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PREFACE

In this 10th year of our young but thriving democracy, we are all engaged in some way or the other, in critically reflecting on the achievements we have secured over the past years as well as the unfinished work that lies ahead. In the context of the various rights guaranteed by our Constitution, they seek in their totality to ensure that the individual and the society are able to develop to their full potential and indeed that human rights becomes a central feature of our society. In this regard we have made much progress, and in the main, few argue against the notion that civil and politcial rights are well secured both in law and in practise.

However, the challenge that is situated at the heart of our Constitutional contract is how we advance social and economic rights and in so doing ensure that we advance the interests of the poor and those many who are still to enjoy the full benefits of our democracy. The inclusion of social and economic rights in the Bill of Rights was a clear articulation that democracy was as much about the right to vote, and of free expression and of association as it was about the right to shelter, the right to food, the right to health care, the right to social security, the right to education and the right to a clean and healthy environment.

The Constitution has tasked the Commission with a specific mandate to advance social and economic rights. In particular, section 184(3) requires that: "Each year the Human Rights Commission must require relevant organs of state to provide the Commission with information on the measures that they have taken towards the realisation of the rights in the Bill of Rights, concerning housing, health care, food, water, social security, education and the environment."

A healthy and robust debate exists around these measures that the Constitution requires the State to take. In addition, the human rights discourse sees considerable contestation around issues such as the nature and scope of the right, the adequacy or otherwise of the measures taken and the meaning of the phrase 'progressive realisation of rights.' These are difficult issues and it is not always possible, nor may one say desirable, to always have consenus on them. In some instances the Courts have had to rule on them. We see this Report, however, not only as a contribution to those debates but also as a tool that can assist Government, Parliament and civil society in developing a critical understanding about social and economic rights and their implementation.

The modus operandi of the Commission in discharging its constitiutional mandate to monitor and assess the observance of economic and social rights has in the main focussed on requiring organs of state to report to us on measures they have taken. This continues to pose several challenges, namely: to ensure that organs of State submit to the Commission reports that are timeous, accurate and of good quality . We are pleased that good progress has been made on this front over the past year and the process of presenting draft reports to organs of state and civil society for comment has been most valuable to the Commission in finalising this report .

The launch of the 4th Economic and Social Rights report in April 2003 generated considerable interest and much debate and discussion on the Report ensued. We were invited by numerous parliamentary portfolio commiteees from the National Assembly and National Council of Provinces to present the Report. We certainly found the engagement with Parliament a very useful and mutually rewarding exercise. It provided the Commission with a unique opportunity to share its thinking and vision around its work

with Parliament while it enables us to better understand Parliament's expectation of the Report and its use to them as a tool in their work. There have been numerous valuable recommendations that have emerged from our presentations to Parliament which we are committed to giving effect to from our side.

So as we commence the beginning of the 2nd decade of our democracy the delivery of social and economic rights become crucial to the ongoing success of our nation and the entrenchment of a culture of human rights. It is certainly our hope, and the intention of this Report, to contribute to ensuring that the promise and the vision underpinning our Constitution is shared and enjoyed by all in our country.

Jody Kollapen

Chairperson - South African Human Rights Commission

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INTRODUCTORY SECTION

The aim of the *Introductory Section* is to provide an outline of the common analytical framework used in the reports, briefly discuss the political and economic context of the year under review, and provide an integrated summary of the key findings and recommendations of all eight reports in the series. Details of the report production process are also included at the end of this introduction.

The 5th Economic and Social Rights Report follows a more user friendly format than previous reports. There are now separately bound, less bulky, reports on Land, Water, Environment, Food, Health, Social Security, Education and Housing. Each report has an executive summary to facilitate access to the main findings and recommendations. Issues that connect one right to another are highlighted in the body of each report to emphasise the interrelatedness and interdependence of the rights in the Bill of Rights of the Constitution of the Republic of South Africa Act 108 of 1996 (simply referred to as the Constitution throughout the reports).

A) Analytical Structure and Framework

Each report in this series follows a basic structure:

1. **Introduction**: a discussion of the meaning and content of the right with reference to the Constitution, case law and relevant international human rights instruments.

2. **Progress in the realisation of the right**: a factual description of measures instituted by government during the period under review and their impact, especiallly on vulnerable groups.

3. **Challenges for the realisation of the right**: a description of key challenges that hamper the realisation of the right, and in some cases, government's response to these challenges.

4. **Critique of measures instituted**: a consideration of some of the shortcomings of the measures instituted by government.

5. **Recommendations**: a set of recommendations that may encourage progressive realisation of the right as expeditiously as possible.[1]

Each report consolidates information from various sources including: relevant government protocol responses, government Annual Reports and Strategic Plans, the Intergovernmental Fiscal Review, as well as research funded by government, international donors or other agencies.

All reports employ the standard of reasonableness as laid down in the *Grootboom*[2] and *TAC*[3] judgements of the Constitutional Court, in conjunction with relevant international human rights instruments.

1 Some reports in the series end with a conclusion.

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

The constitutional provisions pertaining to socio-economic rights require the State to "take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of [these rights]".[4] This requirement, read with the provision on the obligation of the State to "respect[5], protect[6], promote[7] and fulfil[8] the rights in the Bill of rights" in section 7(2) of the Constitution ensures an effective guarantee of socio-economic rights in South Africa. The judicial enforcement of these rights by the courts and the constitutional mandate of the South African Human Rights Commission to monitor and assess the observance of the rights by the State[9] and non-State entities also contribute to the effectiveness of the constitutional guarantee of these rights.

The Constitutional Court has played a significant role in ensuring the effective guarantee of socio-economic rights in our country. On the obligation of the State, Judge Yacoob held in the *Grootboom* case:

> *The State is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing.*[10]

On the effective guarantee of basic necessities of life for the poor, Judge Yacoob further said:

> *This case shows the desperation of hundreds of thousands of people living in deplorable conditions throughout the country. The Constitution obliges the State to act positively to ameliorate these conditions. The obligation is to provide access to housing, health-care, sufficient food and water, and social security to those unable to support themselves and their dependants. The State must also foster conditions to enable citizens to gain access to land on an equitable basis. Those in need have a corresponding right to demand that this be done.*[11]

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3 Minister of Health and Others v Treatment Action Campaign and Others (1) 2002 (10) BCLR 1033 (CC)

4 See sections 26(2), 27(2) and 29(2) of the Constitution.

5 Respect is a negative obligation, which requires the State to refrain from denying or limiting equal access for all persons to the enjoyment of the rights. This also means that the State should abstain from carrying out, sponsoring or tolerating any practice, policy or legal measure which violates the integrity of the individual or which in any way interferes or limits his/her right to pursue the enjoyment of the rights in the Bill of Rights.

6 The obligation to protect places a positive obligation on the State to prevent the violation of any individual's rights by a third party.

7 The obligation to promote places a positive obligation on the State to create a conducive atmosphere in which people can exercise their rights and freedoms by promoting awareness of their rights through public education.

8 The duty to fulfil places a positive obligation on the State to institute active measures that enable each individual to access entitlements to the right and which cannot be secured through exclusively personal efforts. State parties are also obliged to provide a specific right when an individual or group is unable, for reasons beyond their control, to realise the right themselves by the means at their disposal. e.g. people in disaster situations or those in dire need.

9 See sections 184(1) and (3) of the Constitution.

10 Government of the Republic of South Africa and Others v Grootboom and Others 2000(11) BCLR 1169 (CC) [24]

On the role of the courts in ensuring that the State fulfils its role in giving effect to these rights and thus ensuring that there is an effective guarantee of these rights, Judge Yaccob said:

> *I am conscious that it is an extremely difficult task for the State to meet these obligations in the conditions that prevail in our country. This is recognised by the Constitution which expressly provides that the State is not obliged to go beyond available resources or to realise these rights immediately. I stress however, that despite all these qualifications, these are rights, and the Constitution obliges the State to give effect to them. This is an obligation that Courts can, and in appropriate circumstances, must enforce.*[12]

A similar position was taken by the Constitutional Court in another seminal judgment, *Minister of Health and Others v Treatment Action Campaign and Others*, where the Court held:

> *The state is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflicts our society. The courts will guarantee that the democratic processes are protected so as to ensure accountability, responsiveness and openness, as the Constitution requires in section 1. As the Bill of Rights indicates, their function in respect of socio-economic rights is directed towards ensuring that legislative and other measures taken by the state are reasonable.*[13]

In outlining the role of the courts, the Court also stated:

> *The primary duty of courts is to the Constitution and the law…Where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to do so.*[14]

While there might be some criticism directed at the Constitutional Court pertaining to the determination of when there are no available resources for the State to fulfil its obligation pertaining to socio-economic rights, the courts, particularly the Constitutional Court, have and will continue to play an important role in ensuring that the provisions in the Bill of Rights are effectively guaranteed for our people.

B) The Political and Economic Context of the Year Under Review

The period under review, 1 April 2002 to 31 March 2003, followed the 11 September 2001 attacks and a 24% depreciation of the South African currency (Rand) near the end of 2001. Consumer Price Inflation, especially for goods and services bought predominantly by the poor, increased sharply to the highest level since 1994. Concerns were signalled to the Competition Commission about the impact of import parity pricing in several sectors of the economy, most notably in food production, processing and retailing as well as metals and engineering. Interest rates were raised in an attempt to curb inflation, with a

11 Ibid., [93]

12 Ibid., [94]

13 Minister of Health and Others v Treatment Action Campaign and Others (1) 2002 (10) BCLR 1033 (CC) [36]

14 Ibid., [99]

subsequent dampening effect on the rate of economic growth in the latter part of the financial year. According to the Reserve Bank Quarterly Bulletin for March 2003, economic growth stood at a robust 3% in 2002.

As a result of prudent fiscal management, the government introduced a more expansionary Budget in February 2002. Total government expenditure increased from R262,6 billion in 2001/2002 to R291,8 billion in 2002/2003. Overall, the budget directed more resources towards reducing poverty and vulnerability, improving education and training, developing skills amongst the youth, building and enhancing physical infrastructure and basic municipal services, as well as making communities safer places to live, work and play.

It is also important to note that the February 2003 Budget provided for significantly greater expenditure than the previous year. Total expenditure was R331,7 billion for 2003/2004. The additional allocations accomodated substantial policy changes for all three spheres of government and also provided for *higher than anticipated inflation in 2002*.

By the end of the reporting period in March 2003, the Rand had appreciated by 18%. This created concern about the job losses that could arise out of an increase in import competition. Therefore, during the period under review, the goals of progressively realising economic and social rights took place in the context of significant macro-economic volatility, inflation and an expanding government budget.

C) Key Interrelationships Amongst Economic and Social Rights

The Right to Land

The State was responsible for achieving progressive realisation of the right to land during the reporting period. The Commission demonstrates that there was a year on year improvement in land delivery performance by the State, especially through the Land Restitution and Land Redistribution sub-programmes. Improvements in rural tenure reform were less noticeable.

Between 2000 and 2001 there were 12 094 settled Restitution claims, while in February 2002 there were approximately 32 000 settled claims. By March 2003, there were 36 488 settled claims recorded. Although the majority of these claims were in the urban areas, settled rural claims show a substantial increase. The people working on the Land Redistribution for Agricultural Development sub-programme delivered 103 682 ha against a target of 81 555 ha for the year under review. Whereas the Department had targeted to benefit 3 601 people, the programme ended up benefiting 6 170. Concerning tenure reform, the State initially delivered 30 000 ha of land through 201 projects. Beyond that, the State is working towards bringing the Extension of Security of Tenure Act (ESTA) and Labour Tenants Act (LTA) together in the Consolidated ESTA/Labour Tenants Bill.

Throughout the report, the Commission reflects on the demand, voiced by landless people and others, that the pace of land redress is too slow and inattentive to vulnerable groups. The report recommends accelerating land reform to meet its new targets by relieving budgetary constraints and the associated problems of personnel shortages, lack of quality training and understandable communication; land acquisition; and improvements in monitoring and evaluation.

The Commission would also like to highlight that it was informed by the Department of Land Affairs that it was impossible to represent the racial and gender composition of land purchase transactions and repossessions, according to the size and value of land parcels.

The Right to Education

The right to education is analysed as a continuum of three bands of schooling- General Education and Training, Further Education and Training and Higher Education and Training. The State instituted measures to respect, protect, promote and fulfil the right to General Education and Training, and in the Commission's overall assessment, it succeeded in achieving progressive realisation of this right.

The Department of Education succeeded in ensuring that all targcoeted Early Childhood Development sites for children between the ages of five and six were operating. However, the Department acknowledges the challenge, which has budgetary implications, that only 13% of all children have access to the programme. In the context of a substantial increase in the rate of student enrolment in primary schools between 1994 and 2001, the National Department focused on further increasing access to General Education and Training through reviewing public school financing and the system of school fee exemptions. The report highlights the shortcoming that some schools and Provincial Departments of Education failed to make parents aware of the school fee exemption.

While progress was made in eliminating instances where learners are forced to receive education in environments that are not conducive to teaching and learning, the report emphasises that more needs to be done to address infrastructure backlogs, especially when it comes to water and sanitation. The Department also made progress in developing a redistribution model for personnel and operating expenditure that would achieve equality of teaching quality and equality of learning outcomes in the schooling system from 2003/2004 onwards. All stakeholders in education, including the SAHRC need to explore and come up with a definition of quality basic education which could be measurable and relatively easy to monitor.

Conditions in farm schools were identified as hinderance to progress in the realisation of the right to General Education and Training. The issue of street-children also has to be given some serious attention by all the relevant stakeholders. Amongst other recommendations to further observance of the right to General Education and Training, the report calls for better-published medium term strategies and improved spending on Adult Basic Education and Training. In the 2001 Census, 4,5 million people aged 20 years and older did not have a formal education and 4 million people had primary schooling only.

Most of the developments in the Further Education and Training band met the Constitutional requirement to respect, protect, promote and fulfil the right. *Dinaledi*, the programme that seeks to improve participation and performance of learners from historically disadvantaged backgrounds in Mathematics, Science and Technology (MST), reportedly surpassed its target of 10% of students enrolling for MST in its first two years of implementation. The development of Recognition of Prior Learning (RPL) is another development that contributes to the realisation of the right to Further Education and Training. RPL recognises non-formal and/or non-academic education. RPL also stands to maximise learning opportunities for those without formal and/or academic qualifications to acquire formal qualifications in Further Education and Training institutions, which must all be registered with the State.

Areas where the State fell short of its obligations to progressively realise the right to Further Education and Training include: insufficient public education on school fee exemptions and insufficient Learner Support Materials and/or their late delivery. The report also highlights that participation rates in education by girl learners were being negatively affected by girls' involvement in income generating activities.

While Higher Education and Training is not explicitly recognised as a right in the Constitution, it obviously depends on the learning outcomes achieved in General and Further Education and Training. Here, there seems to be room for improvement as the average graduation rate for university and technikon students is 15%; less than half the ideal average of 33%.

Key challenges associated with the Higher Education and Training band include assisting potential students with subject selection choices and career guidance at school and university level, as well as lowering the high costs of accessing higher education and applying to different tertiary institutions. The report recommends ensuring that admission requirements to tertiary institutions are transparent and fair, promoting indigenous languages as academic/scientific/legal languages, mobilising funds for bridging courses and improving access for mature and post-graduate students, including part time students.

The Right to Water

Ever since 2001 and the introduction of Regulations Relating to Compulsory National Standards and Measures to Conserve Water, the State instituted a national measure to fulfil the right to water by supplying 6000 litres of free, clean water, per household per month, otherwise known as Free Basic Water.

During the reporting period, approximately 1,6 million people gained access to improved piped water supplies through Department of Water Affairs and Forestry's Community Water Supply and Sanitation Programme. Approximately 65 thousand toilets facilities were constructed during the reporting period under the same programme, but it should be noted that these figures exclude the large number of sanitation facilities that were delivered as part of the State's housing programmes. Less than 530 000 households also benefited from water and sanitation projects through the Department of Provincial and Local Government's Consolidated Municipal Infrastructure Programme. Although the above indicates that the roll-out of water and sanitation infrastructure is proceeding towards the Department's medium delivery targets, the report raises concerns about the level of dysfunctional infrastructure and projects, especially in rural areas.

At the end of the reporting period in March 2003, access to Free Basic Water by poor people stood at 38% or approximately 12,2 million people. Access to Free Basic Water by non-poor households stood at close to 100% or approximately 14,2 million people. A large number of poor people (19,6 million) were still to receive their Free Basic Water allocation. Where Free Basic Water was not available, the average cost of 6 kilolitres (kl) was approximately R13 per month. The price for 6kl of life-line supply was highest in Limpopo province at approximately R19 per month. Gauteng and KwaZulu-Natal also had comparatively high average charges for life-line supplies where Free Basic Water services were not operational.

In order to remove these glaring inequities in Free Basic Water provision, the report calls for an urgent revision of the pricing system to include a significantly greater level cross-subsidisation from high volume water users to low volume users in the 0-6 kl range.

More support and funding is required to assist municipalities with capacity problems in implementing Free Basic Water. During droughts, local governments should ensure that Free Basic Water supplies for domestic users are assured and that a situation cannot develop where agricultural, mining and industrial users are allocated large volumes of water at similar prices to low-volume users.

The report describes some aspects of the devolution of domestic water quality monitoring and testing from Provincial Departments of Health to local munipalities and calls for rapidly providing sufficient funds for water quality monitoring to prevent serious disease outbreaks and illness.

The report recommends that the Department of Water Affairs and Forestry (DWAF) should take a leading role in making sure that farm dwellers, residents near commercial farms and poor households in rural and urban areas access clean water and proper sanitation services. DWAF should also ensure that it develops and implements a plan to address the specific problems of water access experienced by people living with HIV/AIDS.

The report suggests that monitoring bodies should be created at local level to effectively monitor the implementation of policies and laws aimed at fulfiling the right of access to water. The report warns that monitoring will be only be effective if monitoring bodies from local, regional and national spheres work together. Where possible and when possible, the Free Basic Water allocation should be increased to cater for higher levels of domestic water consumption. A 50kl water allocation per household per month would bring South Africa's Free Basic Water allocation into the 'low level of health concern' range defined by the World Health Organisation.

The Right to Health Care

The report on the right to health care focuses on key developments in three key health programmes of the State (Health Service Delivery, Strategic Health Programmes and Administration). Although the policy and legislative measures developed in the fiscal year under review can be said to be “reasonable” in their conception, there remain large gaps in implementing them in a manner such that all the provinces, urban and rural peoples, rich and the poor have equal access to the same high quality of care.

The three most important, and universally acknowledged, indicators to measure the health status of a nation are Life Expectancy at Birth, the Maternal Mortality Ratio, and the Infant Mortality Rate. Life expectancy has fallen from 56 years in 1996 to 52,5 in 2002 and is projected to fall to 47 by 2005. The infant mortality rate has increased from 45 in 1998 to 59 in 2002. This means that more children under the age of one died in 2002 as compared to 1998. The under five-mortality rate has risen from 61 in 1998 to 100 in 2002. Similarly, the maternal mortality ratio shows a steady increase since 1998 and is estimated to be 150 per 100 000 live births. The National Department of Health, as well as independent researchers, have concluded that this is due to HIV/AIDS related deaths.

The single most important challenge that government faces is the one posed by the AIDS pandemic and the high incidence of opportunistic diseases such as tuberculosis. It is estimated that about one tenth of the population of the population is infected with the HI virus i.e. close to 5 million people. The number of AIDS orphans is estimated to be one million. In a landmark case instituted by Treatment Action Campaign against the Minister of Health, the Constitutional Court, in 2002 confirmed the finding of the High Court that

government's policy to limit Nevirapine to research and training sites was in "breach of the States obligations under section 27(2) read with 27(1)(a) of the Constitution." The report recommends that the Comprehensive National Aids Plan should be rolled out effectively in all the provinces so as to meet targets and timelines in order to substantially reduce new infections and to prolong the lives of those already infected.

In spite of the fact that policies and programmes directed at improving the health status of the country have been put in place such as the Integrated Management of Childhood Illnesses, the AIDS pandemic continues to be the single most cause of death in South Africa. This has placed an enormous strain on an already overburdened health system and undermines the efforts made by the State. This is compounded by the fact that the other economic and social rights, which contribute substantially to the health status of a nation, are also not fully enjoyed by the vast majority of poor South Africans due to the huge backlogs inherited from the past. Inadequate housing, poor sanitation, overcrowding, lack of clean drinking water, lack of efficiently run social services, insufficient nutrition and health education exacerbate the diseases of poverty. Moreover, a household that is affected by AIDS contributes to depleting the financial resources available to the family, thereby increasing the level of poverty.

government developed legislative and other measures to comply with its constitutional obligations in terms of section 7(2) of the Constitution. However, despite national policies and programmes, which, in the main comply with international standards and targets, the health care system has not been able to successfully deliver quality health care on an equitable basis in all the provinces. Provinces do not spend the same amount per capita on health care delivery, and there is a serious lack of managerial capacity in the health system. The biggest challenge facing the efficient running of the health system is training managers to operationalise efficient systems especially for running clinics and hospitals where many problems have been identified. Efficient management systems in conjunction with effective engagement with labour should be operationalised with immediate effect in the public health sector so as to ensure that hospitals and clinics run well.

The report also recommends that there is a need to increase efforts in promoting preventative health measures by the State as well as by non-state actors. Programmes and policies should also be put in place to address the needs of the poor and vulnerable members of society, including a National Health Insurance System. Inequities in the health system such as intra- and inter-provincial health expenditures, access to clinics and hospitals, number of doctors, specialists, and nursing staff need to addressed so as to give meaning to the constitutional right to universal and equal access to everyone. Finally, Departments of Health are strongly advised to improve their monitoring, evaluating, and reporting systems

The Right to Social Security

The Constitution provides that everyone has a right to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. The number of social assistance beneficiaries increased dramatically by 966 311 people from April 2002 to the end of March 2003, mostly as a result of increased registration for Child Support Grants for children up to the age of seven. By the end of March 2003, 5,6 million people were beneficiaries of social assistance, which mostly comprised of child support grants (2,5 million people), old age pensions (2 million people), disability grants (897 050 people) and foster care grants (133 309 people). The most rapid increases in uptake of social grants took place in Gauteng, Free State, KwaZulu-Natal, Mpumalanga and

Limpopo. Take up rates were considerably lower in the Northern Cape, North-West, Eastern Cape and Western Cape.

Most provincial departments indicated that the allocated budget was not enough and that numbers of grant beneficiaries were constantly increasing, resulting in overspending for social security. However, the delivery of social services has not been efficient in some parts of the country as a result of administrative problems, lack of documentation as barriers to accessing grants, poor conditions at pay points, as well as corruption and maladministration.

