is still in its early stages and there is much confusion regarding the organisational arrangements and responsibility for service delivery. This is due to the lack of clarity of definition of municipal health services in the Constitution is a stumbling block which is compounded in the rural areas by lack of resources and infrastructure.

A survey conducted by the Health Systems Trust in 2000 looked at 445 clinics, including mobile clinics in all the provinces.³⁷ They found that while there was an improvement, since 1998, in many of the parameters they looked at such as antenatal care, immunisation, family planning, home visits, turn-around times of laboratory tests, availability of condoms, oral contraceptives and penicillin. However, there were serious shortfalls which included the unavailability tests for HIV, pap smear, rhesus and pregnancy tests. There was also a lack of skills updating on TB and STD treatment, lack of piped water, telephones, electricity supply, basic equipment, incineration facilities for medical waste, certain drugs, and TB record keeping was poor. Another important finding was the irregularity of feedback on reports submitted by PHC facilities. Only 52 percent, 27 percent and 46 percent respectively, of fixed, satellite and mobile clinics received regular feedback.

HIV/AIDS

It has been estimated by the joint United Nations Programme on HIV/AIDS and the World Health Organisation (WHO) that more than seventy percent of all human immuno-deficiency viral infections in the world occur in sub-Saharan Africa. In South Africa, there has been an alarming increase in the incidence of AIDS in the last decade. According to the Department of Health, in the year 2000, there were 3.8 million people living with AIDS in 2000 and this figure will rise to 6 million by 2005, which is the fastest growing pandemic in the world.

Life expectancy has been significantly reduced amongst the 15-49 year age group where young women between the age of 20-30 have the highest prevalence rates and

³⁷ Dingle van Rensburg, Renier Viljoen, Christo Heunis, Ega Janse van Rensburg and Annalize Fourie, "Primary Health Care Facilities Survey 2000," *The South African Health Review*, 2000 <http://www.hst.org.za/sahr/2000/>

women under 20 have the highest percentage increase. This translates to early deaths amongst youth and economically active people, which will impact negatively on the economy of the country, not to mention the tragic loss of life and suffering caused to families and AIDS orphans.

*HIV/AIDS/STD Strategic Plan for South Africa 2000-2005*³⁸

The Aids Strategy is a national plan and its implementation involves a range of government departments, local authorities and civil society structures. Oversight of the direction for the AIDS programme is provided by an Inter-Ministerial Committee chaired by the Presidency. The Health Department plays a key role in providing technical guidance and in co-ordinating implementation.

The proposed national strategy to fight the pandemic consists of essentially of four areas: prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance. Youth will be targeted as a priority population groups especially for prevention efforts. The primary goals are to reduce the number of infections and reduce the impact of the disease on individuals, families and communities.

To ensure prioritisation of key objectives the government launched a National Integrated Plan (NIP) to implement key strategic areas: increased information, education and communication; increased voluntary counselling and testing, improved STD management and treatment of opportunistic infections, promote increased use of condoms, improved care and treatment of HIV positive persons and those living with AIDS to promote a better quality of life and limit the need for hospital care.

For effective implementation, the plan proposes monitoring and evaluation in the areas of policy development, institutional strengthening and service delivery where implementing agencies, partners and stakeholders contribute to the accomplishment of policy aims. The plan also proposes research on the cost effectiveness of selected interventions. The following data was extracted from the NDH's Annual Report 2000.

Preventing HIV Infection

The programme is involves social mobilization to increase public awareness of HIV/AIDS, education and communication strategies, condom distribution, effective management of sexually transmitted diseases, ensuring blood safety, promoting voluntary counselling and counselling, exploring viable interventions to reduce mother-to-child transmission of the virus.

The 13th International Conference on AIDS in Durban served to highlight the plight of the African continent where the disease has the highest prevalence. Although the debate around the causes of AIDS was heated, it served to established that poverty and poor health are linked and that poverty is an aetiological factor in many diseases.

The Beyond Awareness Campaign

³⁸ [HIV/AIDS/STD Strategic Plan for South Africa 2000-2005](http://196.36.153/Department%20of%20Health/policy/norms/contents.html) [http://196.36.153/Department of Health/policy/norms/contents.html](http://196.36.153/Department%20of%20Health/policy/norms/contents.html)

R26 million was spent on this programme which involved mass media, tertiary institutions and other organizations. It succeeded in distributing 25 million leaflets, posters, and other items and boosted the AIDS help line calls by 32 percent. 250 million condoms were distributed in 2000/2001 and it documented social factors that shape teenage response to the disease. An information system to manage the logistics of condom distribution has also been put in place.

The School Life skills Programme

This is major effort to educate the youth on prevention in schools. Models for community based care, the care of orphans and strengthening the capacity for voluntary counselling received R75 million. This does not indicate whether these programmes were monitored and how effective they were.

Sexually Transmitted Infections

Through the antenatal surveillance system, the incidence of syphilis has been halved in the last two years but other STIs have not shown a similar decline. This is of particular concern since HIV infection has a high correlation with STI prevalence. In fact, the incidence of HIV has increased dramatically.

Treatment, Care and Support

Guidelines for care and treatment were established in order to train health workers in their use, but no data is available on the effectiveness of these interventions. Since TB is one of the major opportunistic infections associated with HIV, and since TB already has a high prevalence rate in South Africa, an integrated strategy was piloted in four provinces.

Voluntary Testing and Counselling

According to the NDH Annual Report, this strategy was successful: the number of patients testing for HIV quadrupled, 99 percent of returned for their test results, and more than one out of three received drugs to prevent active TB. It can only be assumed that the NDH considers the increase in the number of people testing for HIV and TB a positive development in so far that they would now be treated under the pilot project whereas previously they would have gone undetected.

The challenges of providing affordable drugs to fight HIV and opportunistic infections are huge for poor and middle income countries. However, Pfizer entered into a partnership with the government to supply fluconazole free for two years to treat cryptococcal meningitis and oesophageal thrush- two common opportunistic infections in immune deficient patients. The government, sceptical of the long-term efficacy of triple ARV treatment, began to develop guidelines, but no universal roll out of ARVs nor were short course treatment of Neviripine for the MTCT or PEP

programmes instituted. The government has argued that 18 pilot projects were testing the efficacy of Neviripine and that universal roll out was not affordable.³⁹

Community Based Care, including Orphans

Given the shortage of hospital beds and limited capacity in the public sector, it was impossible to give palliative care for extended periods and home-based projects are an alternative. Lack of trained personnel and budget constraints remain a major impediment to the success of this programme.

Research, Monitoring and Surveillance

The most important initiative is government's commitment of R10 million to research efforts in developing an AIDS vaccine appropriate to all strains prevalent in South Africa. Although significant advances have been made, no vaccine has yet been developed. Annual ante-natal surveys to establish the prevalence of HIV and syphilis has been successful and the model has been adopted by WHO. Surveillance will in future encompass establishing incidence as well as prevalence, surveying sentinel sites and establishing trends in social and sexual behaviour. Increased use of condoms and declining rates of STD infection has been shown amongst sex workers in Gauteng and the Free State, but not amongst the target group of youth.

Human and Legal Rights

The focus is on advocacy campaigns to achieve an environment of tolerance and minimize the stigma attached to people living with HIV/AIDS. The governments AIDS Action Plan "Men make a difference" to the containment of AIDS was a response to the disempowered status of women in South Africa, their subservient position, the prevalence of cultural machismo and the high rates of sexual violence and rape.

Despite the creation of one of the most comprehensive policies and enabling legislation in the world, South Africa has not succeeded in implementing these plans sufficiently to make an impact on the reduction of the prevalence of HIV/AIDS and deaths due to the disease. What then are the factors which contribute to the failure to stem the tide of the pandemic? Some of these which can be identified include poverty and inequality of access to adequate prevention and care. This also includes the inability to access adequate and nutritious food by the poor and indigent. Another factor is the uncertainty and confusion restructuring of the public sector, a high turn over of medical staff, lack of capacity and commitment, lack of strong leadership and the failure to mainstream HIV activities at all levels of society.

While South Africa has made huge strides in the area of policy and the introduction of a universal health system, the AIDS pandemic currently ravaging South Africa and sub-Saharan Africa has had a negative impact on the already scarce resources available to the state to provide access to health for all. The World Health Organisation's (WHO) goal of Health for All by the Year 2000⁴⁰ remains a distant

³⁹ At the time of going to print the government was ordered by the Constitutional Court's ruling to roll out Neviripine at all public health care facilities. See the Introductory chapter of this Report for details

⁴⁰ WHO Global Strategy Health for All by the Year 2000. <http://www.who.org>.

goal. It is estimated that the number of deaths worldwide is higher than the sum of lives lost in both world wars. HIV prevalence in South Africa has risen from 0.7 percent in 1990 to 24.5 percent in 2000. Despite a comprehensive HIV/AIDS plan there has been a continuous increase in the prevalence rate indicating the inadequacy of the implementation of the plan.⁴¹ Life expectancy has fallen from 67 years to 53 years in the same period.