As a result of rapid inflation in the cost of basic goods bought by the poor, in 2002/2003, the State moved swiftly to implement above inflation related increases in social grants. The old-age pension was increased by R20 to R640, the child-support grant increased by R10 to R140, the grant in aid increased from R120 to R130, the foster-care grant from R450 to R460, and the care dependency grant from R620 to R640.

The National and Provincial Departments of Social Development spent 90% of the R49 million allocated to the HIV/AIDS (home based/community based care) programme. The Home/Community Based Care programmes, through the collaborative work of government, non-governmental organisations, including faith-based organisations, and communities have benefited 29 612 children orphaned or vulnerable to HIV/AIDS by the end of March 2003. The programme reached 75 000 children orphaned or vulnerable owing to HIV/AIDS since its inception in 2000.

The State also instituted new measures to to further the right to social security, including disability assessment panels, a social relief of distress policy and the implementation of the National Food Emergency Scheme/Programme. Figures of the number of households that were assisted with food parcels in the pilot phase of the National Food Emergency Programme from December 2002 to the end of March 2003 range from 60 089 to 149 779.

The social security system at present does not cater for everyone and not everyone in need of social assistance is afforded such assistance. This is especially so for children in child headed households and children who live in the streets who sometimes engage in exploitative forms of labour. Some parents also fail to provide and take care of their children and put strains on the maintenance and social assistance systems.

The report recommends that the Department of Labour should take the International Labour Organisation's Decent Work for All Strategy forward in South Africa. It is also recommended that the relevant organs of State achieve better regulation of the insurance, health and maintenance systems. Particular attention should be paid to the coverage of old age pensions for workers in non-formal employment. The Department of Social Development is encouraged to continue fostering collaboration with all stakeholders, such as other government departments, Faith Based Organisations and Non-Governmental Organisations. The Basic Income Grant should continue to be considered as a viable option for addressing poverty in the country, especially amongst people of working age. The proposal to extend social assistance to all children in need (up to the age of 18), should also be kept alive.

The Right to Food

The report concludes that many people, and children in particular, had their right to food violated during the reporting period as they lost access to affordable food due to high prices and/or unreasonable plans devised and supervised by government. During the reporting period, 101 152 children were admitted to hospital with severe malnutrition and it was not possible for the Commission to state how many children died of malnutrition. However, it is alarming that case fatality rates for severe malnutrition in two under-resourced hospitals in the Eastern Cape ranged from 21% to 38%.

The report finds the National Department of Health's targets for reducing malnutrition to be unreasonable in their conception because the targets for 2000 and 2005 were virtually identical. The report also finds two elements of the Primary School Nutrition Programme to be unreasonable in their conception.

The first issue concerns the reduced allocation of resources to the programme in 2002/2003 as compared to 2001/2002. In 2001/2002 the total cost of the school food "meal" ranged from approximately 99 cents to R2.10. In 2002/2003, the maximum budgeted resource available per targeted learner per day was less than 67 cents. This is clearly an unreasonable set of parameters for the programme to be improved to meet the higher standards set by Cabinet.

The second element of the programme that was unreasonable was the reduction in the targeted number of children who should benefit from the programme. In the context of increasing numbers of children enrolled in schools, the Primary School Nutrition Programme did reach 4,5 million children in grades R to 7, however this was 151 615 children less than the year before. The drop in the number of learners who were reached is connected with government reducing its target from 5,4 million learners in 2001/2002 to 4,9 million learners in 2002/2003 as well as rapid increases in the cost of food procured for the programme. A three month gap in the implementation of the programme in the Eastern Cape also reduced access to the programme.

Non-State actors appear to have fallen short in their observance of their positive obligations to fufil the right to food. As one example, the Yiyo Lena sifted maize relief programme introduced by a group of companies is alleged to have sold relief maize packs at a 20% discount, despite that fact that the companies announced that the programme would entail a 50% discount.

High basic food prices during the reporting period, were partly attributable to inadequate safeguards on the South African Futures Exchange, where maize prices are formed. High prices for maize were passed on to low-income consumers, who could ill afford such dramatic basic food price increases for such a sustained period of time. The potential for market manipulation should have been prevented by the Johannesburg Securities Exchange when allegations of abuse were first signalled in 2002. The report identifies that there are weaknesses in the State's observance of its obligation to protect against fraud, unethical behaviour in trade and contractual relations.

There were some signs of improvement in the State's delivery of production support to emerging farmers and people who grow their own food. For example, the Comprehensive Farmer Support Package was instituted during the reporting period to assist land reform beneficiaries. However, it was implemented in some provinces only.

The LandCare programme, which is one of the major production support programmes from the National Department of Agriculture, was heavily underspent at 65% of the total conditional grant to provinces. There is also a significant gap in production support for rural restitution beneficiaries.

It was found that very few Provincial Department's of Agriculture were operating well funded programmes designed specifically to provide grants or revolving loans to support increased access by small scale and emergent farmers to production and/or marketing related infrastructure. Production support materials and learning support materials that are relevant to resource to poor farmers in water scarce areas were also not readily available.

On the whole, the report determines that the State absorbed the heavy burden of duty to achieve the progressive realisation of the right to food as expeditiously as possible, within its available resources. However, there was a crucial weakness in the measures to protect the right to food from being violated by non-State actors or third parties that need not be repeated in future.

The report suggests that there is a need for greater care in the preparation of strategic and financial planning targets so that they inspire civil society to marshal their resources in support of the progressive realisation of the right. The report recommends: public education to raise awareness of malnutrition, rolling out the Integrated Food Security Strategy at a provincial level, improving food safety, achieving better regulation of the food industry through State procurement, accelerating agrarian reform, and communication policy and legislative developments more effectively. Finally, the report supports the call for government, labour, community and business representatives to negotiate an agreement at the National Economic Development and Labour Council (NEDLAC) to ensure the right to food and quality job creation in the food industry.

The Right of Access to Adequate Housing

In order to fill some gaps in the housing policy framework, the State identified medium density housing, rental housing, social housing and emergency housing as the key policy priorities for 2002/2003. Emergency, medium density, rental and social housing are part and parcel of addressing inequalities in access to transport and the legacy of racial segregation. The Emergency Housing Policy Framework was conceptualised as a result of the *Grootboom* judgment and aims to assist groups of people that are deemed to have urgent housing problems, owing to circumstances beyond their control (e.g. disasters, evictions or threatened evictions, demolitions or imminent displacement or immediate threats to life, health and safety). The report highlights that it was not clear whether the Emergency Housing Policy should also cover people living in informal settlements, because they are living in intolerable circumstances. Social Housing projects demonstrate that socially, environmentally and sunshine conscious design principles can make a difference to the quality of State subsidised housing.

The State reported on measures to protect the right to housing in the form of the Prevention of Illegal Eviction from Occupation of Land Amendment Bill and the commencement of the Home Loan and Mortgage Disclosure Act 63 of 2000. With a view towards curbing discriminatory practices, the Act compels financial institutions to disclose information in their financial statements on home loan patterns according to categories of persons and geographic areas (both of which may be prescribed). The Community Reinvestment Bill confirmed the State's intention to increase private sector investment in the lower end of the housing market. The report highlights that the State

was also attending to some aspects of the Housing Act 107 of 1997, as amended, in order to ensure that the Act, and its implementation, did not violate an individual's right to property in terms of the Constitution.

In terms of on-going policies and programmes, in 2002/2003, the State reported 203 288 houses completed or under construction, whilst the State approved 519 498 subsidies to households with a joint monthly income less than or equal to R3 500, or R1 500 if the house was built under the apartheid system. By the end of 2002/2003, the State reported that over 1,4 million houses had been delivered since 1994, whilst the number of families without houses (i.e. dwellings in backyards, informal dwellings, backyard dwellings in shared properties and caravans/tents) was reflected as 2 399 825- from the 2001 Census. The State also increased the subsidy amounts for the housing programme to keep pace with inflation and maintain the well-known quality and size of housing. Sixty-three projects were also completed as part of the Human Settlement Redevelopment Programme in order to correct imbalances and dysfunctionalities in existing settlements that cannot be funded through the housing subsidy scheme (e.g. sports facilities, business hives, labour exchanges, cemetaries, parks and ablution blocks).

There was under expenditure on housing delivery amongst many provincial departments responsible for housing. Reporting on the constraints associated with underspending was not complete, but included the following in some cases: failure to secure suitably located land, delays in tender adjudication, municipalities failing to submit business plans, delays in the National Department approving projects, weaknesses and staff shortages at municipal level, incompetence, corruption, political intervention and nepotism, slow delivery associated with the People's Housing Process and delays at the Deeds Office.

Comparing performance in relation to targets was a problem in that provincial information was reported in the format of the number of units completed *or* under construction. Nevertheless, Gauteng and Limpopo provinces stand out as the only provinces to show a reduction in units, whether complete or under construction, from 2001/02 to 2002/03. The Gauteng Department of Housing reported delivering 59% of the target in the incremental housing programme and 39% of the target in the Social Housing programme. A Customer Support Service in the province acknowledged 83 714 queries and responded to a further 11 774 by letter.

According to the National Department of Housing, in 2002/2003, 6 469 houses did not conform to the Department's construction and safety standards. The National Home Builders Registration Council's (NHBRC) Warranty Scheme was instituted to provide assurance to beneficiaries that houses built and financed through the housing subsidy scheme are of an adequate quality. After trying to resolve disputes about the quality of constuction, a housing subsidy beneficiary can forward complaints to the NHBRC. However, the report highlights that public education is required to empower consumers to identify quality problems and make use of the complaint procedures of the NHBRC. The Mpumalanga Department of Housing also reported that building works inspectors from provincial government and local government monitored the work of contractors.

The report makes one urgent recommendation, namely: to establish the dedicated fund for acquiring well-located land for low-cost housing. Other recommendations include reducing policy incoherence and institutional fragmentation, improving monitoring and evaluation, interpreting the Peoples' Housing Process as a route for strengthening culturally adequate housing, creating an informed and supportive environment for whistleblowing, and ensuring effective participation in the delivery of housing. Specific

attention is drawn to the plight of farmworkers and vulnerable groups, especially HIV/AIDS orphans and People with Special Needs.

The Right to a Healthy Environment

Section 24 of the Constitution establishes the right to environment in order to ensure the health and well-being of present and future generations. At its core, the right to environment aims to grant this benefit to everyone in South Africa, not just to the few. Although, translating this vision of the benefit of environmental health into reality has become increasingly complicated, ensuring that there are no violations of this right is as urgent as any violation of other rights in the Bill of Rights.

Analysts of data from South Africa's Global Atmosphere Watch station at Cape Point contend that continued emissions of greenhouse gases are cause for concern. Like many countries, South Africa is sensitive to global climate change and there are also occasions, especially in major urban areas, when more localised air pollution becomes a health threat.

By way of illustration, the Johannesburg *State of the Environment Report 2003* indicates that "while in many parts of Johannesburg, air quality is within acceptable standards, approximately 20% of the City, particularly dense settlements and lower income townships, experience severe air pollution, with ambient air pollution levels exceeding acceptable guidelines by approximately 20-30% particularly during winter when temperature inversions prevent emissions from dispersing." The report goes further to state that "levels of particulate matter in certain townships can exceed the World Health Organisation standards by as much as 250% in winter."

Progress in the realisation of the right to environment could not be very well monitored and observed by the Commission during the year under review because annual progress reports in terms of section 11 of the National Environmental Management Act 107 of 1998, were inaccessible at the time of writing. These progress reports should contain detailed information on the implementation of measures instituted to ensure the right to environment.

Nevertheless, the Commission did observe the growing influence of the Committee for Environmental Co-ordination through an interpretation of its review, and subsequent consolidation, of Environmental Implementation Plans and Environmental Management Plans submitted by relevant organs of State. These reports contain the planned and *aligned* outputs of national and provincial departments with an impact on, or management function over, aspects of the right to environment. The Commission also recognises that some Environmental Co-ordinating Committees were established at the provincial sphere, also for the purposes of alignment and co-operative governance.

Progress has been made, through the courts and other avenues, towards realising the procedural aspects of the right to environment (access to information, participation in decision-making processes, redress and remedy). The report includes several examples of objections and court applications lodged by Non-Governmental Organisations, with a view towards safeguarding environmental health in low-income areas. Despite these opportunities to access information and participate in decision making, some remedies for old violations could not be realised without concerted action on the part of the State. One example, is the case of workers with mercury poisoning, which first occurred many years

ago. In March 2003, Thor Chemicals was served with a R60 million toxic chemical clean-up directive by the State.

On the substantive issue of waste management and pollution control, what was reported by government to the Commission fell short of what was expected in terms of the strategic objectives of the policy and strategy for pollution and waste management. The report highlights that there is still no clear understanding among the different mandate holders for this function of what they are required to do and as a result, implementation was not as effective as it could be. Having said this, there were positive developments during the period under review, including the introduction of waste buy-back centres which address brown issues and could assist in strengthening the bargaining power of the very low income people who do the hard work of collection.

On the issue of Air Quality, the report acknowledges that progress was made in the Southern Industrial Basin through the focused action of the State and Community Based Organisations (CBOs) in linking asthma in school children to emissions, however there is an urgent need for national legislation to institute mechanisms and standards to effectively protect against pollution that threatens health and well-being, possibly including pollutant release and transfer registers.

Several new control measures were introduced to manage water pollution, including the second draft of the National Water Quality Management Framework Policy and the Waste Discharge Charge System. The Working for Water programme succeeded in protecting and preventing against water loss due to alien invasive plant species, however it was not clear how much of this work focused unfairly on commercial farmlands and not on areas inhabited by vulnerable sections of the population.

Most of the work by the State on inland as well as marine and coastal biodiversity and conservation was reasonable in as far as it related to tourism and the economic development of the country.

The report highlights that the challenges facing South Africa in terms of the right to a healthy environment include: allocating sufficient resources for progressive realisation of the right for the benefit of vulnerable groups; educating and training communities; ensuring that proper implementation systems are in place; ensuring effective co-operative governance; operating proper monitoring and evaluation systems.

The report recommends that while most policies and laws are in place or about to be instituted, there should be a quantum shift in focus towards implementation of measures to further the right to environment for vulnerable groups in a more decentralised way. Provincial government and local government should be resourced to concentrate their energies on implementation, in association with community based organisations that have already developed innovations to further the right, sometimes in the face of extreme resource scarcity.

The State has made valuable contributions to promoting the right to environment through for example, the “Bontle ke Batho” or the clean schools, wards and towns campaign; however, organs of State could do more to ensure that their own internal operations reflect implementation of the right to environment. For example, the Council for Scientific and Industrial Research (CSIR) implemented International Standards Organisation 14001 standards for handling and disposing of its own hazardous waste. This initiative by an organ of State seems to have afforded the CSIR the opportunity to gain some capacity and

insight, which could be applied to other relevant contexts in the public or private sector within the South Africa.

The report also recommends that monitoring and evaluation systems need to be simplified where possible and improved. Annual progress reports in pursuit of targets and plans laid down in Environmental Implementation Plans and Environmental Management Plans should include a focus on the substantive aspects of the realisation of the right for vulnerable groups. The contents of the reports should also be widely communicated so as to avoid conflict and encourage effective participation. The Committee for Environmental Co-ordination could also be complemented by the National Environmental Advisory Forum (NEAF) envisaged in the National Environmental Management Act 107 of 1998. This provision to encourage participation should be effected without delay.

D) Protocols and the Report Production Process

The production process for this report began with the SAHRC sending questionnaires, which are called protocols, to various organs of State for their comment in May 2003. The Commission then took some time to revise the protocols, which were resent to all relevant organs of State for comment and suggestions in June 2003. The response from relevant organs of State was not satisfactory; with the Department of Housing (Gauteng Province), the Department of Land Affairs and the Department of Water Affairs and Forestry being the only organs of State to respond. However, the Commission acknowledges that further work is required, in the next reporting cycle, to ensure that the protocols are improved for all spheres of government and parastatals.

The final protocols were sent to various organs of state (national and provincial government, parastatals, metropolitan and local councils) in July 2003, as mandated by section 184(3) of the Constitution. In future, the Commission will pay more attention to smaller municipalities by focusing field research on the implementation of programmes and projects at a local level.

The first deadline for the release of this Report was in December 2003. However, the Commission had major problems in getting timeous responses from organs of State and as a result, the Commission took a decision to subpoena several departments and postpone the release of the Report until sufficient information had been received (see summarised list overleaf).

SPHERE	INSTITUTION	DATE RESPONSE RECEIVED
2 - Provinces	GAU Social Services andPopulation Development	21 August 2003
1 - National	NATIONAL Labour	29 August 2003
2 - Provinces	EC Health	29 August 2003
2 - Provinces	WC Agriculture	29 August 2003
2 - Provinces	LIMPOPO Agriculture and Environmental Affairs	31 August 2003
2 - Provinces	FS Health	1 September 2003
2 - Provinces	NW Health	1 September 2003
2 - Provinces	WC Social Services	1 September 2003
2 - Provinces	EC Education and Training	5 September 2003
2 - Provinces	GAU Health	5 September 2003
2 - Provinces	KZN Agriculture and Environmental Affairs	9 September 2003
4 -Parastatals	PARASTATAL Rand Water	9 September 2003
2 - Provinces	KZN Traditional and Local Government	10 September 2003
2 - Provinces	MP Local Govt and Traffic	10 September 2003
2 - Provinces	NW Education	10 September 2003
1 - National	NATIONAL Land Affairs	12 September 2003
2 - Provinces	FS Social Welfare	12 September 2003
2 - Provinces	GAU Housing	12 September 2003
2 - Provinces	NC Health	12 September 2003
2 - Provinces	NC Social Services and Population Development	12 September 2003
1 - National	NATIONAL Agriculture	15 September 2003
1 - National	NATIONAL Water Affairs and Forestry	15 September 2003
2 - Provinces	EC Agriculture and Land Affairs	15 September 2003
2 - Provinces	FS Education	15 September 2003
2 - Provinces	GAU Education	15 September 2003
2 - Provinces	MP Housing and Land Administration	15 September 2003
2 - Provinces	WC Education	15 September 2003
2 - Provinces	WC Environmental Affairsand Development Planning	15 September 2003
2 - Provinces	WC Health	15 September 2003
2 - Provinces	WC Housing	15 September 2003
2 - Provinces	NC Agriculture Conservation and Environment	15 September 2003
2 - Provinces	KZN Health	16 September 2003
1 - National	NATIONAL Education	18 September 2003
2 - Provinces	MP Health	18 September 2003
2 - Provinces	NW Agriculture, Conservation and Environment	23 September 2003
2 - Provinces	MP Social Services and Population Development	25 September 2003
3 -Metropolitan Councils	METRO Greater Tswane Metropolitan Council	2 October 2003
3 -Metropolitan Councils	METRO Nelson Mandela Metro Council	2 October 2003
1 - National	NATIONAL Correctional Services	3 October 2003
1 - National	NATIONAL Social Development	3 October 2003
2 - Provinces	LIMPOPO Health and Welfare	3 October 2003
2 - Provinces	EC Social Development	3 October 2003
1 - National	NATIONAL Health	10 October 2003
2 - Provinces	GAU Agriculture, Conservation, Environment and LandA	10 October 2003
4 -Parastatals	PARASTATAL Medicines Controls Council	10 October 2003
2 - Provinces	FS Local Govt and Housing	29 October 2003
1 - National	NATIONAL Housing	30 October 2003
1 - National	NATIONAL Provincial and Local Government	30 October 2003
1 - National	NATIONAL Environmental Affairs and Tourism	31 October 2003
4 -Parastatals	PARASTATAL Agriculture Research Council	31 October 2003
1 - National	NATIONAL Minerals and Energy Affairs	3 November 2003
2 - Provinces	KZN Education and Culture	3 November 2003
2 - Provinces	EC Housing, Local Government and Tradtional Affairs	4 November 2003
2 - Provinces	GAU Development Planning and Local Government	4 November 2003
2 - Provinces	LIMPOPO Education	4 November 2003
2 - Provinces	MP Agriculture, Conservation and the Environment	4 November 2003
2 - Provinces	NC Local Govt and Housing	4 November 2003
2 - Provinces	WC Planning and Local Govt	4 November 2003
4 -Parastatals	PARASTATAL National Education Financial Aid Scheme	4 November 2003
2 - Provinces	NW Developmental Local Government and Housing	5 November 2003
3 -Metropolitan Councils	METRO Eastrand Metropolitan Council	5 November 2003
4 -Parastatals	PARASTATAL Umngeni Water	5 November 2003
3 -Metropolitan Councils	METRO Cape Town Metro Council	6 November 2003
4 -Parastatals	PARASTATAL Medical Research Council	6 November 2003
2 - Provinces	FS Agriculture	7 November 2003
2 - Provinces	KZN Welfare and Pensions	7 November 2003
2 - Provinces	LIMPOPO Local Govt and Housing	7 November 2003
2 - Provinces	MP Education	7 November 2003
2 - Provinces	NC Education	7 November 2003
4 -Parastatals	PARASTATAL National Housing Finance Corporation	7 November 2003
2 - Provinces	KZN Housing	14 November 2003
3 -Metropolitan Councils	METRO eThekwini Metropolitan Council	17 November 2003
4 -Parastatals	PARASTATAL Landbank*	17 November 2003
4 -Parastatals	PARASTATAL Council for Scientific and Industrial Council	18 November 2003
2 - Provinces	FS Environmental, Tourism and Economic Affairs	19 November 2003
3 -Metropolitan Councils	METRO Greater Johannesburg Metropolitan Council	17 December 2003
2 - Provinces	NW Social Services**	

First deadline

Extended deadline

Subpoena hearings begin

Subpoena hearings end

* Extension granted as a result of communication problems
** No subpoena served, a letter explains the breakdown in communication

Most organs of State submitted their reports before they were meant to appear at a subpoena hearing. However, the North West Department of Social Services, Arts, Culture and Sport did not provide a response to the Commission as a result of problems with network cabling and the resignation of the personal assistant to the Acting HoD. The Department submits that it was not out of irresponsibility and deliberate disregard of the law that the Commission did not receive a report from the Department.

In order to improve the quality of the information, analysis and recommendations in the reports and to forge closer and better working relationships with government and non-governmental entities, a set of draft reports were released for comment to government and civil society before a National Input Workshop on 27-28 January 2004. Comments made at the workshop, and in writing, have been considered by each report writer.

A set of second draft reports were then made available to the Director General of the relevant national department in February 2003 to correct any remaining problems with factual information. Responses were received from the following departments: Water Affairs and Forestry, Minerals and Energy, Provincial and Local Government, Health, Social Development, Education, Land Affairs, and Housing. The final reports were also reviewed intensively within the Commission before being published.

E) Conclusion

One of the concerns acknowledged by the Commission about the monitoring process so far is that it still relies heavily on reports from government.

Furthermore, even though the Bill of Rights applies vertically and horizontally and binds State entities and non-State entitites, the Commission has some capacity problems in extending its mandate to non-State entities, especially big corporations.

In the next reporting cycle, the Commission will place more emphasis on conducting its own primary research in addition to improving on the existing protocols for each right and making better use of annual report information as soon as it becomes available.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
ARVs	Anti-retrovirals
BCG	Bacillus Calmette-Guérin (BCG) vaccine for TB developed in 1906
CESCR	Committee on Economic, Social and Cultural Rights
CHBC	Community and Home Based Care
CHC	Community Health Centre
DHIS	District Health Information System
DHS	District Health System
DOT	Directly Observed Therapy
ECDoH	Eastern Cape Department of Health
EMS	Emergency Medical Services
EPI	Expanded Programme on Immunisation
FSDoH	Free State Department of Health
GTDoH	Gauteng Department of Health
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDP	Integrated Development Plan
IMCI	Integrated Management of Childhood Illness
KZNDoH	KwaZulu-Natal Department of Health
LODoH	Limpopo Department of Health
MinMeC	Minister and Members of the Executive Council
MMR	Maternal Mortality Rate
MPDoH	Mpumalanga Department of Health
MRC	Medical Research Council
NALEDI	National Labour, Economic and Development Institute
NCDoH	Northern Cape Department of Health
NDoH	National Department of Health
NWDoH	North West Department of Health
PEP	Post Exposure Prophylaxis
PFMA	Public Service and Financial Management Act
PHC	Primary Health Care
PLWAS	People Living With AIDS
PMTC	Prevention of Mother-to-Child Transmission
SANAC	South African National Aids Council
SANC	South African Nursing Council
SLA	Service Level Agreement
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TB	Tuberculosis caused by an airborne bacterium
TOP	Termination of Pregnancy
UDHR	Universal Declaration of Human Rights
UNICEF	United Nations Childrens' Fund
UN	United Nations
VCT	Voluntary Counselling and Testing
WCDoH	Western Cape Department of Health
WHO	World Health Organisation
WSSD	World Summit on Sustainable Development

EXECUTIVE SUMMARY – THE RIGHT TO HEALTH CARE

Constitutional obligations

The object of this chapter is to assess the "progressive realisation" of the right to health care as provided for in the Constitution. Key developments in the realisation of the right from 1 April 2002 to 31 March 2003 will be assessed, taking into account the provisions of section 7(2) of the Constitution which define the States obligations, in conjunction with, the application of the test for "reasonable" measures as defined by the Constitutional Court in the Grootboom case.

The right of access to health care services is enshrined in the Bill of Rights, which guarantees not only civil and political rights but also economic, social and cultural rights to everyone. Section 27(1)(a) provides for universal access to health care services, including reproductive health care. Section 27(3) states that "No one may be refused emergency medical treatment". Children's rights to "basic health care services" are provided for in section 28(1)(c), while section 35 (2)(e) provides for "adequate medical treatment" for detainees and prisoners at the State's expense. The right to health care must be read in the context of other rights, which form the underlying determinants of health since rights are indivisible and interdependent as outlined in the Vienna Declaration. Other rights in the Bill of Rights which contribute to the underlying determinants of health are the right to a healthy environment, the right to adequate food and housing, safe drinking water, land, and social security.

Human Rights instruments with a general application, which include the right to health, are the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 25 of the UDHR of 1948 was the first to recognise the right to health. In 1966, the right to health was defined more precisely in article 12 of the ICESCR, which provides for the "enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity". The constitution of the World Health Organisation (WHO), in 1977, reiterated the view that health is a "state of complete physical, mental and social well-being and not just the absence of disease or infirmity". The WHO also sets norms and standards for health, which countries endeavour to meet.

The UN Committee on ICESCR, in General Comment No.14, defines the normative content of the right to health as equal access for all, on the principle of non-discrimination, to health care facilities, goods and services. These 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. The right to equality of health care services requires that vulnerable groups should enjoy special protection.

Progress towards the realisation of the right to health care

Key developments in three key strategic programmes (Health Service Delivery, Strategic Health Programmes and Administration) form the core of the assessment of the right to health in this report: In terms of section 7(2) of the Constitution, the State is obliged to respect, protect, promote and fulfil the rights in the Bill of Rights. The following section is an attempt to interrogate whether organs of State have complied with their constitutional obligations.

Respect

The State in this reporting period has respected the right to health care in so far that it has refrained from infringing on the right.

Protect

The duty to protect the right places a positive obligation on the State to prevent the violation of any individual's right by the State or a third party. There have been several important developments to protect the individual's right of access to health care services and medicines, mainly against powerful third party interest groups such as mining companies, the pharmaceutical industry and also private medical schemes.

Through the Competition Act 89 of 1998, the State established the Competition Commission and Competition Tribunal as independent statutory bodies entrusted with ensuring that companies do not abuse their dominant positions in the market place. In September 2002, Hazel Tau and Others lodged a complaint with the Competition Commission against GlaxoSmithKline and Boehringer Ingelheim, alleging that these pharmaceutical companies were engaged in conduct prohibited by the Act. The complainants alleged that the companies were charging excessive prices for anti-retroviral drugs (ARVs) i.e. AZT, 3TC and Nevirapine, to the detriment of consumers. It was also alleged that these companies had refused to issue licences to manufacturers in South Africa to produce cheaper generics locally.

A settlement in favour of the complainants was reached between the Competition Commission and the respondents and the matter was not referred to the Competition Trubunal. Suffice to say, that the State fulfilled its obligation of conduct to protect the right by establishing a statutory body to oversee complaints of unfair practices by third parties. In this case, the right of a vulnerable group i.e. people living with AIDS,(PLWAs) to access affordable ARVs that are included in the WHO's Core List of the Model Essential Medicines Lists. ARVs are a minimum essential entitlement as defined in General Comment No.14 on the right to health.

Another measure aimed at protection was the Medicines and Related Substances Amendment Act 59 of 2002.

This amendment regulates the manufacture and marketing of medicines and related substances and makes them more accessible in terms of pricing by protecting the consumer against high and excessive price structures for imported medicines. It also established a Council to license the manufacture, importation and exportation of medicines.

The Government also passed the Medical Schemes Amendment Act 62 in 2002, which regulates the activities and fees charged by brokers. This further protects the right of individuals to access affordable health care in the private sector.

The Occupational Diseases in Mines and Works Amendment Act 60 of 2002, protects miners from third parties infringing on their right to compensation. Specifically, mine owners are obliged to pay compensation to workers who contract occupational diseases while in their employ. Mining companies, in the past,did not compensate workers who contracted diseases while in their employ. Many mineworkers contracted silicosis and asbestosis and died without receiving any form of compensation.

Promote

The obligation to promote the right requires all organs of State to take reasonable steps to create a conducive atmosphere in which people can exercise their right to health care by raising awareness of their rights through public education.

The National Department of Health, in addition to formulating policies and guidelines which it has disseminated to provincial departments, has also printed posters, held media conferences, organised awareness campaigns and provided training for health professionals and community workers. In addition, certain days of the year are designated to raise awareness around specific health issues such as, preventing abuse of the elderly, inherited disorders, AIDS, and other diseases. Government has also embarked on partnerships with NGOs such as LoveLife to promote education around AIDS.

Provincial Departments of Health reported similar activities, which promote awareness of the entitlements provided by the right to health care. However, in some cases, these efforts are inadequate in educating people to take preventative measures. A case in point is the annual outbreak of cholera, which can be, prevented through proper education of vulnerable communities, many of who, are forced to use contaminated water from nearby rivers in the absence of clean, potable water. Another glaring case is education aimed at the 15-49 age group (reproductive and economically active population group) that is susceptible to contracting AIDS. The prevalence rate for AIDS in this age group has not shown a substantial decrease suggesting that there has not been a significant change in sexual behaviour. However, a recent study, conducted by the Nelson Mandela Foundation and the Human Sciences Research Council of South Africa, concluded that there have been some behavioural changes amongst young people in recent years. This is encouraging and shows that more work needs to be done in promoting preventative measures by the State as well as by non-State actors.

Fulfil

The obligation to fulfil the right to health care imposes an obligation on the State to take policy, legislative, administrative, and other measures towards the progressive realisation of the right and within its available resources.

In order to improve administration, new Guidelines for District Health Planning and Reporting were issued to facilitate and improve planning and reporting at district and local spheres and to promote better inter-governmental co-operation.

Emergency medical services have seen an improvement during this reporting period with an increase in the number of ambulances in provinces and also a reduction in response times. However, many areas are still under-serviced, especially rural areas.

In this reporting period the State introduced several new legislative measures. The most important of these is the National Health Bill, which was enacted into law at the end of 2003. This framework legislation will standardise policies and practices across provinces. The Act defines provincial and municipal competencies with respect to health care services as well as structures for the District Health System. To date there is still a lot of confusion regarding the health responsibilities of different spheres of government. Budget allocations for implementing specific tasks by municipalities and by provincial departments are also at issue.

The Mental Health Care Act 17 of 2002 provides legal recourse and protection for the mentally ill and sets the stage for de-institutionalisation and home-based-care. The Children's Bill and the Older Persons Bill protect these vulnerable groups against abuse.

Several regulations and notices were promulgated to regulate professional boards and set standards for practioners of complementary and traditional medicine. This is important in a country where traditional medicine is widely practiced and where alternative forms of medicine are becoming increasingly more popular.

Notices for community service for several other categories of health professionals were promulgated in an effort to ensure their services in under-serviced and rural areas. These include dietetics, clinical psychology, environmental health, occupational therapy, physiotherapy, radiography, speech, language and hearing therapy.

The implementation of the Government's HIV/AIDS Strategic Plan 2000-2005 remains problematic. In a landmark case instituted by the Treatment Action Campaign (TAC) against the Minister of Health, the Constitutional Court, in 2002 confirmed the finding of the High Court which had found the Government's policy to limit Nevirapine to research and training sites to be in "breach of the States obligations under section 27(2) read with 27(1)(a) of the Constitution." The Court utilised the test of "reasonableness" as expounded by

Justice Yacoob in the Grootboom case. In evaluating the policy to limit Nevirapine (an anti-retroviral drug) to research and training sites, the Court ruled that the "Government policy was an inflexible one that denied mothers and their newborn children … the opportunity of receiving a single dose of Neviripine" in public sector facilities outside the pilot sites. In addition, the Court ruled that "waiting for a protracted period" to make it available was "not reasonable" within the meaning of section 27(2) of the Constitution.

As regards children's rights, the Court further ruled that the State is obliged to ensure that children are accorded protection contemplated by section 28. In this case, children born in public hospitals and clinics to mothers who are for the most part indigent and who require the protection of the State and should therefore receive a single dose of Nevirapine at birth to prevent transmission of the virus from mothers who are HIV positive.

Overall assessment

Government has developed legislative and other measures to comply with its constitutional obligations in terms of section 7(2) of the Constitution. However, despite national policies and programmes, which, in the main comply with international standards and targets, the health care system has not been able to successfully deliver quality health care on an equitable basis in all the provinces. Provinces do not spend the same amount per capita on health care delivery, with rich provinces like Gauteng and the Western Cape far exceeding the amount spent by poor provinces such as Limpopo. Mpumalanga and the Eatern Cape.

There is a serious lack of managerial capacity in the health system. The biggest challenge facing the efficient running of the health system is training managers to operationalise efficient systems especially for running clinics and hospitals where many problems have been identified. According to NALEDI, these problems include insufficient cleaning staff, nurses, doctors, dentists, pharmacists, psychologists, and specialists. This places an enormous pressure on existing staff. New staff are often unhappy with their working conditions, some of whom resign. Many opt for better remuneration and working conditions in the private health care sector or go abroad.

The three most important and universally acknowledged indicators to measure the health status of a nation are Life Expectancy at Birth, the Maternal Mortality Ratio, and the Infant Mortality Rate. Life expectancy has fallen from 56 years in 1996 to 52,5 and is projected to fall to 47 by 2005. The infant mortality rate has increased from 45 in 1998 to 59 in 2002. This means that more children under the age of one died in 2002 as compared to 1998. The under five-mortality rate has risen from 61 in 1998 to 100 in 2002. Similarly, the maternal mortality ratio shows a steady increase since 1998 and is estimated to be 150 per 100 000 live births. The National Department of Health, as well as independent researchers, have concluded that this is due to HIV/AIDS related deaths. In spite of the fact that policies and programmes directed at improving the health status of the country have been put in place such as the Integrated Management of Childhood Illnesses and other excellent pogrammes, the AIDS pandemic continues to be

one of the leading causes of death in South Africa. This has placed an enormous strain on an already overburdened health system and undermines the efforts made by the State. This is compounded by the fact that the other economic and social rights, which contribute substantially to the health status of a nation, and which form the underlying determinants of health are also not fully enjoyed by the vast majority of poor South Africans. This is mainly due to the huge backlogs inherited from the past. Inadequate housing, poor sanitation, overcrowding, lack of clean drinking water, lack of efficiently run social services, insufficient nutrition and health education exacerbate the diseases of poverty. Moreover, in a household that is affected by AIDS, there is a further depletion of the financial resources available to the family, thereby increasing the level of poverty.and the ability to survive.

The single most important challenge that Government faces is the one posed by the AIDS pandemic and the high incidence of opportunistic diseases such as tuberculosis. It is estimated that about one tenth of the population of the population is infected with the HI virus i.e. close to 5 million people. The number of AIDS orphans is estimated to be one million.

In order to assess whether there has been progressive realisation of the right of access to health care facilities, the test of "reasonableness" as defined by Justice Yacoob in the Grootboom case has to be applied. Although the policy and legislative measures developed in the fiscal year under review can be said to be "reasonable" in their conception, there remain large gaps in implementing them in a manner such that all the provinces, urban and rural peoples, rich and the poor have equal access to the same high quality of care.

Recommendations

- There is a need to increase efforts in promoting preventative health measures by the State as well as by non-state actors. Proper sanitation especially in formerly disadvantaged areas and in informal settlements needs to be vastly improved and public awareness on preventative measures should be stepped up so as to empower communities on how to prevent contracting such diseases as cholera, TB, malaria, diarrhoea in children, amongst others. Education on eating habits and nutritional value of foods will enhance the capacity of the poor to improve their nutritional status and boost their immune status to combat infections.

- Efficient management systems in conjunction with effective engagement with labour should be operationalised with immediate effect in the public health sector so as to ensure efficiently run hospitals and clinics. Intergovernmental responsibilities should be clarified to avoid duplication and confusion as to which structure is responsible for which function.

- A culture of commitment and observance of the Patients Charter to be instilled in health care workers to improve the quality of care accessed by the majority of South Africans. Low morale amongst professional and support staff in health facilities impacts negatively on the quality of care received by patients and infringes on their right to dignity and access to quality care.

- The Comprehensive National Aids Plan should be rolled out effectively in all the provinces so as to meet targets and timelines in order to substantially reduce new infections and to prolong the lives of those already infected.

- Government needs to reconceptualize its housing policy to cope with almost a million AIDS orphans and also propose innovative and culturally appropriate housing projects to care for people living with AIDS. This applies equally to older persons..

- The State should plan to meet the Millennium Development Goals and the targets set by the Johannesburg Summit on Health.

- Programmes and policies should be put in place to address the needs of the poor and vulnerable members of society such as a National Health Insurance System

- Inequities in the health system such as intra- and inter-provincial health expenditures, access to clinics and hospitals, number of doctors, specialists, and nursing staff need to addressed so as to give meaning to the constitutional right to universal and equal access to everyone.

- All Departments of Health are strongly advised to improve their monitoring, evaluating, and reporting systems and to make the requisite information and statistics available to the South African Human Rights Commission (SAHRC) for the next monitoring cycle, which will assess, amongst other programmes, the progress made on the delivery of ARVs to PLWAs as outlined in the National Plan..

1 INTRODUCTION

The right to health is a fundamental human right essential for the exercise of other human rights. It is guaranteed by various international and regional human rights instruments. The right of access to health care services is enshrined in the Constitution, which makes it obligatory on the State to provide equal and universal access to everyone.

The object of this report is to assess the "progressive realisation" of the right to health care services as provided for in the Constitution. Key developments in the realisation of the right from 1 April 2002 to 31 March 2003 will be assessed, taking into account relevant international human rights instruments and the test for "reasonable" measures as defined by the Constitutional Court in the *Grootboom* case.[1] In order to meet the test of reasonableness, the measures need to be "co-ordinated, comprehensive, coherent, balanced and flexible" and must in addition make appropriate provision for short-, medium- and long-term needs. Furthermore, the Court ruled that measures that do not provide for those in dire need and who find themselves in desperate circumstances do not meet the test of "reasonableness".

Key policy, legislative, budgetary and other measures as reported by organs of state will be analysed and assessed. Where the information provided was inadequate or incomplete, information was gathered from other sources through independent research. In some cases, statistics provided in the Responses to the South African Human Rights Commission's (SAHRC) protocols by provincial Departments of Health are summarised in tablular form. Where statistics were available from other sources, they have been included.

In section 2, information pertaining to the National Department of Health (NDoH)[2] is presented first, followed by provincial governments. Information from independent sources was incorporated where it was deemed necessary.

1.1 Constitutional Provisions and the Normative Content of the Right to Health Care

Health rights are recognised in many United Nations (UN) conventions, the first of which is article 25 of the Universal Declaration of Human Rights (UDHR) of 1948.[3] In 1966, the right to health was defined more precisely in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which provides for the "enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity". The constitution of the World Health Organisation (WHO), in 1977, echoed the view that health is a "state of complete physical, mental and social well-being and not just the absence of disease or infirmity".[4]

1.1.1 Constitutional Provisions

The South African Constitution provides for universal access to health care services including reproductive health; emergency medical services; basic health care services for children; and medical services for detained persons and prisoners. Section 27(1)(a) provides for universal access: "Everyone has the right to have access to health care services, including reproductive health care ..." 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. In addition to these, section 24 of the Constitution provides that everyone has a right to an "environment that is not harmful to their health or well-being".[5]

Section 27(2) stipulates that "the state must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of each of these rights".[6] The Limburg Principles[7] define "progressive realisation" to mean that 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 the minimum core entitlements as defined by the Committee on Economic, Social and Cultural Rights (CESCR) (hereafter the Committee).

The South African Bill of Rights provides for universal *access to health care services* and not the right of everyone to the "highest attainable standard of physical and mental health" as provided for in article 12 of the ICESCR and the WHO constitution. Notwithstanding this difference, the South African Bill of Rights guarantees other economic and social rights which comprise the underlying determinants of health. These are the right to adequate housing, food, safe drinking water, education, social security, land and also such civil and political rights as the right to life and the right to pursue economic activities.[8] This is in line with the Vienna Declaration and Programme of Action, which states that all rights are "universal, indivisible and interdependent and interrelated".[9]

1.1.2 Normative content of the right to health

In the General Comment No. 14, the Committee defines the normative content of the right to health as equal access for all, on the principle of non-discrimination, to health care facilities, goods and services. These 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.[10]

The right to equality of health care services requires that vulnerable groups should enjoy special protection. Their rights are guaranteed by specific conventions which include women,[11] children,[12] people living with HIV/AIDS,[13] prisoners and detainees,[14] refugees and asylum seekers.[15]

1.1.3 Core Entitlements

In General Comment No. 3 the Committee confirms that State parties have to ensure the satisfaction of minimum essential levels of all the rights enunciated in the ICESCR, including essential primary health care. In the Committee's view, this core includes at least the provision of essential drugs as defined by the WHO's Programme on Essential Drugs: ensuring equitable distribution of health facilities, goods and services; adopting and implementing a national public health strategy and a plan of action on the basis of epidemiological evidence; addressing the health concerns of the whole population; devising and reviewing the strategy and plan; and giving particular attention to all vulnerable or marginalised groups. The Committee also confirms that obligations of comparable priority include taking measures to prevent, treat and control epidemic and endemic diseases.[16]

The provision of minimum core benefits has been interpreted by the South African Constitutional Court to being relevant to the "reasonableness" of the measures adopted by the State and within the boundaries of "available of resources" to the State. In the landmark *TAC* case[17] the Court made the following observations in referring to the *Grootboom* judgement:

> Although Yacoob J indicated that evidence in a particular case may show that there is a minimum core of a particular service that should be taken into account in determining whether measures adopted by the state are reasonable, the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated to as possibly being relevant to reasonableness under section 26(2) , and not as self-standing right conferred on everyone under section 26(1) and 27(1)

1.1.4 State obligations

The steps to be taken by State parties to the ICESCR to achieve the full realisation of the right to health include those necessary for:

- the provision of the reduction of the still-birth rate, 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.

The Human Rights Committee, which monitors compliance with the International Covenant on Civil and Political Rights (ICCPR), has defined the role of the State in protecting the right to life, to include obligations to undertake

measures to eliminate epidemics.[18] In 2002, the WHO issued guidelines for the use of ARVs in resource-poor countries. ARVs are included in the Core List of the Model Essential Medicines List. It is important to note that for effective treatment, people living with AIDS (PLWAS) should have access to (almost) all ARVs, and not just one essential drug on the List.[19] This is of particular relevance to South Africa where the AIDS pandemic has reached alarming proportions and where ARVs are not yet available to all in the public health care sector.[20] Only those who can access private medical aid schemes, can afford expensive, ARV drug therapy.

1.2 Implementation

As regards implementation at the national level, the Committee recommends that States should have framework legislation to operationalise their national strategy. The framework legislation should establish national mechanisms for monitoring and supporting the implementation of national health strategies and plans of action. It should also include provisions on the targets to be achieved and the timeframes for their achievement; the means by which the right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organisations; and institutional responsibility for the implementation of the national plan of action.[21] South Africa, at the time of writing is in the process of passing such framework legislation in the form of the National Health Bill.It will probably be promulgated into law before the end of 2003.

In addition to national framework legislation governing health, States are also required to develop policies and strategic plans and programmes for the delivery of health care services. In the *Grootboom* case, Justice Yakoob stated that the measures adopted by the State must be reasonable in their conception **and in their implementation**. This test was applied in the *TAC* case in which the Constitutional Court ruled that the policy to limit treatment to the 18 pilot sites was in breach of the State's obligations under section 27(2) read with 27(1)(a) of the Constitution. The court found the policy to be inflexible and that it was unreasonable not to make the drug available for HIV positive mothers and their new born babies for a protacted time.In other words The Prevention to Mother to Child Transmission (PMTC) Programme was found to be unreasonable in both conception and implementation i.e.the State was in breach of both conduct and result.

1.3 Recent Developments

The UN Human Development Report 2002[22] acknowledges the need for strengthening efforts in the area of health, and suggests that the answer lies in decentralisation to the district and sub-district levels of management, with greater control delegated to communities. South Africa has introduced a District Health System which will be run along these lines.