The AIDS pandemic impacts negatively on sectors such as education, housing, agriculture, transport, the economy and security as it affects the economically active population. It is a sad fact that South Africa has one of the highest incidences of violence against women and rape. Both are gender issues and need to be addressed effectively. The "Men make a difference" campaign focussed on the role of men in our society. However, in order to change power relations between women and men will require more than one campaign it requires on going education as well as structural changes in society. Changing the power relations between the sexes, societal denial, stigmatisation, and the lack of an effective human rights approach to the problem are other important factors which have not been adequately addressed. What is required is first of all an acceptance of the enormity of the problem and a recognition of the enormous costs in terms of human lives, the cost to economic development and the negative impact on development plans such as NEPAD, not only locally but in sub-Saharan Africa.

Budgetary measures

In his review of the Strategic Framework, Buch⁴² outlines the fault lines in the assumptions made by the NDH which provide some insight into some of the reasons of why the department has not been able to achieve stated goals in the proposed time frames. The first assumption regarding the availability of sufficient financial resources, financial stability and the absence of unfunded mandates is cited here since it is crucial to the success of implementation plans:

⁴¹ Chris Kenyon, Mark Heywood and Shaun Conway, "Mainstreaming HIV/AIDS: Progress and Challenges" in *South African Health Review 2001*, Health Systems Trust, 2001, p. 163.

The assumptions made by the NDH are:

- The availability of sufficient financial resources, the assurance of financial stability during and between years and the absence of unfunded mandates
- The ability to train, retrain, retain and deploy health personnel as needed
- Removal of legislative and other obstacles so as to implement more responsive management systems and an appropriate workforce configuration
- Solid co-operation from all partners, notably other national departments, provincial and local government, the private sector, non-governmental and community based organisations and communities
- The ability to reverse the HIV/AIDS epidemic

⁴² For a comprehensive review see Eric Buch "The Health Sector Strategic Framework: A review" in *South African Health Review 2000*, 68.

This assumption has arisen out of the experience of funding not matching requirements for services, decreases in real health expenditure and expectations of meeting decisions that have financial implications from savings, rather than from an additional fiscal allocation, such as was the case with rank and leg promotions. The financial pressures are not just from the complex inheritance,

limitations on and of management and inadequate controls on spending, but seemingly also from under budgeting for desired services. The question of "sufficient financial resources" raises the question of what "sufficient" is. Unless it is a tactical decision not to, it could have been expected that a sector strategic framework would broadly spell out what it requires to meet its responsibilities, and develop a case to sustain this... In the ongoing negotiations with the national and provincial Treasuries and political decision-makers the core issues need to be opened up clearly for those not familiar with the complexities of health economics and financing.

One of the most important factors impeding the realisation of stated goals of the Strategic Framework is undoubtedly, financial constraints. According to the Director General of Health, financial constraints have created a difficult context for redistribution of resources. Since 1997/1998 there has been a real decline in real per capita spending on health.⁴³ In addition the gaps between comparative spending in provinces have grown wider.

According to Whelan, most provinces plan to increase their total spending on health on real terms over the period starting in 1999/2000 and ending in 2003/2004 but despite these real increases, there continues to be a great deal of variation between provinces. For the period 2000/2001, provinces with a well-established set of health facilities, inherited from the past, continue to allocate over 20 percent of their discretionary funds on health, while the poorer provinces allocate between 16 percent and 17 percent.

Per capita discretionary health spending shows similar trends. Gauteng and the Western Cape were above the average per capita measure (32 percent and 25 percent respectively) while the other provinces were between 10 percent and 20 percent below the average. All provinces except the Western Cape plan to reduce spending on personnel when they lack management tools. This may have a negative impact on service delivery. Capital spending is projected to increase. Over 50 percent of total health budgets are spent on DHS by provinces who have substantial hospital complexes.⁴⁴ An important gap identified in budgetary information is the actual or proposed spending on HIV/AIDs.