The UN Millennium Development Goals (MDG),[23] in recognition of the needs of developing countries, has set eight goals, which South Africa has pledged to

meet by 2015. The MDG calls for the reduction of extreme poverty and hunger; the reduction by two- thirds of the child mortality rate; the reduction by two-thirds of the maternal mortality rate ratio; the halting and reversal of the spread of HIV/AIDS, malaria and other major diseases such as tuberculosis; ensuring environmental sustainability; and developing a global partnership for development which includes the provision of access to affordable essential drugs and the promotion of gender equality and the empowering of women.

Four of the MDG goals relate to health, which serves to emphasise the fact that a nation cannot develop optimally without a healthy population or one that is suffering from a pandemic such as AIDS,[24] which affects the economically active sector of the population. AIDS also poses a security risk as people infected or affected by it are impoverished.[25] Thus a nation's health status impacts not only on the individual's ability to pursue an adequate standard of living but also on the development goals of the nation.

South Africa was party to the Johannesburg Declaration on Health and Sustainable Development in January 2002.[26] The goals set by this forum are relevant to assessing the progress made towards achieving them:

> *We recall the number of laudable development targets for health that have been agreed to at the Millennium Summit, and in other United Nations conferences and inter-national fora. These include, for example, reducing mortality rates for children under five by two-thirds, and the maternal mortality ratio by three-quarters by 2015; and, by 2010, reducing HIV prevalence in all young people (aged 15-24 years) by 25 per cent, and the proportion of infants infected with HIV by 50 per cent; as well as reducing TB deaths and prevalence, and the burden of disease associated with malaria by 50 per cent, also by 2010.*
>
> *We note that, whilst there have been improvements in life expectancy and declines in infant and child mortality, the reality is that the world is not on track for achieving these targets. This is not because they are not achievable, but because the scale of the effort to achieve them falls far short of what is required.*
>
> *We emphasise that it is the joint responsibility of all nations to ensure that these targets are achieved, with a particular focus on, and support for vulnerable developing nations.*

1.4 Children's right to basic health care

As regards children's right to basic health care, South Africa participated in the Special Session on Children at the UN World Assembly in 2002 and adopted a declaration on *A World Fit for Children* and committed itself to an action plan to meet the targets for child development. A Children's Bill has been drafted which will be discussed under the relevant section.

2 PROGRESS TOWARDS THE REALISATION OF THE RIGHT TO HEALTH CARE

In this section, responses from the national and provincial Departments of Health to the Commission's protocols for the 2002/2003 financial year, are analysed. Where information is lacking or unreliable, recourse has been made to other available sources of information. The measures assessed are (1) Policies and programmes, (2) Legislation and (3) Budgets. Since the emphasis on this reporting period is on service delivery and implementation of existing policies and strategic plans, an assessment will be made on the outcomes according to benchmarks and indicators relevant to health care delivery.

The National Department of Health's (NDoH) strategic goals and objectives are guided by the White Paper on the Transformation of the Health System, the ten point plan outlined in the Health Sector Strategic Framework 1999-2004, and the HIV/AIDS Strategic Plan for South Africa 2000-2005.[27] Key objectives and programmes for 2002/03 are based on the 10-point plan that includes:

1) decreasing morbidity and mortality rates;

2) improving quality of care;

3) speeding up delivery of primary health care;

4) revitalising public hospitals;

5) improving resource mobilisation and management;

6) improving human resource development and management;

7) re-organising support services;

8) legislative reform;

9) improving communication and consultation;

10) strengthening international co-operation.

2.1 Key Programmes

The following three key programmes identified by the NDoH and the National Treasury (i.e. the budget reporting framework) will be the focus of this analysis:

A. *Health Service Delivery*: primarily at the provincial and local spheres of government which deal with sub-programmes directed towards preventive, promotive, curative and palliative care and which include the delivery of quality care, co-ordination of hospital services, human resources, support services and environmental health.

B. *Strategic Health Programmes:* the co-ordination of critical sub-programmes including those that are organised into clusters, namely: the HIV, AIDS, STIs and TB cluster and the Maternal, Child and Women's Health cluster, which includes the Integrated Nutrition Programme;[28] and

C. *Administration:* which provides for the overall management of the National Department, including the policy and legal services of the Offices of the Minister and Director General.

Due to time and capacity constraints it is not posssible for one researcher to treat all of these in the detail they deserve. Only key programmes will be treated in this Report.

2.2 New Policy and Programmatic Measures

2.2.1 The Right to Health Care Services for Everyone

2.2.1.1 National Sphere[29]

There appear to be no new major policies or programmes instituted for Health Service Delivery and Strategic Health Programmes during this reporting period. Under Programme C, the following new guidelines were issued to facilitate administration:

2.2.1.1.1 Guidelines for District Health Planning and Reporting

The publication of the *Guidelines for District Health Planning and Reporting* is intended to assist district health managers from provincial and local government to prepare and implement medium-term, sub-district and district health plans, and to assess and report progress in achieving their stated goals and objectives. According to the guidelines, plans and reports are to meet the requirements of the Public Service and Financial Management Act (PFMA) No. 1 of 1999 and the Public Service Regulations. They should also serve as a basis for the health component of the Integrated Development Plan (IDP).

This is an important development since previous Economic and Social Rights reports identified the lack of capacity at managerial level as a constraint to the efficient delivery of services.[30] If *implemented successfully*, this planning and reporting tool in the hands of competent managers should result in a more efficient District Health System (DHS) and promote better intergovernmental co-operation between the local and provincial spheres in the delivery of health care services.

2.2.1.2 Provincial Sphere

The Mpumalanga Department of Health (MPDoH), the North West Department of Health (NWDoH), and the Northern Cape Department of Health (NCDoH) reported no new policy measures but listed existing ones.

The Eastern Cape Department of Health (ECDoH) reported the *Zanempilo Pilot Project*, which provides laboratory testing for TB in rural areas. The extension of laboratory services to the rural areas will impact positively on the rural poor who do not have ready access to clinic and hospital services.

The ECDoH stated that it intended to increase the number of nurses annually. Candidates selected from targeted areas will be expected to return to these communities upon qualification and will be required to sign a four-year contract with the Department. The loss of nurses from the profession has resulted in a serious shortfall of trained staff and this policy is to be welcomed in order to train and retain staff.

The KwaZulu-Natal Department of Health (KZNDoH) instituted a policy on the management of rape victims but provided no details.

The Limpopo Department of Health (LMDoH) instituted a protocol for providing a comprehensive package of care for the Prevention of Mother-to-Child Transmission (PMTCT) programme and policy guidelines for its implementation, while the MPDoH reported implementation of these guidelines.

The NCDoH reported the following new policy measures: a 24-hour service at Primary Health Care centres; in certain instances an operational call system; and training and teaching at the Henrietta Stockdale Nursing College. This Department is in the process of revising its cervical cancer policy guidelines as well as those on contraception. This will be beneficial to women and people of reproductive age.

The WCDoH reported that it was in the process of developing a policy framework- Health Care 2010, which aims at revitalising the Primary Health Care System (PHCS) by means of people management. Budget increases for delivery of services are also envisaged with a cross-sectoral approach across other departments.

The policies/programmes instituted by the provinces are based on previous ones developed by the NDoH and, if implemented, should impact positively on the delivery of PHC and HIV/AIDS services. These programmes cater for such vulnerable groups as women, children, the rural poor, people living with AIDS and HIV positive mothers and their babies. An increase in the number of nurses will impact positively on the quality of patient care since the loss of trained staff due to attrition has resulted in a shortage of nurses.

2.2.2 Children's Rights to Basic Health Care Services

2.2.2.1 National Sphere

There appear to bo no new policies developed for this reporting period.

2.2.2.2 Provincial Sphere

The KZNDoH reported a policy that facilitates the admission of abandoned children to hospitals and their placement with social workers. An immunisation programme for children with missed opportunities was also instituted. A *Baby Friendly Hospital Initiative* was accredited by UNICEF in November 2002 and exclusive breastfeeding was reported to be taught and practised at Port Shepstone Hospital.

The NWDoH reported the following new policies/programmes but provided no descriptions thereof:

- Draft proposal for Rapid Assessment of Health Care Needs of Children with Disabilities;
- Perinatal Education Programme to Improve the Quality of Care of Infants and Children; and
- Provincial Plan of Action

These policies/programmes are to be welcomed since they will improve the quality of care for children and also those with disabilities.

2.3 Developments in Key On-going Programmes and Projects

Key developments in Health Service Delivery and Strategic Health Programmes took place mainly in the implementation of ongoing programmes and/or projects, the issuing of guidelines, and training of health workers. These are discussed under the three key programmes identified above.

2.3.1 Health Service Delivery

2.3.1.1 Reducing Morbidity and Mortality Rates (Maternal, Women)

2.3.1.1.1 National Sphere

Maternal Death Notification and Confidential Enquiry into Maternal Deaths[31]

This programme was instituted to ensure that all maternal deaths are reported and investigated to ensure that there is no negligence during childbirth. The NDoH reported that according to the most recent triennium report on Saving Mothers (1999-2001), it would appear that there has been an increase in the number of maternal deaths in South Africa from 150 per 100 000 live births in 1998 to probably in the order of 175-200 per 100 000 live births in 1999-2001. The Maternal Mortality Ratio (MMR) is the total number of maternal deaths per 100 000 live births.

Table 1: Maternal Mortality Ratio (MMR) for provinces

Province	*Number of deliveries*	*Number of deaths*	*MMR*	*MMR (est.)*
Free State	44 201	96	217	199
Gauteng*	113 825	169	148	112
KwaZulu-Natal*	168 238	243	144	
Limpopo*	92 529	62	67#	
Mpumalanga	42 506	124	292	281
North West	36 900	112	304	289
Northern Cape*	16 080	27	168	
Western Cape**	146 087	92	63	54

Source: Saving Mothers – Second Report on Confidential Enquiries into Maternal Deaths in South Africa; 1999-2001, published in 2002, provided by the National Department of Health.

Data excludes deliveries from private institutions and community health centres and includes all referrals from other provinces. Coincidental deaths are excluded when known. MMR (est.) is calculated from an estimate of deliveries in private institutions from the SADH survey and a survey in Gauteng, estimates are for the number of births in CHCs from the 1998-1999 data.
**2001 data, ** 2000+2001 data. # Illustrates under-reporting.*
No figures were provided for the Eastern Cape province.

These deaths are most likely due to HIV/AIDS as there has been an increase in non-pregnancy related infections as a cause of death among mothers reported to the National Committee for the *Confidential Enquiry into Maternal Deaths*. The five major causes of maternal deaths were non-pregnancy related infections (mainly AIDS), complications of hypertension in pregnancy, obstetric haemorrhage, pregnancy related sepsis and pre-existing medical conditions. Women 35 years and older were at greater risk of dying than younger women in their twenties and those in their first pregnancy or with 5 or more pregnancies were also at greater risk.

The NDoH reported that training workshops were conducted in two provinces on the national *Maternity Case Record*, the *Policy and Management Guidelines for Common Causes for Maternal Deaths* and *the Guidelines for Maternal Care*. In addition, advanced training of midwives from NCDoH was supported.

National Contraception Policy Guidelines for the Sterilisation Act No. 44 of 1998

The overall goal for the contraception policy guidelines is to improve the sexual and reproductive health of all people in South Africa and enable everybody to exercise their contraceptive choice safely and freely. According to the National Department of Health's Annual Report, the Department of Health launched the

National Contraception Policy Guidelines in March 2002 . Training of trainers was subsequently conducted in Limpopo, Gauteng, Northern Cape, Mpumalanga, the Free State and the Western Cape.

Prevention of Violence Against Women

This policy is based on the Domestic Violence Act No. 116 of 1998 and the *Integrated Quality Social Strategy* of the GTDoH (1999). In addressing gender-based violence, the national department was in the process of developing the following documents:

- Policy guidelines for the management of survivors of sexual assault
- Case record for use as a guide to examination of sexual assault survivors

A men's workshop was organised during the 16-day campaign of Non Violence Against Women and Children in November 2002. Post-exposure prophylaxis (PEP) for rape survivors is operational in 100 per cent of medico-legal centres. The report failed to provide any figures on the number of women who had suffered violent abuse.

Termination of Pregnancy (TOP)

The Choice of Termination of Pregnany Act 93 of 1996 allows abortion on request for all women in the first twelve weeks of pregnancy and in some cases in the first twenty week.

According to the NDoH's Annual Report there was an increase in the number of providers trained in manual vacuum aspiration, post abortion care and family planning from 293 in 2000 to 439 in March 2003. However, due to the high attrition rate and the allocation of trained nurses to other services, the number of abortion service providers has actually dropped. No figures were provide for the actual number of abortions performed nationally or per province.

According to the South Africa Yearbook (2002/03)[32] there has been a significant reduction in the maternal mortality rate from unsafe abortions from over 64 per cent in 1994 to 9,5 per cent in March 2002.

Breast Cancer and Cervical Screening

According to the NDoH's Report, the National Policy Guidelines require all women between the ages of 35-55 to be screened to reduce mortality due to cervical cancer, which is a major cause of death in women. Screening of cervical cancer remains a challenge. Implementation of the cervical cancer screening policy is at different levels in the provinces. Campaigns for both cervical and breast cancer are conducted annually. No statistics were provided or any other information on implementation levels.

2.3.1.1.2 Provincial Sphere

Maternal Death Notification and Confidential Enquiry into Maternal Deaths

According to the Gauteng Department of Health Annual Report 2002/2003, the *Saving Mothers Report* released in March 2003 estimates the Maternal Mortality Ratio for Gauteng as 112 per 100 000 live births. The major direct causes of death were identified to be hypertension, haemorrhaging, abortions, ectopic pregnancies, sepsis and non-pregnancy-related infection, mainly due to HIV. Eleven patients died from backstreet abortions according to the *Maternal Death Notification Report.*

According to its Report to the Commission, KwaZulu-Natal's Maternal Mortality Ratio was 158 per 100 000 live births. Eight maternal death assessors were trained and the number of advanced midwives was increased. Antenatal attendance at clinics increased to four visits per woman.

The MPDoH reported a Maternal Mortality Ratio of 291 per 100 000 live births in spite of training an additional 66 midwives.

The NWDoH reported a rate of 231 per 100 000 which is regarded as a conservative estimate. The figure has risen since 2001 when it was 194 per 100 000 live births[33] The rise in the death rate is attributed to non-pregnancy-related causes: 55 per cent were due to HIV/AIDS, 21 per cent to pneumonia, 19 per cent to sepsis, 11,5 per cent to obstetric bleeding after birth. Patient-related avoidable factors also ranked relatively high.

National Contraception Policy Guidelines for the Sterilisation Act 44 of 1998

The GTDoH reported that emergency contraceptive services were being provided in all primary health care facilities. In total, 37 master trainers were trained on the *National Contraceptive Guidelines.* The Sterilisation Act is implemented in all hospitals and panels have been set up to make decisions relating to sterilisations. Over 2 500 sterilisations were performed in the reporting period but there was no indication if these were performed on men or women.

The FSDoH reported that 30 master trainers in *Sexual and Reproductive Health* were trained, and that 22 hospitals in the districts offered sterilisation. In 2002, 1 634 sterilisations were performed. There was no gender disaggregation of the figures.

The KZNDoH revised its training package and increased the number of trained personnel.

The WCDoH reported that it had been extensively involved in the development of the *National Contraceptive Policy Guidelines* in 2002. which outline the rights of the client, the needs of service providers and new definitions of sexual

and reproductive health. The province reported two seminars (one by satellite to five distance learning centres). A *Revised Sterilisation Policy* was put in place but no figures were provided.

Termination of Pregnancy (TOP)

The GTDoH has implemented TOP in 14 hospitals and 10 PHC facilities. Some 16 000 terminations were performed resulting in a 33 per cent reduction in early pregnancy-related deaths due to septic abortion and ectopic pregnancy. Thirty-eight midwives were trained for first trimester terminations in PHC facilities and 86 midwives and doctors were trained in seven hospitals for second trimester terminations.

The KZNDoH's Annual Report states that a total of 8 298 TOPs were performed, 54 per cent of which were in public hospitals. A total of 421 personnel were trained in counselling.

The WCDoH reported that out of a total of 30 hospitals which provided TOP services, 17 were urban and 13 rural. A total of 6 745 pregnancies were terminated of which 5 282 were in urban areas and 1 463 in rural areas.

Most of the provinces have instituted training programmes, but the number of TOPs performed in the public health sector remain low since many facilities still do not provide the service.Because of the stigma attached to abortions, many women still resort to backstreet abortions which often present with complications from unprofessional and unhealthy practices.

Breast Cancer and Cervical Screening

The GTDoH reported that the programmes had been implemented in all PHC facilities and service providers had been trained. About 25 000 women between the ages of 35 and 55 had been screened for cervical cancer and 180 female employees had been screened for breast cancer. An awareness campaign was held in October 2002.

The KZNDoH Annual Report states that the *Cervical Screening Policy* was distributed. A total of 74 district trainers were trained in screening, and 3 615 PAP smears were done, a 32 per cent increase from the previous year.

The WCDoH reported that mammograms were not readily available in the public sector but that 53 817 cervical smears had been done on women. Early detection numbers were not provided neither was it clear that the figure provided was for the reporting period or cumulative.

Screening for breast and cervical cancers is an important development in preventive measures to promote women's health. Most of the provinces did not even report on this important preventative measure. Judging from the few figures provided, much remains to be done to reach most women who qualify for this service.

2.3.1.2 Reducing Morbidity and Mortality Rates in Children

2.3.1.2.1 National Sphere

Integrated Management of Childhood Illness (IMCI)

According to the WHO every year, in developing countries, some 12 million children die before their fifth birthday. Seven out of ten of these children die from acute respiratory infections (mainly pneumonia) diarrhoea, measles, malaria, malnutrition or a combination of these diseases.[34] T*he National Plan of Action for Children* requires the promotion of children's health and survival. The core intervention is the integrated case management of these diseases in children, with a view towards improving health care at a facility and community level.

The NDoH's Annual Report states that in March 2003, 1 261 facilities were implementing the IMCI. A total of 4 997 health workers had been trained in IMCI and 29 per cent of health facilities have at least one IMCI trained professional. In addition, surveys were conducted in seven of the nine provinces to assess the quality of care given to sick children. The findings indicated improved assessment and management of children by IMCI trained professionals and an 85 per cent decrease in the wastage of antibiotics.[35]

Expanded Programme on Immunisation (EPI)

The NDoH's Annual Report views this as a priority programme and reported that it has achieved results in terms of vaccine preventable childhood diseases. Full immunisation has increased to 70 per cent, there have been no deaths due to measles since 1999 and the elimination of neonatal tetanus was validated in 2002 by WHO, UNICEF and the NDoH. Coverage of oral polio vaccine for the third dose was 89 per cent compared to 74 per cent in 1998. This exceeds the WHO's recommended target of 80 per cent. However, the acute flaccid paralysis detection rate was 1,3 rather than the required rate of 1,0 to qualify for polio-free certification from the WHO. Steps, which include training, monitoring and surveillance in all the provinces, have been taken to improve health workers' knowledge and to create public awareness around immunisation.

Human Genetics Policy Guidelines

The main purpose of the genetics guidelines for the management and prevention of genetic disorders, birth defects and disabilities is to facilitate the integration of genetic services into the primary health care package of services. This policy includes screening for genetic defects, counselling parents, management and

referral, and birth defect surveillance. The NDoH did not provide any details of this programme but indicated that due to cutbacks in funding this programme was not being implemented as planned.

Training of health care workers on genetics by National Department of Health (NDOH) and the Provinces is ongoing. The NDoH's Annual Report states that primary health care workers received training on human genetics in KwaZulu-Natal, LODoH and the NCDoH.

Foetal Alcohol Syndrome

A task team in the National Department of Health comprising of officials from the directorates of Women's Health and Genetics, Mental Health and Substance Abuse, Communication, Health Promotion, Child Health, District Health Systems Development, Nutrition and Health Systems Research, Research Coordination and Epidemiology is engaged in monthly meetings to coordinate the work on Foetal Alcohol Syndrome (FAS) within the health sector. Provinces are also encouraged to duplicate a similar structure in each of the provinces and to focus on issues of prevention of FAS.

Studies of Foetal Alcohol Syndrome (FAS) revealed high incidence in children, especially in the Western, Northern and Eastern Cape. A workshop was conducted in the ECDoH.and it was found that less 10 per cent of districts, compared to a target of 40 per cent set in 2001, were implementing the guidelines, due to budgetary constraints. This impacts negatively on children and parents with genetic disorders. The Department's request for the budget to be topped up met with no success. It was suggested during these sessions that support should be given to trained health workers to collect data on congenital/birth defects, so as to identify the extent of the problem of genetic disorders, birth defects and disabilities in the respective districts.

2.3.1.2.2 Provincial Sphere

Integrated Management of Childhood Illness (IMCI)

KZNDoH reported that all districts implemented the IMCI. The policy also aimed to improve the care of children in homes and communities. The following achievements were reported:

- 60 per cent of PHC professional nurses were IMCI trained; and
- There was at least one IMCI trained nurse in 244 clinics, resulting in a 46 per cent coverage.

The NWDoH reported that the IMCI implementation begun in 1999 in the Brits sub-district and had been gradually rolled out through case management training to cover 100 per cent of districts and 85 per cent of sub-districts, by March 2003. The province provided information on relevant indicators for 2000/2001

rather than the current reporting period. However, it stated that 11,6 per cent of children were underweight at 6-71 months; and there were 6 000 AIDS orphans. Most of the provinces did not provide the information on outcomes and indicators required by the SAHRC.

The FSDoH reported that 4 per cent of children 6-71 months suffered from wasting, and 30 per cent between 6-71 months were underweight. The early neo-natal death rate was 7,7 per 1 000 live births within seven days after birth. The late neo-natal from 7 to 28 days was 3 per 1 000 live births; prevalence of measles was 0,0013 per cent. There were 31 hospitals, with 1 266 available beds for children and 28 840 paediatric patients.

Expanded Programme on Immunisation (EPI)

The ECDoH's response was very poor and in the few instances where figures were provided for indicators, they related to 2000/2001.

The FSDoH stated that there was 84 per cent immunisation coverage for children 0-11 months; 85 per cent for measles at 9 months; 78 per cent for BCG.

The NWDoH reported that 72 per cent of children were covered for measles immunisation at 9 months.

KZNDoH[36] reported a 89 per cent EPI immunisation coverage with a less than 10 per cent drop out rate; no measles or neo-natal tetanus cases; 22 nurses had completed the first phase of EPI training , and that 14 active birth surveillance sites had been established.

Human Genetics

GTDoH's Annual Report stated that 15 health care workers had been trained in human genetics in Sedibeng and an albinism support group had been established. Awareness campaigns were conducted on congenital abnormalities.

Other provinces reported similar training programmes but acknowledged that the shortage of trained staff and the lack of capacity prevented them implementing this policy. The impact of this is that children will continue to be born with birth defects, placing an additional burden on parents and the State.