For the period 2001/2002 the variation in the shares received by health across provinces retains the same pattern as outlined above. Mpumlanga and the Northern Cape are planning the fastest real expansion of 5.2 percent and 3.7 percent respectively, while the Northern Province and the North West are planning more

⁴³ A. Ntsaluba, 'Director-General's Review' *Department of Health Annual Report* (2000/2001).

⁴⁴ Paul Whelan, "A Review of Provincial Health Budgets 2001" <http://www.idasa.org.za/bis> Accessed December 2002.

modest expansion. The Eastern Cape is planning to cut its budget 2.3 percent per year. KwaZulu-Natal and the Western Cape small real decrease over the period from 2001/2002 and 2004/2005. This means that health's share in total provincial spending declines from 22.8 percent to 21.3 percent.

The national average per capital discretionary spending is highest in Gauteng, KwaZulu-Natal, the Northern Cape and the Western Cape while the Eastern Cape moves from 7.7 per cent to 6.5 percent, which is a cause for concern, given that the Eastern Cape is one of the poorer provinces with huge problems in service delivery. Real concerns have also been raised about the Eastern Cape's budget between 2001/2002 and 2002/2003 regarding the large real decreases projected in total health, personnel, district health, and medicines which calls into question the credibility of this budget.⁴⁵

Furthermore, the fact that there are huge inequalities among the nine provinces with regard to the adjusted provincial expenditure on health, means that delivery of PHC and other programmes is highly variable among provinces. By way of example, Table 4 shows that while the Gauteng Department of Health an average of R6 million in 2001 and 2002, the Limpopo Department of Health only spent an average of R2 million. There is also a wide gap in per capita allocation across provinces

Another factor is under-spending of allocated funds by some departments. The overall effect is that the goals of equity and access to care are indeed not within reach in the proposed time frames. This holds true for all the programmes outlined in Strategic Framework.

Other factors identified by the NDH relating to implementation difficulties include stigmatisation by communities of mental health patients and PLWAs, the Telemedicine Policy was stalled due to lack of digital lines in rural area, the lack of trained staff, the high attrition rate of health care workers, financial constraints, lack of adequate infrastructure especially in rural areas and poor communication between management of and health workers and the high expectations placed on overburdened staff. Similar difficulties were identified at the provincial sphere.

The Gauteng Department of Health reported that it lacked systems to measure baseline information for monitoring and evaluating progress on implemented measures. It also reported a shortage of specialist skills in public health, nutrition, planning and financial management. In addition to these the Limpopo Department of Health reported low staff morale while the Western Cape Department of Health reported lack of coordination of information flow.

8. RECOMMENDATIONS

The reporting by national and provincial departments of health can be much improved. The previous reports ESR Reports of the SAHRC have identified the poor quality of government reporting as an impediment to carry out its mandate. It is crucial that departments put in place a mechanism to deliver reports of a high quality. It is suggested that the national and provincial departments of Health appoint an

officer, trained in a human rights approach to health care provision, to oversee their responses to the SAHRC's protocols. The person tasked with this responsibility will ensure that the response from the department is of a high quality by ensuring that the information requested by the SAHRC is gathered during each monitoring period and is available when requested.

Since many of the departments indicated that their databases were not designed to collect much of the information requested it seems appropriate that the SAHRC should meet with the NDH so as to reach a common understanding of the type of information which departments are able to provide.

The cholera outbreak shows that preventative measures for the eradication of cholera, malaria, STIs and other endemic diseases must be put in place and be closely monitored. Department of Water Affairs and the Department of Health at the three spheres of government need to work in close cooperation to avoid further outbreaks, and deaths due to cholera are avoidable.

Capacity building at the administrative level and retention of professional health care workers should become a priority. One of the ways to retain doctors, nurses, and other professionals is by providing incentives such as competitive salaries and benefits and generally to improve the conditions of work and the availability of adequate infrastructure, drugs and other resources for an improved standard of service delivery.

Measures to stamp out maladministration, corruption and theft must be introduced and strictly adhered to.

Inter-governmental cooperation at the three spheres of government must be streamlined and the responsibilities of each must be clearly demarcated.

The capacity of NGOs and CBOs to provide home-based care should be increased by injecting sufficient funds and trained personnel. Access to health care should be made more effective and the number and frequency of mobile clinics should be increased especially in remote rural areas.

Many of the difficulties experienced by the government departments have been identified in the previous ESR Report. It is essential for government departments to address these challenges by putting effective mechanisms in place in order to delivery effective and quality health care to all.

HIV/AIDS

The Constitutional Court's ruling regarding the treatments of HIV positive mothers and their newly born infants must be implemented immediately. A National Action Plan for the universal access to ARVs should be government's top priority and it is highly recommended that the National Budget reflect this. The urgency of reducing new infections and treating people living with AIDS requires not only political commitment but additional funding to tackle this pandemic which is affecting the lives of millions of South Africans especially the very poor whose right to health care and human dignity are being jeopardised.

A culture of caring needs to be instilled so that a human rights approach falls on fertile ground not only amongst citizens but especially amongst care givers in all sectors of all society. Most importantly, life style changes and sexual behaviour patterns must be changed. Women and girls must be empowered and be regarded as potential victims of abuse. Leaders from all sectors of society must exert their influence in the call for a moral regeneration in our society.

The National Department of Health should lobby more vigorously for the health envelope to be increased during the budget process since financial constraints remain a major obstacle to service delivery. It is also incumbent on the Minister of Health and MEC's for Health to impress a rights based approach to health budgets at both the national and provincial levels.

The provision of the right to health care is possible only if the pandemic is contained since available resources are not sufficient to provide universal quality care. Government, corporations and other stakeholders in the health sector need to take decisive steps to combat the spread of AIDS and to minimise the loss of life.⁴⁶ This can only be made possible if all role players and stakeholders adopt a human rights approach.

9. CONCLUSION

The democratic government, after 1994, set itself the task of transforming the fragmented health system inherited from the apartheid era, into a single National Health System, based on equity and accessibility to all. Substantial progress has been achieved in establishing a Primary Health Care System (PHCS); bringing health care to many previously under serviced areas;⁴⁷ and the introduction of a District Health System. Enabling legislation has been passed in support of these measures including the regulation of medical schemes. Many changes in processes of restructuring have resulted in a state of uncertainty and flux. In some instances, the roles and responsibilities of the different spheres of government are still unclear leading to delays in service delivery.

Policy and other measures introduced during this reporting period are significant steps taken towards the progressive realisation of the right to health care services. These conform to international best practice. The introduction of the National Health Bill is especially to be welcomed since this will provide a framework legislation binding all stakeholders involved in the provision of health care. However, implementation difficulties in all the provinces remains a challenge especially in the providing access to the poor rural communities. The goal of equity and implementation of quality and efficient service delivery in the public sector remains to be realised. In his judgement in the *Grootboom* case, Justice Yakoob stated that:

Policies and programmes must be reasonable both in their conception and their implementation. An otherwise reasonable

⁴⁶ See the United Nations report. [http:// www.who.org](http://www.who.org)

⁴⁷ See 1st, 2nd and 3rd Economic and Social Rights Reports, (1999, 2000, 2001), SAHRC for a comprehensive discussion on right to health up to 31st March 1999.

programme that is not implemented reasonably will not constitute compliance with the State's obligations.⁴⁸

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-retro Viral drugs
CS	Cervical Screening
DOTS	Directly Observed Treatment Short-Course
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant of Economic, Social and Cultural Rights
IMCI	Integrated Management of Childhood Illnesses
INP	Integrated Nutrition Program
MCC	Medicines Control Council
MEC	Member of the Executive Committee
MTCT	Mother-to-child transmission
MTEF	Medium-term Expenditure Framework
MDN	Maternal Death Notification
NDH	National Department of Health
NDP	National Drug Policy
NGO	Non-Governmental Organisation
NHISA	National Health Information System of South Africa
NHLS	National Health Laboratory Services
NHS	National Health System
PEP	Post Exposure Prophylaxis
PFMA	Public Finance Management Act
PHC	Primary Health Care
PHCS	Primary Health Care System
PLWA	People Living With AIDS
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TB	Tuberculosis
TOP	Termination of Pregnancy
UN	United Nations
UDHR	Universal Declaration of Human Rights
VCT	Voluntary Counselling and Testing

⁴⁸ *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC), para 42.

WHO

World Health Organisation

Provinces of the Republic of South Africa

EC Eastern Cape

FS Free State

GT Gauteng

KZN KwaZulu-Natal

LO Limpopo

MP Mpumalanga

NC Northern Cape

NW North West

WC Western Cape