Indicators

The tables show a summary of health status indicators provided by organs of State and from independent research organizations.

The indicators to assess the progress made in reducing morbidity and mortality in mothers, women and infants show an increase rather than a decrease in numbers. The infant mortality rate, the maternal mortality ratio and the under 5

mortality rate have all increased according to the figures in Tables 2 and 3. The under five mortality rate is higher in rural than in urban areas. This is corroborated by data from the UN Human Development Report of 2002, which shows that there has been a reversal of these important health indicators in South Africa since 1999. Life expectancy has also been reduced.

Table 2: Infant Mortality Rate, Maternal Mortality Ratio and Life Expectancy

Province	*Infant Mortality Rate Infant deaths per 1 000 live births*	*Maternal Mortality Ratio Maternal deaths per 100 000 live births*	*Life expectancy at Birth Years*
EC	62	133	60,7
FS	66,6	*	51,6
GT	46	112	54,8
KZN	84	158	-
LO	37,2	30	-
MP	-	291	-
NC	-	*	-
NW	42	231	53,3
WC	-	-	-

Source: These figures are taken from reports submitted by provincial departments of health to the SAHRC's protocols

** denotes irrelevant information provided ; - denotes no information provided*

Definitions:

Life expectancy at birth is defined as the average number of additional years a person could live if current mortality trends were to continue for the rest of that person's life.

Maternal mortality ratio(MMR) is defined as the number of women who die as a result of childbearing, during the pregnancy of within 42 days of delivery, per 100 000 live births during one year.

Infant mortality rate is the number of children less than one year old who die in a year, per 1 000 live births during that year.

The exact figure depends on the study and the method utilised. A comparison of Table 2 and 3 show statistics from different sources vary according to how the data was collected and the method of calculation. There are discrepancies between the statistics provided by NDoH, Provincial Departments of Health and research organisations. Another example of this is the number of deaths due to AIDS. The MRC's AIDS Report (2001) estimated that about 25 per cent of all deaths were due to HIV/AIDS. Statistics South Africa recorded 9 per cent of deaths due to HIV/AIDS. This was based on information recorded on death

certificates. In the absence of the HIV/AIDS status of the deceased this conclusion was arrived at from indicator conditions associated with the AIDS syndrome.

The policies and programmes put in place to reduce morbidity and mortality in mothers, women and infants, if implemented successfully, should achieve the desired results. However, in South Africa a reverse trend is observed, that is, there are more deaths rather than a decrease in the number of deaths, in spite of these programmes. This is attributed mainly to AIDS and AIDS related deaths.

Table 3: Health Status Indicators

Indicator	*Date*	*EC*	*FS*	*GT*	*KZN*	*LO*	*MP*	*NC*	*NW*	*WC*	*ZA*
Life Expectancy at birth	1996[1]	60,4	52,8	59,6	53,0	60,1	53,5	55,6	53,3	64,0	57,0
	2002[2]	53,5	51,7	54,8	47,5	54,4	49,5	58,8	52,7	62,7	52,5
	2005[3]										47,0
MMR	1998	-	135	67	-	-	-	-	-	50	150
Maternal deaths	2000	103	92	164	228	74	126	29	78	46	940
Infant mortality rate	1998 2002	61,2 72,0	53,0 63,0	36,3 46,0	52,1 68,0	37,2 53,0	47,3 59,0	42,8 46,0	42,0 56,0	30,0 30,0	45 59,0
Under 5 mortality rate	1998 2002	80,5 112,0	72,0 106,0	45,3 82,0	74,5 124,0	52,3 87,0	63,7 106,0	55,5 72,0	56,0 95,0	39,0 46,0	61,0 100,0

Sources : Health Systems Review 2002[37]

References:1. Statistics South Africa (SSA) Human Development Index (HDI) 2001(Table I) in Health Systems Review 2002 p 439.

2. HIV Indicators 2002 in Health Systems Review 2002 p439 (The figures for Limpopo probably oversate the impact of HIV

3. Actuarial Science of South Africa (ASSA) 2000 in Health Systems Review 2002 p439

Number of maternal deaths is defined as the number of women who die as a result of childbearing, during the pregnancy of within 42 days of delivery. (the denominator is excluded due to the difficulty in obtaining accurate data on this) Note that the number of maternal deaths in a year is not generally considered an indicator.

Under 5 mortality rate is the number of children under 5 years who die in a year, per 1 000 live births during that year.

2.3.1.3 Infectious Diseases

2.3.1.3.1 National sphere

Cholera

According to the NDoH's Annual Report, there was an 80 per cent reduction in cases in 2002 from 2001. The case fatality rate for 2002 was 0,64 per cent, well below the 1 per cent target set by the WHO. 165 deaths due to cholera were reported in 2001 and 105 in 2002 with a total number of cases of 98 061 and 16 376 in the respective years. The case fatality rate for 2001 was 0,17 per cent, while that for 2002 was 0,64 per cent, which indicates that a higher proportion of deaths occurred in 2002.

This figure suggests that in spite of the public awareness campaigns, and the provision of safe drinking water by the Department of Water Affairs and Forestry, these measures were not adequate to reduce the case fatality rate in 2002. It is estimated that about 1,5 million households receive free basic water and that around 4,6 million people lack adequte sanitation. Considering that the population of South Africa is about 45,5 million, the proportion of people who live in dire poverty and in poor sanitary conditions is alarming.Clearly, more needs to be done to prevent loss of life due to cholera in South Africa.

Measles

The case fatality rate of measles for 2000, 2001 was 0,00 suggesting the disease has been eliminated.

Malaria

According to the South African Year Book decline in the number of cases since 2000 was due to: a revision of drug treatment policy; change of insecticide used for spraying; increased cross-border malaria control; increased laboratory capacity and unfavourable climatic conditions for malaria transmission. Through the Lubombo Spatial Development Initiative, government has been able to reduce malaria transmission by 76 per cent in KwaZulu-Natal, 64 per cent in Swaziland and 40 per cent in the southern parts of Mozambique.

The WHO has honoured South Africa with an award for the best malaria control in Southern Africa. Deaths due to malaria in 2001 declined by 74 per cent compared to 2000 and by a further 21 per cent in 2002.[38] However, judging from the graph provided in the Annual Report there had been a steady increase in reported cases since 1996 with the highest number reaching 70 000 in 2000. The lowest number of reported cases was in 1971 and South Africa has not yet reached its target goal or returned to the 1971 figures.

The NDoH offered the following explanation to explain to account for this:

Due to the change in epidemiological situation surrounding malaria transmission in South Africa post 1994, it is extremely challenging to expect malaria transmission in South Africa to reach the 1971 figures, using the current interventions. One of the key factors that needs to be taken into consideration is cross-border movement of the malaria affected populations. Government is in the process of addressing cross-border malaria control with neighbouring Zimbabwe and Mozambique and through this intervention it is expected that malaria cases will approach the figures reported in the 1971, similar to the good results obtained in the malaria project in the Lubombo Spatial Development Initiative.

2.3.1.3.2 Provincial Sphere

In 2002 there ware cholera outbreaks in KZN, Limpopo, and Gauteng.None of these provinces mentioned the cholera outbreak in their Annual Reports, nor in their responses to the SAHRC's protocols. This cannot be interpreted as an oversight and is not acceptable since these outbreaks received extensive media coverage. In KZN and Gauteng communities were using water from contaminated rivers. There were no proper toilet facilities, nor municipal services for sanitation.

Provinces in which malaria is endemic also failed to report.

Table 4: Provinces where malaria is endemic

Province	*Total No. of Cases Year*		*Total No. of Deaths Year*		*Case Fatality Rate % Year*	
	2002	*2003*	*2002*	*2003*	*2002*	*2003*
Limpopo	4 836	7 017	44	90	0,9	1,3
Mpumalanga	7 965	4 201	29	23	0,4	0,5
Kwa-Zulu Natal	2 345	2 042	16	3	0,7	0,1
Rest of SA	473	35	7	0	1,5	NA
TOTAL	15 619	13 295	96	116	0,6	0,9

Source: Dr Brian Sharp MRC- from fogures compiled by the NDoH

Although the total number of cases since 2000 has shown a steady decline from about 64 000 to 13 000 in 2003 according to figures supplied by the NDoH, the number of total fatalities in the country has not changed much from 119 in 2001, 96 in 2002, and 116 in 2003. In 2003, the number of cases in Limpopo increased by almost double than those reported in 2002, while the reverse took place in Mpumalanga. There was not much change in the total number of cases in KZN. Limpopo and Mpumalanga remain the two provinces most affected by malaria.

2.3.1.4 Non-Communicable Diseases

2.3.1.4.1 National Sphere

Disabilities

The National Department reported the purchase of 315 wheelchairs and a donation of a further 142 from the Buddha's Light International Association. Repair centres had been established in most parts of the country, including rural areas. People with disabilites had been trained to repair wheelchairs as a business initiative. MPDoH received the trophy for 2002 for the best province in the delivery of assistive devices and training in issues relating to disability.

Older Persons

An awareness campaign on the needs of older persons to combat neglect and marginalisation (International Day for Older Persons) was conducted in the NW province on 1 October 2002. No other specific programmes or projects were reported. None of the other provinces reported on specific policies or programmes dedicated to the health needs of older persons. Instead older persons had to access generalised ones which cater for geriatrics.

Speeding up Delivery of PHC

Delivery of the PHC package is through the District Health System (DHS). The goal is for it to become a municipal competency, wherever the capacity to deliver exists. The NDoH reported that it annually assesses district development, using a standardised set of indicators.[39] However, none were provided. It reported that GTDoH, ECDoH, FSDoH, and the WCDoH have signed service level agreements (SLAs) with municipalities.

According to the NDoH, more facilities were providing PHC during 2002/03, the cost of which has increased, partly due to inflation, from R176 per capita in 2000/2001 to R216 per capita in for 2002/03.[40] According to the IFGR the average per capita spending for the same period is R148.

Effective planning and reporting mechanisms are essential for the DHS to function optimally. With the assistance of the Equity Project, guidelines for provinces and municipalities[41] have been issued.

2.3.1.5 *Emergency Medical Services (EMS)*

2.3.1.5.1 National Sphere

The aim of this service is to render rapid emergency medical services and patient transport.

An efficiently run emergency medical service is essential to reduce mortality and morbidity especially where there is a high level of violent crimes and also where physical and economic access to clinics and hospitals in rural areas is hampered by poverty, insufficient means of transport and in many cases bad roads which results in delays before patients receive treatment.

The NDoH is planning to introduce norms and standards, costing models and business plans for 2002/03 as well as providing services for international events held in South Africa. The NDoH reported that 444 emergency vehicles had been acquired and an additional 213 personnel were employed. Ten new emergency medical services bases and four new communication centres were established.

2.3.1.5.2 Provincial Sphere

Gauteng passed the GTDoH Ambulance Service Act and purchased 44 new ambulances. Service Level Agreements (SLAs) were signed with all six local authorities who had 209 ambulances with a further 10 at hospitals for transfer of patients. GTDoH also reported that there were four ambulances at Zola Clinic for the transfer of patients, as well as private sector ambulances in use.

According to its Annual Report, an improved response time of 15 minutes for 82,6 per cent of priority one patients was achieved and that 100 per cent of these patients were attended to by trained ambulance personnel.

The FSDoH reported on new developments in Emergency Medical Services. In order to improve service standards and enhance access, despite staff shortages the following circulars were implemented during the reporting period:

- Medical Support Services Circular No. 1 of 2003: Standing Operational Procedures for Emergency Care Practitioners;

- Medical Support Services Circular No. 7 of 2002, which determines that no volunteers be utilised in EMS. Appointed casual workers may, however, work additional hours as voluntary work.

During the reporting period, 53 new ambulances, 13 rescue vehicles and 19 planned patient transport vehicles were purchased to enhance both access to and the quality of care.

KZNDoH reported a policy change whereby maternity and paediatric calls are now coded red with intermediate life support response thus ensuring a faster response time and a higher level of life support for these patients. According to its Annual Report 2002/03 its Emergency Rescue Services has two sub-programmes: Emergency Patient Transport and Planned Patient Transport. Improved access had been achieved by:

- training 150 staff in medical dispatch procedures

- improvement in response times- in the urban areas reduced to between 16-30 minutes and in the rural areas to between 1-2 hours

- communicaion centres had been established in all Districts

- the percentage of isiZulu speaking staff had increased from 56 per cent to 60 per cent (target is 80 per cent)

- ambulances with two crew members are being phased in within the limited resources available in towns which previously had no emergency services

- In all, 15 new patient support vehicles were purchased so as to separate emergency cases from patient transport services

- 116 ambulances were purchased of which 11 were ALS response units

- an additional 44 vehicles were deployed during peak holiday periods.

To improve the quality of care 6 mobile intensive care units of the 22 envisaged for the province had been introduced.

The NCDoH reported that regulations governing Emergency Medical Services were being applied. A three-year replacement policy of vehicles has been introduced and 25 new ambulances have been allocated to areas that had no services. A two-crew ambulance system was being implemented and towns with no services were being prioritised.

Emergency services were also separated from patient transport by the acquisition of 15 patient transport vehicles.

The NWDoH, through the establishment of a Planned Patient Transport programme, reported that 18 new ambulances were bought, two new EMS stations were opened, and 12 people (with disabilities) were appointed in administrative positions. Major constraints were a lack of suitable vehicles and trained staff. In order to address these constraints:

- Private EMS services were utilised so that there was no lack of continuity of service delivery to the community; and

- Staff were sent to private institutions for training.

Table 5 provides a breakdown of EMS by region provided by the NWDoH.

Table 5: Emergency Medical Services in the North West Province

Indicator	*Bojanala Region*	*Southern Region*	*Central Region*	*Bophirima Region*	*Total Province*
Number of vehicles per 1 000 people	3,7	3,81	3,99	4,12	3,9
Number of vehicles replaced	5	5	5	7	22
Total kilometres travelled	2 241 780	1 378 959	346 000	234 434	4 201 173
Number of patients transported per 1 000 people	188	143,24	140	101,68	143,23
Percentage of call outs answered by single person crew	0 per cent	0 per cent	0 per cent	10 per cent	2,5 per cent
Percentage of locally based staff with training in life support at basic level	88,68 per cent	86,67 per cent	88,33 per cent	88,89 per cent	88 per cent
Percentage of locally based staff with training in life support at intermediate level	11,32 per cent	13,33 per cent	11,67 per cent	11,11 per cent	12 per cent
Percentage of locally based staff with training in life support at advanced level	0 per cent	0 per cent	0 per cent	0 per cent	0 per cent
Cost per patient transported	R340.33	R408.59	R414.43	R589.40	R438.21
Percentage of response times within current national targets	72 per cent	68.75 per cent	71 per cent	74,5 per cent	70,18 per cent

The WCDoH's provincialisation of EMS was not completed by the anticipated date of July 2002 when the Unicity EMS staff were to be transferred to the province due to labour-related matters. It is envisaged that provincialisation will result in improved deployment of resources and reduced emergency response time.

Improvements in Emergency Medical Services are to be welcomed. An increase in the number of ambulances and the shortening of response times will impact positively on those who require emergency treatment. This is of great relevance in South Africa where violent crime is one of the major causes of death. It is also important since access to health care facilities is not always within the reach of poor. It is estimated by the NDoH that 80 per cent of the South African population live within a 5 km radius of the nearest hospital.. One hundred and seven mobile clinics were in use. However, 840 000 people were without a medical clinic within a 5 km radius.

2.3.1.6 *Revitalisation of Public Hospitals*

It has been estimated that one third of public facilities required rehabilitation and that 40 per cent of hospital infrastructure need revitalisation or repair. Public hospitals account for more than 50 per cent of public healh expenditure. In 2002/03, 27 hospitals (three in each province) were earmarked for revitalisation to refurbish old ones or to provide new services. Allocations to upgrade infrasturcure and equipment are made from the Hospital Facilities Revitalisation Grant. Three new hospitals were built in the last financial year: the Durban Academic Hospital, the Umtata Hospital and Pretoria Academic Hospital.

2.3.1.6.1 Costed Norms Approach

The development of integrated strategic planning to drive the budget process is important in that a costed norms approach gives a more realistic basis for expenditure. The system of cost centre financial accounting was in use in 46 hospitals and the plan is to extend this to others in order to ensure a more cost effective and efficient use of resources.

2.3.1.6.2 Indicators

According to UNDP's South Africa Human Development Report 2003, there are over 4 000 clinics and five hundred mobile clinics. The Table below shows the number of private and public health facilities in the country.

Table 6:Number of Private and public facilities

Total private hospitals	350
Total public hospitals	399
District hospitals	257
National central hospitals	11
Provincial tertiary hospitals	7
Regional hospitals	66
Specialised hospitals	58
Number of private sector beds	37 671
Number of public sector beds	106 084

Source: Medical Research Council (2003)

There has been an improvement in the number of health facilities in the country with more clinics providing antenatal services. But there are still regional and sub-regional differences in access to health care services where access is easier in the urban centres and also in the richer provinces while the poorer ones and former bantustatans and rural areas are still under-served.

Maintenance expenditure is currently underfunded by about 2 per cent while replacement of equipment is estimated at R1.02 billion per year which sum far exceeds the current budget. Budgetary constraints have also led to widespread shortages of medicines, beds, linen, food and other essential items. This is in spite of increases in the overall health budget and the annual per capita expenditure from 1995 to 2003.

The table below gives the number of public health care personnel per 100 000 population (2000-2002)

Table 7: Public Health Care Personnel per 100 000 Population (2000-2002)

Category	*2000*	*2002*
Dental		
Dental practioners	1.7	1.59
Dental specialists	0.2	0.15
Dental therapists	0.3	0.33
Nursing		
Enrolled nurses	59.7	54.5
Nursing assistants	81.3	75.9
Professional nurses	120.3	106.8
Student nurses	21.6	19.2
Doctors		
Medical practitioners	21.9	19.3
Medical specialists	11.2	9.8

Category	*2000*	*2002*
Environmental officers	_	1.42
Medical researchers	_	0.5
Occupational therapists	1.2	1.1
Pharmacists	3.1	3.3
Physiotherapists	1.3	1.22
Psychologists	0.7	0.71
Radiographers	6.1	5.3
Total health sector posts		
Total number	268 122 (2001)	197 898
per cent Posts vacant	57.3 (2001)	42.5
Community service professionals (CSP)		
Number of CSP dentists	164 (2001)	
Number of CSP doctors	1 194 (2001)	
Number of CSP pharmacists	406 (2001)	341

Source: Medical Research Council (2003)

From the above table it can be seen that there has been a decline in the number of key health care professionals in the public sector from 2000 to 2002. This is compounded by the fact that currently there are about 42 per cent of posts that have not been filled. Insufficient medical and support staff places an extra burden on staff who are running the health care system. It also means that patients are deprived of quality care. The retention of skilled and trained doctors, specialists and nurses remains a major area of concern. Many opt to go into private sector hospitals where remuneration and working conditions are more attractive or go abroad. The decline in the number of nurses is alarming and not enough are being trained to fill their positions.

Not only is there a shortage of doctors in the country but they are inequitably distributed across provinces. According to the UNDP[42] hospitals in the North West and Limpopo have 0.8 and 0.9 doctors per 10 000 people respectively, while Gauteng has 6.8 per 10 000. The bed- to- doctor ratio is about 27:1 in the two provinces while Gauteng's is 5.7:1. Staff shortages have a negative impact on morale which contributes to abusive treatment of patients and adverse media attention. It must be noted that financial constraints has been cited as the single source of frustration amongst hospital staff. This is exacerbated by the AIDS pandemic which places an additional burden on an already overburdened health system.

Despite the fact that South Africa spends about 17 per cent of its GDP on health care, it has not as yet been able to reverse the problems inherited from the apartheid era. Inter- and intra-provincial inequalities result in unequal access. Provinces like Gauteng and the Western Cape have excess hospitals beds while the poorer provinces like the Eastern Cape, Mpumalanga and Limpopo have

shortfalls in the thousands. These inequalities are also manifest in the number of specialists available in these provinces and the quality of care received by patients.

At an inter-"racial" level, one finds that about 70 per cent of White South Africans belong to Medical Aid Schemes while less than 10 per cent of Black South Africans are covered by private Medical Aid Schemes.

The case studies below serve to highlight the poor conditions at Gauteng's Chris Hani Baragwanath Hospital, which serves mainly the Black population. The plight of poor farm communities is also highlighted.

2.3.1.7 *Case Studies*

2.3.1.7.1 A Survey of Hospitals conducted by the SAHRC in the Eastern Cape

Following complaints to the SAHRC and press reports regarding poor conditions in hospitals in the Eastern Cape, the SAHRC's legal department conducted an investigation in March 2003.

The table below summarises the findings of the SAHRC's team which conducted site visits of eight hospitals in the Eastern Cape.[43]

For details see the South African Human Rights Commission's Report: *Site Visits & Investigation, Eastern Cape Hospitals.* SAHRC, Johannesburg 2003. The report is based on interviews conducted by members of the Legal Department of the Commission with Medical Superintendents, CEOs, chief nursing officrs and patients.

Table 8: Summary of the SAHRC's Report on Site Visits of 8 Eastern Cape Hospitals in 2003

	Frontier	*Fort Beaufort*	*Hewu*	*Bambisane*	*St Elizabeth*	*Holy Cross*[44]	*Madwaleni*	*St Barnabas*	*Umtata General*
Access: Roads	Poor	Good	Good	Poor	Very Poor	Poor	Poor	Poor	Poor
Access: Wheelchair	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Access: Phones	Yes	Yes	Yes	No	No	No	No	No	No [45]
Ambulances	Metro	Metro	Metro	Metro	2[46]	No	Metro	Metro	Metro
Over-crowding	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Adequate Staffing	No	No	No	No	No	No	No	No	No
PHC provided	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
Drugs, Food & Linen Shortages	Yes	No	No	No	Yes	Yes	Yes	No	Yes
Administration	Poor	Good	Good	Very Poor	-	Poor	Satisfactory	Very Poor	Poor

Source: SAHRC Report on Site Visits & Investigation of Eastern Cape Hospitals

Physical and economic accessibility

Accessibility was determined by the following indicators: the distance clients had to travel, road conditions, wheelchair access for the disabled, availability of ambulance services, and telephone access. Poor accessibility in most areas was found to be due to the poor road conditions and long distances people had to travel to get to hospitals, which were, on average 30 km-50 km away. The investigating team found that ambulance service was either inadequate or absent altogether. Where ambulance services were available from Metro Councils, they were totally inadequate to meet the needs of people, especially in the rural areas. In some cases, it was reported, that the ambulance arrived after a day, when the patient had already died. In many instances private transport had to be used, which for the rural poor, made medical care economically inaccessible.

It is obvious from the summary above that most hospitals visited were not accessible, especially to the rural poor. Poor physical access in 5 out of 8 hospitals investigated is tantamount to being denied access to health care services.

Shortages

There were a shortage of staff and inadequate supplies of drugs, and clean linen in most of the hospitals.

Hospitals delivering Primary Health Care

Although clinics are the designated facilities to deliver PHC, most hospitals visited were not turning away patients who complained that clinics were not adequately resourced in terms of staff, infrastructure and medicines to attend to their needs. Hospitals were therefore delivering PHC, placing an added burden on already understaffed facilities as well as their supply of drugs and other resources.

Poor administration

There was general dissatisfaction with the manner in which hospitals were being administered and at St Barnabas the post of the CEO had not been filled.

The team from the Commission concluded that “most of the problems emanate from poor administration and that “ the responsible organs of state are obliged to provide answers to that apparently unsatisfactory state of affairs.”

The SAHRC’s Report concluded that “ there were many omissions in the health services in the hospitals visited which are in a sorry state and constitute “at least on the prima facie level- violations of human rights which call for responses from the relevant service providers.” The MEC for Health in the province was informed of the findings of the SAHRC's legal team and his response was that measures would be put in place to address the problems identified. A followup

visit by the SAHRC to the province is therefore necessary to assess whether the recommendations have been effected.

2.3.1.7.2 Chris Hani Baragwanath Hospital

Poor administration due to lack of proper management in hospitals appears to be of general concern. A case study of Gauteng's Chris Hani Baragwanath tertiary hospital, the largest hospital in the world illustrates this. In a study carried out by the National Labour and Economic Institute (NALEDI)[47] one of the main reasons for the appalling conditions at the hospital, was " ... a managerial vacuum caused by an acute shortage of senior managers and ineffective management structures and systems." The report further states that dysfunctional management structures and practices give rise to poor decision-making, inefficiency, conflict, lack of discipline and frustration. Dissatisfaction with poor working conditions and remuneration have resulted in health workers emigrating or joining the private health care sector.

2.3.1.7.3 Farming communities

The SAHRC conducted an inquiry into human rights violations in farming communities and according to its Report[48] of 2003, the challenges facing farming communities in the provision of health care are:

- Physical and economic access to PHC clinics. These are more than the "golden standard" of five kilometres away, there is a lack of transport and when it is available poor communities cannot afford the cost. Another problem is that clinics do not offer services after hours, on weekends and holidays when workers can attend clinics especially since many employers don't allow them to go during working hours.

- Mobile clinics often do not offer a comprehensive package of services

- Emergency services are extremely poor and often non-existent

- Lack of telecommunications services

- Lack of information regarding their rights to access social grants and little or no information or education on health, sexual and reproductive health, and other related matters.

- Provisions for home-based care for the terminally ill is difficult

- The National Department of Health was requested to respond to the concerns raised by the SAHRC (outlined above) . The response provided is summarised below:

- The Department acknowledged the problems identified by the SAHRC and stated that these were in part due to

- the difficulty in staffing rural clinics as a result of the exodus to urban areas and overseas, as well as a loss of health care professional to AIDS.

- the lack of knowledge and prompt medical care which contibuted to high maternal mortality rates

- TOP facilities are concenetrated in urban areas

- there was a lack of cervical screening and genetic services in some areas

- and that strengthening the DHS was the best way to address the health issues of farming communities.

2.3.2 Strategic Health Programmes

2.3.2.1 **The Syndromic Management of HIV/AIDS, STIs and TB**[49]

The Strategic Plan for HIV/AIDS and Sexually Transmitted Infections (STIs) was adopted in 2000. The plan corresponds with international instruments to which South Africa is a signatory such as the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, and the Ungass Declaration of Commitment on HIV/AIDS.

The Strategic Plan calls for a partnership with civil society and outlines four strategic areas: prevention of infection; treatment, care and support; human and legal rights; and monitoring, evaluation and research.

New Policies and Guidelines

The following policies and guidelines were formulated in 2002/03 according to information provided by the NDoH after the workshop on first draft of the 5th ES Report:

Prevention of mother-to-child transmission

- Guideline for management of transmission of HIV and STI in sexual assault cases, 2002

- Training in PMTCT and infant feeding in the context of HIV/AIDS, 2003

- Revised HIV/AIDS protocol and PMTCT, 2003

- Monitoring and Evaluation Framework for PMTCT 2003
- Follow up strategy for mothers and babies 2003

Voluntary Counselling and Testing (VCT)

- Guidelines on pre and post test counselling 2002
- Guidelines on ongoing counselling 2002
- Guidelines on group information session 2002
- Guidelines on couple counselling 2003
- VCT sites assessment document 2003

Community Home Based Care (CHBC)

- Integrated Community Home Care (ICHC) in South Africa 2002
- Integrated Home /Community based care models options 2002
- STI Prevention and Care
- National STI guidelines revision and reviewing process, June 2002

A new phase of the awareness campaign was launched in September 2002 with R98 million of government funding in partnership with organisations such as Love-Life. Three hundred and fifty million condoms were distributed during the campaign. The distribution of the female condom was expanded from 114 to 203 sites, an increase of 78 per cent. Female condoms are distributed in addition to male condoms in six of the national departments. The South African AIDS vaccine initiative was scheduled to start clinical trials in 2003. Traditional healer task teams were established in all the provinces to assist in the fight against AIDS.

The following informtion was obtained from the Annual Report of the NDoH, the South African Year Book and from the responses to the SAHRC's protocol.

2.3.2.2 Prevention of Mother to Child Transmission (PMTCT)

After the Constitutional Court ruling to roll out Nevirapine to all who are prescribed the drug, all the provinces received guidelines for implementation of the PMTCT package and will expand services according to their capacities. The GT, WC, KZN and the NW Departments of Health have already begun rolling out Nevirapine to pregnant HIV positive mothers and their babies.

Approximately 1 200 nurses and doctors were trained in 2002 to facilitate the growth of the programme.

According to the NDoH's Annual Report, a total of 650 sites were established by January 2003 bringing national coverage to about 60 per cent of facilities providing antenatal care. At the time of writing, all the provinces had actually begun rolling out nevirapines to pregnant HIV positive mothers and their babies according to the NDoH.

The NDoH provided the following additional information after comments from them were solicited following the workshop where stakeholders were invited to offer a critique of the draft reports.

HIV/AIDS Prevention and Treatment

- VCT sites increased from less than 982 to 1700 (although Annual report says 472 in March 2002 and 1 625 operational sites in March 2003]
- CHBC organisations increased from around 400 to 892 organisations
- Ongoing STI/HIV and minor ailment support for 10 after hour roadside clinics targeting the long distance trucking industry
- 80 per cent of the public health facilities have a health worker trained in STIs
- Training of trainers (TOT) on the comprehensive approach (HIV/AIDS/STI and TB) completed
- 30 per cent of districts have implemented the District STI Quality of Care Assessment (DISCA) as monitoring and evaluation (M&E) tool
- National STI Baseline Assessment conducted, May 2003
- Male condom distribution increased from 250 million in 2000 to 350 million in 2002
- Male condoms are distributed in all 26 government departments. Female Condoms are distributed in addition to male condoms in 6 of the departments (23 per cent).
- Access to female condoms increased from 27 sites in 2000 to over 200 sites in 2002

- Integration of VCT into Maternal and Child Health Care Services

- Implementation of the first Youth Risk Behavioural Surveillance Survey (BBS) in 2003

Cooperation between private and public services

- 360 Health Care Professionals from professional unions, organisations and associations trained in HIV/AIDS/STI and TB fundamentals, capacity building and HIV/AIDS/STI/TB and employment

- Provision of technical support to the mine sector on STI and TB

- Appointment of two traditional healers in the HIV/AIDS and TB directorate

- Department of Health trained 120 master trainers who in turn trained 429 Local Government Councillors and officials as an integration of HIV/AIDS at Local Government level

Unequal distribution of resources

- The conditional grant from HIV/AIDS to the provinces including expanding VCT and PMTCT will increase significantly (from R210 million in 2002/3 to R334 million in 2003/4)

- The Department aims to address the infrastructure issues relating to the provision of VCT services. The R90 million grant from Germany will allow for construction of counselling rooms at existing facilities

- Public service interdepartmental HIV/AIDS interventions

- 25 of 26 departments (96 per cent) have HIV/AIDS policies. Senior managers were appointed in 22 (85 per cent) of these departments. Half of the Government departments have a budget for their HIV/AIDS Programmes.

- Expanding the Partnership and Support Against AIDS (NGO Funding)

- Establishment of 30 new partners of Women's organisation

2.3.2.3 Tuberculosis

Tuberculosis is one of the leading causes of death in South Africa and is the most common opportunistic disease associated with HIV/AIDS. The South African Year Book 2002/03 states that the epidemic is growing by about 20 per cent a year and can be attributed to high levels of poverty, especially in the rural areas where 75 per cent of the poor reside and where health care services are under-developed and often inaccessible. A TB team has been set up at national level while all the provinces have TB co-ordinators. A reporting system which tracks the outcomes of all infected patients has been implemented countrywide. In June 2002, the number of Directly Observed Therapy (DOT) districts increased to 150. In January 2002 the Government launched the National Medium Term Development Plan for the National TB Control Programme. The plan aims at achieving the following goals by 2005:

- a cure rate of between 80-85 per cent;
- decreasing the treatment interruption rate to 10 per cent
- detecting 70 per cent of estimated new smear positive TB cases.

It aims to achieve these objectives through improving accessibility and efficiency of laboratory services. Table 9 is a compilation of data provided by provincial departments and shows percentages of infectious diseases in the provinces.

Table 9: Infectious Diseases

Province	*HIV prevalence estimates for 2002*	*STD s*	*TB*
EC	23.6	-	-
FS	28.8	5.0	0.6
GT	31.6		35
KZN	36.5	3.8	*
LO	15.6	6.3	0.3
MP	28.6	20	*
NC	15.9	-	-
NW	26.2	-	13.7
WC	12.4	2.7	0.9
National	26.5		

** denotes irrelevant information provided Source: Data compiled from STDs and TB of Provincial Departments of Health submitted to the SAHRC, HIV prevalence is sourced from Department of Health's 2003. National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa: 2002*

2.3.2.4 *Home-based care*[50]

Home-based care (HBC) comprises three legs: The Integrated Strategy on Children and Youth Affected/Infected with HIV/AIDS, Step-down Facilities, and Home-based Care Services. These programmes are intended to provide an integrated package of care to the chronically ill, the aged, HIV/AIDS and TB patients.

The table below summarises the distribution of HBCs.

Table 10: Distribution of Community and Home-based Care [51]

Province	*No. of CHBC projects*	*No. of beneficiaries*	*No. of caregivers*	*No. getting stipends*
EC	160	2 420	-	-
FS	60 per cent of towns	-	1 046	440 (R500 pm)
GT	69	28 616	1 470	-
KZN	142	89 199	17 212	7 404
LO	44	57 124	534	335
MP	65	-	-	-
NC	23	2 715	498	374 (R800 pm)
NW	162	17 931	1 133	147
WC	39	9 850	634	-

Source: National Department of Health Annual Report 2002/03

2.3.2.5 Provincial Sphere

2.3.2.5.1 HIV/AIDS Prevention and Treatment

The FSDoH reported that programmes for rapid HIV/AIDS testing and counselling were being finalised by the National Department of Health and would be instituted when these were completed. The LODoH province reported several programmes under the PMTCT roll out plan: however, no descriptions of these were provided.

A policy on the care of abandoned children brought in by police and those who were left behind in hospital wards by relatives indefinitely, was introduced which allowed these children to be admitted A social worker should be notified to investigate the situation.

The roll out of Nevirapine under the PMTCT programme to all districts was extended beyond the two pilot sites in each province in compliance with the order made by the Constitutional Court. Antiretroviral therapy was also made available to survivors of rape and sexual abuse. Table 11 shows progress made in various programmes.

Table 11: Provincial Achievements in the PMTCT, VCT and HBC Programmes

Province	*PMTCT Achievements*	*VCT Achievements*	*Operational VCT Sites*	*HBC Achievements*
EC[52]	*	Personnel trained in 70 per cent of pilot sites	199	-
FS	-	Implemented in all five districts and 2 non-medical sites; Extensive training of volunteers and health care professionals; 15 763 HIV tests administered	149	-1 046 caregivers trained 60 trainers trained 410 NGOs registered
GT	100 per cent coverage for PMTCT 89 697 women tested since inception	84 VCT units operational; 40 000 people tested	80	-
KZN	56 per cent implemented	Four VCT established	109	*
LO	Systems in place in all six districts, 84 counsellors trained	*	401	-
MP	-	-	97	-
NC	Roll out of the PMTCT started December 2002 at three hospitals Provincial and district AIDS councils formed in five districts	93 VCT sites established in five districts 130 counsellors trained 455 professional nurses trained	87	
NW	*	*	256	Programmes established in five districts; 498 caregivers trained 377 caregivers receive R800 per month
WC	84 per cent of pregnant mothers have access to PMTCT programme	VCT implemented at medical sites 120 counsellors trained offering VCT at 150 medical sites	247	Training instituted in all regions

Source: Figures for PMTCT, VCT and HBC taken from responses from provincial departments to the SAHRC's protocols Operational VCT Sites from National Department of Health Annual Report 2002/2003
*- denotes no information provided; *denotes irrelevant information provided*

The NWDoH reported that its target was to reduce STDs by 30 per cent in five years. In 2001, only a 3,6 per cent reduction was recorded. No figures were given for this reporting period.

Since government responses did not, in the main, provide comprehensive and reliable statistics, the following information was obtained from *the Nelson Mandela / HSRC Study of HIV/AIDS: South African National HIV Prevalence, Behavioural Risks and Mass Media.*

HIV Prevalence

The study estimates the overall HIV prevalence in the South African population (over the age of two) to be 11,4 per cent. HIV prevalence among those aged 15-49 was 15,6 per cent.

Gender

Females accounted for 12,8 per cent of those testing HIV-positive, while 9,5 per cent of males tested positive. Amongst the youth (15-24), double the number of females (12 per cent) was infected as males (6 per cent). Women are biologically more susceptible to HIV infection than men. Men are also more effective at transmitting the virus as semen is more infectious than vaginal fluid. Women may also have undetected sexually-transmitted infections, which increase the risk of HIV-infection.

Race

HIV prevalence among Africans was highest (12,9 per cent). This can be explained by historical factors, such as labour migration and relocation, as well as the fact that more African people live in informal settlements.

The infection rate among whites was 6.2 per cent. This is considerably higher than countries with predominantly white populations such as the US, Australia and France, where prevalence among whites is less than 1 per cent. Prevalence among coloureds was 6.1 per cent and among Indians, prevalence was 1,6 per cent.

Table 12: HIV prevalence by sex and race

Sex and race	*N*	*HIV+(per cent)*	*C.I.*
Total	8 428	11,4	10,0-12,7
Male	3 772	9,5	8,0-11,1
Female	4 656	12,8	10,9-14,6
African	5 056	12,9	11,2-14,5
White	701	6,2	3,1-9,2
Coloured	1 775	6,1	4,5-7,8
Indian	896	1,6	0-3,4

Table 13: Provincial HIV prevalence

Sex and race	*N*	*HIV+(per cent)*	*C.I.*
Total	8 428	11,4	10,0-12,7
Western Cape	1 267	10,7	6,4-15,0
Eastern Cape	694	6,6	4,5-8,7
Northern Cape	1 579	8,4	5,0-11,7
Free State	540	14,9	9,5-20,3
KwaZulu-Natal	626	11,7	8,2-15,2
North West	896	10,3	6,8-13,8
Gauteng	1 272	14,7	11,3-18,1
Mpumalanga	550	14,1	9,7-18,5
Limpopo	679	9,8	5,9-13,7

Age

The highest prevalence rate was among the 25-29 age group (28 per cent), followed by the 30-34 group (24 per cent). The prevalence rate for children 2-14 was unexpectedly high at 5.6 per cent and it remains unclear how these children were infected since transmission is through exchange of bodily fluids.[53]

Locality type

People living in urban informal settlements have the highest HIV prevalence (21.3 per cent), followed by formal urban areas (12.1 per cent). Tribal areas have a rate of 8.7 per cent and farms 7.9 per cent.

The mobility and transient nature of life in informal settlements, rather than socio-economic status, makes those living in these areas most vulnerable to HIV. This is reflected in the finding that 23,5 per cent of men living in informal settlements reported more than one sexual partner in the past year, in comparison to 19,2 per cent in tribal areas, 10,2 per cent in urban formal areas and 8,2 per cent in farms. Youth (15-24) in informal settlements also showed a significantly higher rate of sexual experience (74 per cent) than their peers in rural areas (58,3 per cent) and formal urban areas (53,2 per cent).

There was no significant difference in HIV prevalence between those working (14,2 per cent) and not working (12,1 per cent). Wealthy Africans and less wealthy Africans had similar levels of risk.

Voluntary counselling and testing (VCT)

It was found that 18,9 per cent of respondents over 15 years of age had previously had an HIV test and were aware of their status. The main reasons for HIV testing however, were for insurance purposes, and in relation to pregnancy. It was also noted that nearly two thirds of those who were found to be positive in the study did not believe they were at risk of HIV infection.

There was high awareness of VCT services, although only one in five of those who were aware of services had made use of them. Concerns of people who had not been tested included confidentiality, cost and quality of services.

Behavioural changes

The study found that there have been significant changes in sexual behaviour in South Africa over the past four years, when compared with the 1998 Demographic and Health Survey. The number of women who had no current sexual partner had increased, and condom use has increased significantly. Amongst women aged 15-49, condom use at last sexual intercourse has more than tripled, from 8 per cent in 1998 to 28.6 per cent, and amongst women aged 20-24 it has increased from 14,4 per cent to 47 per cent.

Condom use amongst sexually active youth aged 15-24 is high, with 57,1 per cent of males and 46,1 per cent of females having used a condom at last sexual intercourse. This is supported by high levels of perceived access to condoms — with over 90 per cent of youth and adults reporting that they could obtain a condom if they needed one. Condoms were most likely to be obtained through the DoH's free condom programme from public sector clinics and hospitals.

Only 55.6 per cent of males and 57.9 per cent of females aged 15-24 had previously had sex, and there were very low levels of partner turnover. Of youth that were sexually active, 84,7 per cent reported that they had only one partner in the past year. For adults aged 25-49, the rate was 93,5 per cent.

Self-reported behaviour change as a result of HIV/AIDS was also high. Nearly half of all males and over a third of females over 15 years reported that they had changed behaviour. Steps taken included staying faithful to one partner, condom use, sexual abstinence and reducing the number of sexual partners.

The Report concluded :

> *It is important that a prevention and care strategy should include increased voluntary counselling and testing services, coupled with access to better nutrition, improved healthy living and access to treatment using antiretroviral therapy. Such a strategy would help to alleviate the plight of people living with HIV/AIDS*

2.4 Legislative measures

2.4.1 National Sphere

The Medical Schemes Amendment Bill and the Occupational Diseases in Mines and Works Amendment Bill were promulgated into law during this period. Several other bills were tabled (see Table 14), notably the National Health and the Children's Bill.

The table below summarises major legislative developments during the reporting period. The table and much of the discussion is based on an article in the SA Health Review 2002[54].

Table 14: Summary of Bills Drafted, and Passed in 2002/2003 and their key impacts[55]table

Bill	*Drafted*	*Passed*	*Key Impact*
Mental Health Act no 17of 2002		*	Protects the interests of the mentally ill and provides for de-institutionalisation
Medical Schemes Amendment Bill (B37-2002)		*	Regulation of the Practice of Brokers Bill
Occupational Diseases in Mines and Works Amendment (B39-2002)		*	Owners of mines to paycompensation to workers who contract diseases while in their service within two years
Medicines and Related Substances Amendment Bill (B40-2002)		*	Provide for appointment of deputy registrars; regultions on marketing of medicines, council to licence manufacture, importation and exportation of medicines
The Nursing Amendment Bill	*		Updates nursing legislation in line with health policies adopted since 1994
Children's Bill	*		Will replace the Child Care Act No.96 of 1983 and provides for primary and secondary prevention approaches to support vulnerable children and families
Older Person's Bill B68-2003	*		Protects the rights of older persons against abuse

Source: South African Health Review 2002

2.4.1.1 The Mental Health Care Act 17 of 2002

This legislation was passed in June 2002. Its intended impact is to provide legal protection and recourse for the mentally ill and it serves to protect their interests. Provinces are now obliged to align their legislation and practices with nationally determined guidelines. The mentally ill, who often suffer neglect and stigmatisation, are now offered protection against abuse. The policy of de-institutionalisation of people into home- or community-based care programmes is under-funded and does not have the capacity to provide quality care for these people. To release the mentally ill into the care of families and communities who are already carrying the double burden of poverty and the ravages of AIDS serves to shift the responsibility of the State onto the shoulders of the people. De-institutionalisation may be an option in rich countries where families can carry the costs but it seems to be an additional burden for poor families in South Africa.

2.4.1.2 The Medical Schemes Amendment Act 62 of 2002

The amended Bill was adopted by Parliament in October 2002. The amendment provides for a definition of a "broker" and for the accreditation of brokers by the Council. In essence the Bill provides for the regulation of the practice of brokers – a gap in the principal Act. In the memorandum to the Bill the drafters provide reasons for the need to regulate brokers: "… there has been some lack of clarity on how medical schemes brokers should be regulated in their conduct of business, in particular, as to what extent they can be regulated by the Financial Services Board". The Council for Medical Schemes agreed with the Financial Services Board in February 2002 on how to jointly regulate the conduct of business by medical schemes brokers, thereby ensuring that there is no inadequacy in such regulation.

2.4.1.3 The Occupational Diseases in Mines and Works Amendment Act 60 of 2002

The Bill was debated and passed by Parliament in October 2002. The amendment provides for owners of mines to pay compensation to workers who contract diseases while in their service. This is an important amendment given that employers often "walk away" from their employees who become sick from diseases contracted at work (cf. the asbestosis case currently being fought in the Royal Courts of England). This Act protects workers from third parties infringing on their rights to compensation.

2.4.1.4 The Medicines and Related Substances Amendment Act 59 of 2002

The objective of the Medicines and Related Substances Amendment Act is to amend the Medicines and Related Substances Act 101 of 1965. The amendments provided for:

- the appointment of deputy registrars of medicine;
- regulation by the Minister, after consultation with relevant stakeholders, of the marketing of medicines;
- recording, use and manufacture of certain scheduled drugs; and
- the Council to licence the manufacture, importation and exportation of medicines.

This Act serves to regulate the manufacture and marketing of medicines and related substances and to make them more accessible to the public in terms of prices. It protects the consumer from the high price structures of imported medicines.

2.4.1.5 Regulations and notices promulgated during 2002

A large number of regulations and notices were promulgated during 2002.

To protect the public from malpractices and to promote high standards by a range of health professionals who were previously unregulated, regulations on the constitution of boards for the following health professional groupings were issued during 2002: The Professional board for Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology; Professional board for Homeopathy, Naturopathy and Phytotherapy; Professional board for Chiropractic and Osteopathy; Professional board for Ayurvedic and Chinese Medicine and Acupuncture.

Notices for the commencement of community service for a range of health professionals were also promulgated during 2002. These included: dietetics; clinical psychology; environmental health; occupational therapy; physiotherapy; radiography; and speech, language and hearing therapy. These health professionals are mostly only available to public sector health care users in urban areas, and even here they are in short supply. The extension of community service to these categories of health professionals should improve access to them in rural and underserved areas of the country in 2003 when this notice comes into effect.

2.4.1.6 Bills drafted during 2002

2.4.1.6.1 The National Health Bill

The Draft National Health Bill[56] was revised after public comment and it is hoped that it will be passed in 2003. Passage of the Bill will provide overarching framework legislation to regulate and ensure uniform policies and services across provinces, in line with all the constitutional provisions relating to health care. It concretises the vision outlined in the White Paper[57] for transformation of the health care system in South Africa. It also outlines structures and mechanisms for the progressive realisation of the right to health care.

It is interesting to note that while section 7 (2) of the Constitution provides for the State to respect, protect, **promote** and fulfil the right, section 3 (1) of the Bill states: "The Minister must, within the limits of available resources (a) endeavour to protect, promote, improve and maintain the health of the population". While the Constitution places an obligation on the State in terms of section 7 (2), the Bill requires the Minister only to "endeavour". In addition, the term "fulfil" as defined by the Committee of ICESCR has a different connotation to the terms "improve" and "maintain".

A few key steps to create more certainty and to accelerate the full implementation of the District Health System (DHS) have also been taken and should be welcomed in view of the fact that the Constitution does not define the functions of municipal health services. A joint Department of Health and

Department of Provincial and Local Government technical team proposed a definition of municipal health services to the two respective ministers as well how to implement it and who should render the services. The proposal was accepted and included in the DHS chapter of the revised National Health Bill.

The proposals say that metropolitan and district municipalities should render municipal health services which are defined as environmental services, e.g. sanitation etc., with the exception of the control of malaria, hazardous substances and port health which will be provincial responsibilities. The proposal calls for these additional municipal services to come into effect after two years.

The Health Minister and other Members of the Executive Committee for Health (MINMEC) subsequently discussed the proposals related to the DHS in the Bill. The MINMEC made a range of decisions to strengthen the implementation of the DHS. These included:

- focusing on functional integration over the next two years;
- signing service level agreements between provinces and municipalities to improve efficiency and accountability; and
- a costing of services rendered by municipalities be urgently completed to assist the negotiations around the funding of municipal health services and primary health services in general.

2.4.1.6.2 The Nursing Amendment Bill

The Nursing Act No. 19 of 1997 is in the process of being reviewed and a Bill to replace the Act is being prepared. The South African Nursing Council (SANC) has recognised that the current Act is inadequate to meet the challenges facing the nursing profession to implement health policies adopted since 1994.

Changes to the Act are likely to be based on the recommendations made by a Committee appointed by the Minister to review the functioning of the professional boards. This implies that it is expected that 2003 should see amendments proposed to the legislation that governs all professional boards, e.g. the Health Professional Council of South Africa and the Pharmacy Council.

2.4.1.6.3 The Children's Bill

A draft bill has now been published and is expected to be tabled in Parliament for debate and passage in 2003. The Child Care Act 74 of 1983 has been under review for the past five years. While the 1983 Act focused on tertiary interventions and the institutionalisation of children in need of care, the new Bill provides for primary and secondary prevention approaches to support children and families in poverty and those otherwise at risk of vulnerability. This development has major implications for improvements in children's health and therefore for the whole health care system. The new Bill also envisages inter-

sectoral co-ordination, with the Department of Health expected to play a role in implementing the Act.

Children's health care rights have been extended in the draft Bill as follows:

- Female genital mutilation or the circumcision of female children as a cultural practice is prohibited;
- Every child has the right to refuse to be subjected to virginity testing, including virginity testing as part of a cultural practice, and not to be subjected to unhygienic virginity testing;
- Every male child has the right to refuse circumcision, and not to be subjected to unhygienic circumcision; and
- Every child has the right to have access to information on health promotion and the prevention of ill-health and disease, sexuality, and reproduction; and confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child.

2.4.1.6.4 The Older Persons Bill

The Bill is to be welcomed since it protects the rights of older persons and makes their abuse punishable by law. The Bill provides for

- special programmes for the development of older persons
- makes provisions for ensuring an enabling environment for the care of older persons
- protects their rights in facilities, and against abuse

2.4.2 Provincial Sphere

The EC, FS, KZN, and the NW Departments of Health reported no new legislative measures.

The GTDoH reported the following legislation:

- the GTDoH Ambulance Service Act No 6 of 2002 was passed, which provides for the regulation of ambulance service delivery and matters connected therewith;
- Ambulance Service Regulations were drafted;

- Amendment Regulations and Tariffs relating to Ambulances, Notice 2584 and 2982 of 2002, and 657 of 2003, were also passed; and

- participation in the finalisation of the National Health Bill

The NWDoH gave a detailed description of national legislation but failed to report on legislation passed by its own legislature. It did, however, mention that the Provincial Health Bill would be amended to conform to the National Health Act when it is passed, which is expected to occur during 2003.

2.4.3 Jurisprudence

The most notable development was the TAC case. The implementation of the Government's HIV/AIDS Strategic Plan 2000-2005, namely the PMTC Programme was challenged by TAC.The Constitutional Court, in 2002 confirmed the finding of the High Court which had found the Government's policy to limit Nevirapine to research and training sites to be in "breach of the States obligations under section 27(2) read with 27(1)(a) of the Constitution." The Court utilised the test of "reasonableness" as expounded by Justice Yacoob in the Grootboom case. In evaluating the policy to limit Nevirapine (an anti-retroviral drug) to research and training sites, the Court ruled that the "Government policy was an inflexible one that denied mothers and their newborn children … the opportunity of receiving a single dose of Neviripine" in public sector facilities outside the pilot sites.

The Court also ruled that "waiting for a protracted period" to make it available was "not reasonable" within the meaning of section 27(2) of the Constitution. The Court further ruled that the State is obliged to ensure that children are accorded protection contemplated by section 28. In this case, children born in public hospitals and clinics to mothers who are for the most part indigent and who require the protection of the State.

The Constitutional Court declared that:

> *a) Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.*
>
> *b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes.*
>
> *c) The policy for reducing the risk of mother-to-child transmission of HIV as formulated and implemented by government fell short of compliance with the requirements in subparagraphs (a) and (b) in that:*

> *i) Doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe Nevirapine to reduce the risk of mother-to-child transmission of HIV even where it was medically indicated and adequate facilities existed for the testing and counselling of the pregnant women concerned.*
>
> *ii) The policy failed to make provision for counsellors at hospitals and clinics other than at research and training sites to be trained in counselling for the use of Nevirapine as a means of reducing the risk of mother-to-child transmission of HIV.*

Government was ordered without delay to:

- Remove the restrictions that prevent Nevirapine from being made available at public hospitals and clinics that were not research and training sites,
- Permit and facilitate the use of Nevirapine,
- Make provision for counsellors based at public facilities to be trained and
- Take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.

The Court did not rule on formula feed to be made available in the public health sector.

In effect the Court's decision obliged government to roll out the PMTCT programme in spite of the objections raised by government. It is also interesting to note that in the TAC case, the Constitutional Court's order to provide Nevirapine to all pregnant mothers and their babies was based on the concept of "reasonableness" rather than "minimum core entitlements" as defined by the Committee.

Another important case in which TAC was also involved was one regarding the pricing of ARVs in order to ensure that the right to life is placed before profiteering . In September 2002, the AIDS Law Project lodged a complaint to the Competition Commission of South Africa on behalf of TAC, COSATU, CEPPWAWU,a number of people living openly with AIDS, health workers treating people with AIDS and the AIDS Consortium.[58] The complainants alleged that GlaxoSmithKline and Boehringer Ingelheim (two giants of the pharmaceutical industry) were acting in violation of Competition Act 89 of 1998, by charging excessive prices for their ARVs and that this was directly responsible for the premature, predictable and avoidable deaths of people, including children living with AIDS. A comparative analysis of the price of patented drugs and generic medicines shows that even when allowance is made

for the cost of research and development, profits, licensing fees and incentives to develop new drugs, the prices of patented drugs remain excessive. This action gained much publicity and international support.

Although the resolution of this matter falls outside of this reporting period, it is however, worth noting that at the time of writing, this matter was resolved in favour of the Complainants.[59] The Competition Comission investigated the complaint and found that the drug prices were in fact excessive. It also expanded its investigation to include the allegation that the Respondents refused to grant generic drug manufacturers access to an essential facility, namely, the patent on Retrovil, Lamivudine, Combivir and Nevirapine. The Respondents had repeatedly refused to issue licesnses to manufacture antiretroviral drugs to generic manufacturers in South Africa.

Before the Competiton Comission could refer the matter to the Competition Trubunal for adjudication, the Respondents indicated that they would be willing to reach a settelment.

2.5 Budgetary Measures

2.5.1 National Sphere

The 2002 Budget Review places special emphasis on reducing poverty and vulnerability by funding social grants and increased interventions to address the impact of communicable diseases such as AIDS.

The budget was divided into three programmes:

1. Administration which refers to activities related to the overall management of the Department
2. Strategic Health Programmes which incorporate sub-programmes that focus on key health interventions such as HIV/AIDS, STIs and TB. The AIDS related sub-programme accounts for more than half of the programme's budget
3. Health Services

The following table summarises the appropriation statement for the NDoH:

Table 15: NDoH Appropriation Statement 2002/2003

Programme	*Revised Allocation R'000*	*Actual Expenditure R'000*	*Savings R'000*	*Expenditure as per cent of revised allocation*
Programme One - Administration				
Current	83 284	83 646	- 362	100 per cent
Capital	11 020	9 258	1 762	84 per cent
Subtotal	94 304	92 904	1 400	99 per cent
Programme Two - Strategic Health				
Current	1 344 273	1 324 795	19 478	99 per cent
Capital	3 046	1 258	1 788	41.00 per cent
Subtotal	1 347 319	1 326 053	21 266	98 per cent
Programme Three - Health Service Delivery				
Current	5 483 766	5 434 172	49 594	99 per cent
Capital	728 608	727 381	1 227	100 per cent
Subtotal	6 212 374	6 161 553	50 821	99 per cent
Grand Total	**7 653 997**	**7 580 510**	**73 487**	**99 per cent**

Source: Department of Health Annual Report 2002/2003 p82

From the above table, the total allocation to the NDoH was R7,65 billion, which is an increase of approximately R1 billion from the previous financial year (i.e. R6 736 441 000 for 2001/2002). There was 1 per cent underspending in 2002/2003 which is a slight increase in underspending from 2001/2002 (when only 0,003 per cent of the budget was unspent). According according to the NDoH, 1 per cent underspending is acceptable financial practice.

A study of the details for Programme 1, Adminstration as provided by the audited financial statement, reveals that the three major expenditure items were personnel, administration, and professional and special services which received allocations of R45 734 000, R20 237 000 and R10 782 000 respectively. Personnel costs in this programme still account for the major portion of this budget.

The budgets for the subprogrammes of Programme 2- Strategic Health Programmes is given in the table below:

Table 16: Programmes 2: Strategic Health Programmes

Subprogrammes	*Revised Allocation R'000*	*Actual Expenditure R'000*	*Savings R'000*	*Expenditure as per cent of revised allocation*
District Health Systems	2 555	2 476	79	97 per cent
International Liaison	37 177	31 376	5 801	84 per cent
SA Developing Communities	2 049	2 361	- 312	115 per cent
Health Monitoring & Evaluation	164 429	161 831	2 598	98 per cent
Maternal, Child & Women's Health	631 521	624 499	7 022	99 per cent
Medicines Regulatory Affairs	20 845	21 330	- 485	102 per cent
Mental Health & Substance Abuse	6 060	4 972	1 088	82 per cent
HIV/AIDS, STIs & TB	463 041	459 951	3 090	99 per cent
Pharmaceutical Policy	16 969	17 257	- 288	102 per cent
Medical Schemes	2 673	0	2 673	0 per cent
Total	1 347 319	1 326 053	21 266	98 per cent

Source: Department of Health Annual Report 2002/2003 p91

The syndromic management of HIV/AIDS, STIs and TB received the biggest proportion of this budget, followed by Maternal, Child and Women's Health and Health Monitoring and Evaluation. According to the NDoH, the over spending by individual sub-programmes has been small which, in combination with greater under spending, resulting in a small surplus. The HIV/AIDS cluster spent 99 per cent of its budget; under spending by the cluster for Maternal, Child and Women's health was largely as a result of a problem in filling of specialised medical positions. Fluctuations in the rand/dollar exchange rate accounted for the rand value of transfers for international commitments such as membership fees for the WHO. Overall, the Department spent 98 per cent of the funds allocated for Strategic Health Programmes.

The budgets for projects falling under Health Service Delivery Programmes is given in Table 17 below.

Table 17: Health Service Delivery Programme 2002/2003

Programme	*Revised Allocation R'000*	*Actual Expenditure R'000*	*Savings R'000*	*Expenditure as per cent of revised allocation*
Disease Prevention & Control	260 444	217 487	42 957	84 per cent
Hospital Services	5 884 943	5 885 086	-143	100 per cent
Human Resources	6 532	6 789	-257	104 per cent
Non-personal Health Services	58 201	51 157	7 044	88 per cent
Health & Welfare Negotiations	2 254	1 034	1 220	46 per cent
Total	6 212 374	6 161 553	50 821	99 per cent

Source: Department of Health Annual Report 2002/2003 p93

2.5.2 Provincial budgets[60]

The provincial departments of health are responsible for key health care services delivery and receive the largest portion of the health vote.

2.5.2.1 Overall budget and expenditure trends- Key Features

According to the Intergovernmental Fiscal Review (IGFR) on health[61], the expenditure by provincial health departments was around R33,2 billion in 2002/2003. The majority of South Africans are covered by the public sector[62] which comprises 13.3 per cent of consolidated national and provincial non-interest expenditure.

The key features of the provincial health budgets are:

- Substantial increases for health services especially in the previously disadvantaged provinces
- Large increases in the Hospital Revitalisation Programme
- Strengthening in the HIV/AIDS Strategy
- R500 million rising to R1billion annually for a new system of rural incentives and scarce-skills strategy

Table 18: Heath expenditure by province

	2001/02 Actual Exp.	*2002/03 Actual Exp.*	*per cent Growth 2001/02 to 2002/03*	*MTEF 2003/04*	*Per capita exp. including conditional grants*	*Exp. per capita as a per cent difference from the national average***
	R million	*R million*	*per cent*	*R million*	*Rand*	*per cent*
Eastern Cape	3 892	4 377	12,4	5 118	668	-13,9
Free State	1 954	2 242	14,8	2 475	969	8,2
Gauteng	6 838	7 675	12,2	8 112	1580	52,3
KwaZulu-Natal	7 030	7 534	7,2	8 056	939	5,4
Limpopo	2 664	3 180	19,4	3 466	586	-27,3
Mpumalanga	1 457	1 712	17,6	2 102	635	-19,9
Northern Cape	517	604	16,7	737	876	1,6
North West	1 699	1 949	14,7	2 357	628	-21,7
Western Cape	3 706	3 964	7,0	4 430	1261	14,7
Total	**29 757**	**33 238**	**11,7**	**36 852**	**911**	

*Exp= Expenditure. *Per capita expenditure includes conditional grants. **These percentages exclude conditional grants.*

The nine provinces are responsible for the major portion of health care delivery and received a combined budget for health expenditure amounting to R33,2 billion in 2002/03 which is expected to rise to R36,9 billion in 2003/04, including conditional grants. Of this, about R6,0 billion was budgeted for out-of-hospital primary health care delivery at the clinic level.

Local Government also plays a role in relation to environmental health and clinic based primary health care services. Combined budgeted spending of the six largest municipalities, or metros, amounts to R1,1 billion in 2002-03.[63]

2.5.2.1.1 Significant growth in health budgets

The steady increase in provincial health expenditure budgets, which started in 2000/01 is in order to strengthen the health sector and to intensify a range of specific programmes. There was an average increase of 12,7 per cent in 2001/02 which fell to 11,7 per cent in 2002/03. The average annual growth in real terms is around 2,6 per cent between 1999/00 and 2002/03 which is set to increase to 3.3 per cent between 2002/03 and 2005/06. Most of the provinces saw substantial increases in health expenditure budgets except for Gauteng and the Western Cape (two of the richer provinces) which remained more or less the same.

The percentage increase for the other provinces were as follows: Eastern Cape 2,7-12,4 per cent; Limpopo 5,5-19,4 per cent; Northern Cape 10,6-16,7 per cent; North West 8,8-14,7 per cent. Mpumalanga saw an increase of 30,4 per cent in 2001/02 and 17,6 per cent in 2002/03 while KwaZulu-Natal's health expenditure budget saw an increase of 21,8 per cent in 2001/02 and 7,2 per cent in 2002/03.

2.5.2.1.2 Expenditure per capita

The gap between provinces is still large. Gauteng and the Western Cape spend the largest amounts at R1 580 and R1 183 respectively, while the lowest per capita spent is in the Eastern Cape (R668), Limpopo (R586) and Mpumalanga (R635).[64] Although the gap between provinces remains large with Gauteng and the Western Cape spending the most per capita, the gap is set to narrow over the medium term because of the above average growth in allocations to the Eastern Cape, North West and Mpumalanga provinces. Significant increases in per capita spending are evident in Mpumalanga, Limpopo (albeit off a very low base) and North West with Limpopo still set at the lower end.

2.5.2.1.3 Reduction in personnel and capital expenditures

The IGFR Report on Health states that due to the continuing trend of reduction in the share of personnel expenditure (from 66,6 per cent in 1999/00 to 58,1 per cent in 2002/03)[65], more funds should be available to accelerate and improve delivery. However, over the medium term, the budget is earmarked to increase to ensure appropriate levels of health service providers and geographical

distribution across provinces especially in the rural areas e.g. the doctor patient ratio for the Eastern Cape is 1 : 8 825 while that for Gauteng is 1 : 273. The strategy is aimed at increasing the rural allowance and to broaden its scope to a wider range of health professionals.[66]

Another strategy is a scarce-skill one which is being devised to improve recruitment and retention of health professionals due to losses from high levels of emigration.[67]

2.5.2.1.4 Non-personnel non-capital spending

These include medicines, laboratory services, surgical consumables and other supplies. Expenditure also shows a trend of growing substantially to reach 27,6 per cent in 2002/03 and is projected to increase over the medium term. However, higher price for blood products and the cost of pharmaceuticals tend to absorb a large proportion of this growth.

2.5.2.1.5 Capital expenditure

A major trend is the growth of capital expenditure since 2001/02 mainly due to the Hospital Revitalisation Grant which amounted to around R694 million. This grant targets the funding of strategic revitalization projects, such as upgrading, replacement and transformation of hospitals. The Nkosi Albert Luthuli Hospital in Durban and the Nelson Mandela Hospital in Umtata have been completed. The Pretoria Academic Hospital saw the first phase of work completed. National government funded about 50 per cent of the construction costs.

The following table represents the percentages of total health budgets spent by the provinces.

Table 19: Provincial Total Health Spending[68]

Province	*% Revised Budget Spent 2001/02*	*% Revised Budget Spent 2002/03*
ECDoH	96,8	98,6
FSDoH	103,3	97,7
GTDoH	100,5	102,8
KZNDoH	104,3	101,4
LODoH	98,4	100,7
MPDoH	96,1	96,9
NCDoH	101,7	101,3
NWDoH	97,9	101,9
WCDoH	99,5	99,9
Aggregate	99,7	100,6

Source: IDASA :Provincial expenditure briefs for the financial year 2002/03[69]

According to Vennekens-Poane's analysis consolidated overspending on recurrent health expenditure in 2001/02 further increased in 2002/03. With the exception of the MPDoH and FSDoH, all provinces overspent on their recurrent health budgets in the face of positive nominal growth in these budgets.

2.5.2.1.6 Health capital spending

Vennekens-Poane's concludes that although there was an increase in health capital budgets, spending in 2001/02 rose from 86,3 per cent to 86,6 per cent during the fiscal year under review. The figures point to continued under spending of the health capital budget resulting in increased under spending from R338 million in 2001/02 to R342 million in 2002/03.

Provinces such as the ECDoH, NCDoH and NWDoH with exceptionally rapid health capital budget growth, under spent significantly. The WCDoH, on the other hand, with a decreasing health capital budget, under spent by about 19 per cent. GTDoH and LODoH were the only provinces that over spent on the capital budget. In Gauteng, this was facilitated by a decreasing capital budget while in Limpopo, health capital spending increased at a faster rate than the budget. Under spending of the health capital budgets implies that provinces have not increased their capital spending capacity, which impacts negatively on their capacity for efficient service delivery.

The table below shows trend inexpenditure on programmes.

Table 20: Trends in expenditure on health programmes

Programme	*2001/02 Actual Expenditure*	*per cent of Total Expenditure 2001/02*	*2002/03 Estimated Actual Expenditure*	*per cent of Total Expenditure 2002/03*
Administration	1 187	4 per cent	1 351	4 per cent
District Health Services	12 051	40 per cent	13 078	39 per cent
Emergency Health Services	812	3 per cent	1 290	4 per cent
Provincial hospitals	7 878	26 per cent	8 952	27 per cent
Central hospitals	5 022	17 per cent	5 243	16 per cent
Health Sciences & Training	652	2 per cent	851	3 per cent
Support services	417	1 per cent	546	2 per cent
Health facilities	1 542	5 per cent	1 833	6 per cent
Other	196	1 per cent	99	0 per cent
Total	**29 757**	**100 per cent**	**33 238**	**100 per cent**

The above table shows that the three programmes-District Health Services (which include PHC, HIV/AIDS, Nutrition and District hospitals), Provincial Hospitals and Central hospitals account for the major portion of provincial health spending. A key trend is the decline of spending on Central hospitals while Emergency Health Services, Health Facilities and Administration saw an increase in spending over the medium term as did the other programmes. Primary health care is expected to grow to R6 billion in 2003/04. This in line with government's goals to transform the health system away from secondary and tertiary care to PHC.

In the 2002/03 PHC budget, the estimated actual amount received by clinics was R2,7 billion, Community Health Centers R1,4 billion and Community Based Services R488 million. While the increases are to be welcomed, the amount for Community Based Services needs to be increased especially where communities are poverty stricken.

Table 21: Per capital Primary Health Care expenditure 2002/03 and 2003/04

Province	*Rand per capita 2002/03*	*Rand per capita 2003/04*
Eastern Cape	91	106
Free State	183	168
Gauteng	238	243
KwaZulu-Natal	163	174
Limpopo	70	75
Mpumalanga	122	148
Northern Cape	199	246
North West	145	172
Western Cape	213	237
Total	**148**	**160**

There are large inequities in PHC expenditure across provinces with the Eastern Cape, Limpopo and Mpumalanga again having the lowest per capita expenditure. This is partly due to greater reliance by rural provinces on district hospitals to deliver primary health care.

2.5.2.1.7 HIV/AIDS

Government increased funding from R345 million in 2001/02 to over R1 billion in 2002/03. This was to focus mainly in preventative measures such as life-skills, condom distribution, voluntary counselling and testing, prevention of mother-to-child transmission and support for the South African Aids Vaccine Iniative, co-funding for Lovelife and treatment for sexually transmitted infections. It also provided funding to strengthen management at provincial level.

2.6 Vulnerable Groups

Policies developed under maternal, child and women's health cater for women and children. In addition PMTCT and VCT cater for HIV positive mothers and neonates. The Children's Bill, when promulgated, will protect the health rights of children. Furthermore, the CHBC programme is designed to cater for the needs of people living with AIDS, and the mentally ill who are de-institutionalised and sent home to be cared for by community based organisations and older persons. The Older Perons Bill provides legal protection for their right to dignity and protection from abuse.

In spite of the fact that most provinces made a general statement that health care services are available to everyone without discrimination, it is evident from the reports that there is a lack of dedicated programmes that address special of needs of the elderly, persons with disabilities, and other vulnerable groups. There are no specific interventions, nor dedicated budgets for the majority of the vulnerable groups identified in the SAHRC's protocols, such as child-headed households, girl-children, children with disabilities, homeless perspns, AIDS orphans, street children, non-nationals (asylum seekers, refugees, permanent residents), unemployed persons, persons living in informal settlements, prisoners and historically disadvantaged goups. Persons living in rural areas are disadvantaged by poor access to PHC facilities as well as tertiary facilities and also trained caregivers and specialists. Although monetary incentives to retain staff in under-serviced areas (which was recommended in the last ESR report) have been introduced, the rural/urban divide exacerbates the inequities suffered by vulnerable groups who find themselves in conditions of dire poverty.

Furthermore, implementation difficulties prevent provinces from achieving their targets. For example, the number of assistive devices dispensed is far below the required numbers and no specific programmes for the elderly were reported.

3 CHALLENGES FOR REALISATION OF THE RIGHT TO HEALTH CARE

Key challenges faced by the national health system can be summarised as follows:

HIV/AIDS

- The biggest challenge facing Government is the scale of the HIV/AIDS pandemic and the implementation of the National Comprehensive HIV and AIDS Care, Management and Treatment Plan (The plan has various components including ARV treament, nutritional support, strengtheing of the health system including laboratory system, information system, monitoring and evaluation, pharmaco-vigilance, training and human resources, communications)

- Reduction of maternal mortality ratio and infant mortality rate due to AIDS and an increase in life expectancy to meet the Millennium Development Goals

- Provide on-going training and improvement of quality service delivery especially for women and children whose health status is affected by AIDS and compounded by poverty - more women are now dying of AIDS than men

- Scaling up of all targets so as to reach more beneficiaries incrementally

- Implement HIV/AIDS prevention for migrant labourers

- Ensure effective syndromic management of STIs

- Ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV positive clients

- Implement measures to facilitate adoption and psycho-social support of AIDS orphans

- Develop policy on the management of persons with mental illness who are HIV positive

- Increase the distribution and use of male and femalecondoms

- Preparation of Local Government support programme on HIV/AIDS

- Development of target specific material addressing the issues of stigma

- Integration of HIV/AIDS activities at national, provincial and local level

- Develop protocol for funding of CBOs, NGOs, in collaboration with UNICEF

The District Health System

- The DHS should be made operational as soon as possible
- Service level agreements (SLAs) between the provinces and local governments need to be operationalised and implemented so as to have a uniform standard of health care delivery in all the provinces as well as in the rural areas
- Provincial Departments of Health have not passed or amended their Provincial Health Acts to conform to the revised National Health Bill. Provinces have taken the view that they will focus on their provincial legislation once the national legislation is finalised. It is therefore anticipated that all provinces will be either amending their Provincial Health Acts or finalising Bills for passage in 2004, once the National Health Bill is passed into law.
- The implementation of the National Health Act in all the provinces

Monitoring and Evaluation

- Monitoring and evaluation systems to be improved
- More trained operators to collect data for the DHS required
- Monitoring and evaluation of programmes to be strengthened

Children's Health

- Children- IMCI strategy requires improvements [70]in
    - in case management skills of health staff through the provision of locally adapted guidelines on IMCI, and activities to promote their use
    - in the health system of effecive management of childhood illnesses
    - in family and community practices with regard to prevention and managing illnesses
    - programmes for children, the disabled and other vulnerable groups to be put in place and implemented

Hospitals and clinics

- Upgrading of hospitals and clinics to be accelerated and efficient quality care with adequate medical and other supplies be made available as soon as is reasonably possible

- Increase the number of mobile clinics and patient transport vehicles andefficient use of ambulances

Administration and Management Systems

- general systems improvement, human resources, procurement and financial management systems

- Managers need special training to be effective

- the high turnover of medical and professional staff to be addressed

Budgetary meausres

- fraud and incompetent practices which hinder quality service delivery

- more efficient use of funding and available resources

- There is a need to improve management of funds to ensure that monies spent result in delivery of quality of care and not merely compliance with the PMFA .

- Inequities between the per capita amounts spent in the private and public sector and between provinces should see a narrowing of the gap over time in order that all should enjoy the highest standard of health care possible

- More monies have to be invested in infrastrucure development, such as roads to make clinics acceessible or provide patient transport. Where this is not immediately possible, well equipped mobile clinics should provide quality care as well be responsible for screening for TB, cervical and breast cancer especially in the rural areas and in informal settlements.

4 CRITIQUE OF MEASURES INSTITUTED

Since 1994, the government has put in place a single National Health System, drafted new policies and legislation to transform and modernise the national health system to be in line with constitutional requirements, international human rights instruments and WHO standards and norms.

Since there were no major policy developments during this reporting period, it was hoped to measure progress made in the implementation of the three key strategic programmes identified in 2.1. utilising the indicators developed by the NDoH.

4.1 The District Health Information System- Indicators

Most of the Departments failed to provide outputs/outcomes for indicators designed by both by the National Department of Health and also those by the SAHRC. They also failed to provide meaningful statistical data and information on budgets for programmes and projects requested by the SAHRC. Efforts to access these from the DG's office responsible for the District Health Information System met with no success. This is of great concern since the information required is available on their database. Furthermore, although the DHIS database is available at provincial level, these Departments too, failed to provide all the information requested. This leads us to surmise that provincial Departments have difficulty in accessing information which requires highly trained and skilled personnel to operate the system.

4.2 Reducing Morbidity and Mortality Rates in Women, Maternal and Children

The NDoH reported that due to financial constraints, some provinces did not implement the Maternity Case Record. Advanced training of doctors and midwives in reproductive health services was also hampered by financial constraints. Programmes for Advanced Midwifery and Neonatal Nursing Science have not been prioritised at provincial level. This impacts negatively on the inquiry into the causes of maternal deaths and points to poor management in this sector. The major cause for maternal deaths in South Africa are HIV/AIDS related and it is not acceptable that some provinces cannot keep records when the District Health Information System is already operational.

As regards Children's Health, the programmes in place record a lowering of infectious diseases. However, the infant mortality rate is recorded to have risen in South Africa and not fallen. Similarly, the maternal mortality ratio has risen – due mainly to the AIDS epidemic. These are important human development indicators whereby a country's development and health status are judged. So, despite the gains made in programmes designed to reduce morbidity and mortality, indicators used to measure a nation's health status reveal a reversal of trends. A comparison of figures from a study by the MRC in 2000[71] and one by the Health Systems Trust show an increase rather than a decrease for infant and adult mortality per cent since 1996.

Table 22: Mortality Estimates for South Africa, 2000

Indicator	*Male*	*Female*	*Persons*
Infant mortality rate per 1000 live births)	62	56	59
Under 5 mortality rate (per 1000 live births)	98	91	95
Total deaths	303 081	253 504	556 585
Adult mortality (per cent)	49,4	35,7	42,9
Life expectancy at birth	52,4		

Source: Health systems Trust Review 2002 p439 Definitions: Infant mortality rate is the number of children less than one year old who die in a year, per 1000 live births. Under 5 mortality rate is the number of children under 5 years who die in a year, per 1000 live births.

Table 23: Mortality Estimates for Provinces, 1998 and 2002

Province	*Infant mortality (SADHS , 1998)*	*Infant mortality HST, 2002*
EC	61.2	72.0
FS	36.8	63.0
GT	36.3	46.0
KZN	52.1	68.0
LO	37.2	53.0
MP	47.3	59.0
NC	41.8	46.0
NW	36.3	56.0
WC	8.4	30.0
South Africa	45*	59

*Source: SADHS- SA Demographic Health Survey 1998 for infant mortality rate. Comparison of different sources revealed that the SADHS 1998 estimates for three provinces required some adjustment. * After adjustment the infant mortality rate for South Africa in 1998 was 45 per 1 000 live births. Infant mortality rate(IMR) is the number of deaths per 1 000 live births.HST- Health Systems Trust Review 2000, p438*

A comparison of IMR for 1998 and 2002 show an alarming increase in all the provinces and in the average for South Africa as a whole. The under five mortality rate has increased substantially and falls far short of the target of 50 by 2015 .

The maternal mortality rate has shown a steady increase in South Africa and can be attributed to AIDS-related deaths. According to Statistics South Africa, the

major cause of death in women (15-49) in South Africa is HIV/AIDS, followed by TB, pneumonia and influenza.[72] Taking into account the deaths due to sepsis, bleeding and other causes such as delay in seeking help, it is obvious that improvements have to be made in maternity care, as well as in the education of mothers-to-be.

Data from the UN Human Development Report of 2003 indicate that there has been a reversal of these health indicators in South Africa which falls far short of the Human Development Index and WHO targets which call for a two-thirds reduction by 2015.

4.3 AIDS and TB

Both the NDoH and other academic studies have confirmed that the increase in these health status indicators is due to AIDs. The lack of treatment with ARVs has contributed significantly to early deaths from the disease and will continue for the next ten years when the disease will take its toll unless a comprehensive plan is implemented to roll out ARVs to all PLWAS immediately.

In its last ESR Report, the Human Rights Commission recommended that a National Action Plan for universal access to ARVs should be government's top priority and that the national budget should reflect this.[73] A technical task team of the National Treasury and the NDoH is working on the cost implications of an expanded response to the impact of AIDS on all sectors of society. In August 2003 the Cabinet convened a special meeting to consider the report of the Joint Health and Treasury Task team and decided that the NDoH should, as a matter of urgency, develop a detailed operational National Plan on an anti-retroviral treatment programme. The Department will be assisted by South African experts and specialists from the Clinton Foundation AIDS Initiative. The Plan was expected to be completed at the end of September 2003.[74]

The Director of WHO, at the 13th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA), declared the lack of access to ARV drugs a "global health emergency". The WHO has thrown out a challenge to the international community to support its target of providing anti-retroviral (ARV) treatment to three million people worldwide by the end of 2005. The TAC has been lobbying for more and better treatment of people living with HIV/AIDS. In partnership with the Congress of South African Trade Unions and others (COSATU,) they lodged a complaint to the Competition Commission of South Africa against two major pharmaceutical manufacturers namely GlaxoSmithKline (GSK) and Boehringer Ingelheim and their assosciates.[75] They argued that these manufacturers of AIDS drugs are pricing them beyond the reach of ordinary South Africans.

WHO's "3 by 5" plan, which aims to provide 3 million HIV-positive people with ARVs by the end of 2005, targets half of the six million people who need treatment now, and a fraction of the 40 million currently living with the virus. Although modest in numbers, the challenge represents a significant hurdle, given

the current state of global funding for AIDS and technical capacity. It is estimated that the "3 by 5" plan will cost at least US $5 billion a year, but the WHO is conducting further in-depth studies to produce a more accurate figure. It is doubtful that South Africa can meet this challenge.

Government's poverty alleviation programme, coupled with its food security programmes and social security grants, is aimed at improving the nutritional status of AIDS suffers which should result in boosting their immune systems to fight the infection.

4.4 Tuberculosis

TB remains one of the main challenges facing the national health system and is on the increase due to the high prevalence of AIDS. Of the 4.7 million infected with AIDS, 1.7 million of these will eventually develop TB. There were 182 690 cases of pulmonary TB in 2002 according to the Annual Report.

The DOT programme in many provinces lacks capacity to ensure that medication is taken regularly and that the treatment regimen is completed. Full coverage of the country by the DOTS strategy should rapidly become a reality. Failure to complete the regimen results in an additional burden to both patients and the health system to provide medication to combat resistance by strains of TB.

4.5 Breast and Cervical Cancer

Most of the provinces have instituted preventive measures for two of the major causes of death in women - breast and cervical cancer - but the numbers of women screened have not reached the target levels, especially in the poorer provinces and in rural areas.

4.6 Violence against women

Violent abuse of women due to rape and domestic violence is one of the highest in the world. In spite of legislation to protect women, practical difficulties such as access to courts by victims of abuse and the poor conviction rate of abusers and rapists still remain one of the major challenges for the criminal justice system to ensure that women in South Africa are accorded the dignity and respect their gender is entitled to as valuable members of society.

4.7 Home-Based Care

The Home-Based Care programmes are underfunded and understaffed and lack trained caregivers. Many care givers are themselves unemployed and work in impoverished communities that are not able to produce the required resources to care for PLWAS, children orphaned by AIDS, the mentally ill and the elderly.

4.8 Programmes for the elderly

It is often difficult for the elderly to access to services due to infirmity or disability. Increased services with mobile clinics will assist the elderly to access care and also better home based care.

4.9 Cholera

While government is seen to act in areas where an outbreak of cholera occurs, this is not sufficient to prevent the recurrence of the disease which requires more stringent preventative interventions and intergovernmental cooperation to ensure access to clean drinking water coupled with efficient and sustained systems of sanitation.

4.10 Legislative measures

There have been notable developments in legislation which are aimed at the progressive realisation of the right to health care and comply with section 7 (2) of the Constitution which enjoins government to respect, protect, promote and fulfil the right in the Bill of Rights These are the revision of the National Health Bill, the passage of the Mental Health Act, and the tabling of the Children's Bill. The latter two serve to protect the rights of these vulnerable groups. The Children's Bill and the Mental Health Act protect the rights of children and the mentally ill, respectively against abuse, and guarantees their right to dignity and other human rights as defined in the CRC, article 12 of the ICESCR, the African Charter for Human and People's Rights. The Children's Bill and the Mental Health Act serve to respect and protect their right to health.

The Medical Schemes Amendment Bill, the Medicines and Related Substances Amendment Bill and the amendment to the Occupational Diseases in Mines and Works seek to protect the rights of people against third parties, i.e. brokers, drug companies who impose high price structures, and owners of mines. Regulations and notices to regulate practioners of complementary medicine are aimed at protecting the public from malpractices and recognising the positive health effects of complementary medicine.

Although the Revised National Health Bill clearly defines the rights and responsibilities of users and health care providers, it makes no mention of the patients' rights to dignity, equality and non-discrimination. The fact that South Africa ranks second only to Brazil in terms of disparity and unequal distribution of wealth, and that access to quality care and to life-saving drugs still remains the preserve of those who belong to private medical schemes, is disconcerting. The provision of services to the poor and those in dire need was highlighted in the court orders in both the *Grootboom* and *TAC* cases. Equity must be read to mean the provision of not only equal access to public health care facilities but also equity in the quality of care provided by the public sector. The fact that we have a two-tier system of health care in South Africa, one private and the other public, serves to highlight the fact that those who can afford it generally have access to better services.

The National Health Bill makes provision for deploying doctors and pharmacists to areas where the need is greatest. This is to ensure that rural and under-serviced areas will receive better care. However, this has met with resistance by some sections of the health profession who maintain that their constitutional right to work in the place of their choice is being violated.

The Occupational Diseases in Mines and Works Amendment should be welcomed in so far as mine owners are now legally bound to pay compensation to workers who contract diseases while in their employ. However, the legislation does not cater for those who contracted asbestosis, silicosis and other occupational diseases in the past. The effects of past exposure are long-term and many people who have contracted these diseases in the past will not have any recourse to compensation.

The regulation of "complementary or alternative" medicine is also to be welcomed in view of charlatans and the un-prescribed intake of dietary supplements, which can lead to ill health. Practices by traditional healers should be recognised and brought in line with practices that are not harmful to the health and welfare of people especially where circumcision rites are concerned, which affect girl and boy children. There have been many reports of deaths of young boys during initiation rites due to surgery under non-sterile conditions.

The NDoH and many of the provinces promote the right to health care services by organising campaigns around particular issues such as ending violence against women and children, distributing relevant information and educating and training health workers and the public. On the positive side, behavioural changes with respect to AIDS prevention has been documented by the Nelson Mandela/SHRC study but clearly more education needs to be done to change attitudes and behaviour in an effort to raise the general health status in the country.

4.11 Budgetary Measures

The growth in allocations and expenditure is to be welcomed since it allows provinces to improve on service delivery. However, the per capita spending in the public sector is around six times less than that spent in private sector resulting in huge inequalities. This is one of the legacies of the apartheid era which government is endeavouring to change over time. The health budget comprises a large proportion of social spending and is set to grow over the medium term which shows governments commitment to improve the health status of South Africans.

Inequities across provinces is another factor which has to be addressed in more meaningful manner. The Eastern Cape, Limpopo and Mpumalanga show the lowest per capita expenditure spending for overall for health care as well as for primary health care.

HIV/AIDS

The large amount of funds injected into the AIDS programme is to be welcomed. Although the prevalence of HIV/AIDS does not show a substantial reduction, several researchers, have shown that behavioural changes are taking place amongst the youth. The rate of infection amongst young women still remains alarmingly high and more should be done to educate and assist women to prevent them contracting the disease. Cultural norms of male domination in sexual matters need to be urgently addressed.

5 RECOMMENDATIONS

5.1Policies

Policies need to be effectively evaluated and monitored and fault lines identified not only at the conceptual level but also in their implementation at provincial and local spheres. Where the need arises policies should be reviewed and adapted to changing demands and conditions so as ensure that targets are met in the short, medium and long term.

5.2 Legislation

It is recommended that the National Health Bill[76] be passed with immediate effect since this will allow the provinces to formulate a uniform health policy to conform to national legislation. Similarly, the Children's Bill, Older Persons Bill and other Bills should also be finalised since they protect vulnerable members of out society and also provide cheaper medicines to the public.

5.3 Budgetary Measures

The over spending and under spending in provincial health budgets should see stricter controls, and capital under spending must be curtailed.

Spending on infrastructure revitalisation, the delivery of quality PHC package, and transfer of funds to Metropolitan Councils should be speeded up so as to implement the DHS which has already been demarcated since 2000. Failure to do so results in confusion of roles and responsibilities, and withholding of essential services. population.

The District Health System and devolution of services to municipalities should be finalised so as to improve delivery of services by local structures. The budgets of local governments should reflect their new responsibilities.

Allocation of funds for health care in the provinces should be standardised by a formula which will ensure equitable service delivery in all the provinces. SLAs should be effectively operationalised as soon as possible.

Government should accelerate its efforts in exploring different avenues to contain the price increases in the health sector including stimulating local production of medicines, sourcing cheaper suppliers, collective purchasing and improved management to ensure that price reductions are passed onto the public sector

Funding to communities who care for PLWAS, the elderly and the indigent should be increased substantially

There should be a dedicated budget for the housing and care of AIDS orphans and PLWAS

Provincial departments of health should have dedicated budgets for the care of older, persons , persons with disabilites, and reproductive health care

5.4 HIV/AIDS/STIs/TB

The AIDS strategic intervention should receive priority status and South Africa should endeavour to meet the targets set by WHO's "3 by 5" Plan. The SAHRC recommended in its last ESR report, the universal rollout of ARVs to all people infected with HIV. After years of debate and delay, South African National Aids Council (SANAC) together with Cabinet has issued a directive to NDoH to devise a National Plan for the universal rollout of ARVs to all those living with AIDS. The decision by the Global Fund and more recently the European Union to fund AIDS programmes in Africa has to be welcomed since this will inject the necessary monies to save millions of lives. However, until a proper costing is done, it remains to be seen just how many PLWAS will receive adequate ARV treatment and nutrition and for what time period.

The integrated management of TB and HIV at the District and Primary Health Care level should receive further support, training and additional resources for effective management of these diseases.

Specific programmes should be designed to cater to the needs of vulnerable groups identified in the SAHRC's protocols such as street children, the elderly, AIDS orphans, refugees and asylum seekers, women and the indigent.

A National Action Plan for the universal rollout of ARVs to those infected with the HI virus should set and clear time frames for short-, medium- and long-term tatget to be achieved. Infrastructure, and training of doctors and other health care givers should be speed up .

5.5 Sanitation

Access to clean piped water and sanitation in poor communities, rural areas and especially in informal settlements should become a priority area for intergovernmental management and effective inter-departmental and cross-sectoral planning, e.g. closer co-operation between the Department of Water

Affairs and Forestry, Health, Environment, Social Services and local governments.

The classic public health lessons of the 19th century in Europe and the USA showed that the key public health interventions to improve population health status lie outside the health sector- i.e. the other determinants of health such as public sanitation, a clean and healthy environment, access to clean water, adequate housing, sufficient food and nutrition, and the enjoyment of other economic and social rights. The burden of avoidable disease and death is attributable to the failure to meet basic needs. For example, 50-70 per cent of lower respiratory infections, diarrhoeal disease, malaria and measles (the big killers) in childhood is due to undernutrition[3]. 88 per cent of diarrhoeal disease is due to unsafe water, sanitation and hygiene, and 99.8 per cent of deaths due to this risk factor take place in developing countries. Through malnutrition, poverty seriously impairs immune function making children more vulnerable to disease of all kinds.[77]

5.6 Information Systems, Monitoring and Evaluation

The DHIS must be capacited by employing more IT professionals. Data should be readily available and intelligible to managers and policy makers.. The progress of programmes and projects can only be assessed on reliable information Moreover, strategic plans, policy formulation and revision should be based on information that is accurate and easily accessible. Key indicators should be integrated with a Geographic Information System (GIS).

5.7 Capacity and numbers of health professionals

Government should devise plans for staff retention by providing better working conditions and incentives. Policies for staff retention must be put in place. Working conditions and terms of service should be made more attractive for health workers so as to minimise the loss of health care workers from South Africa.

It is imperative that capacity constraints in the public health sector be attended to with immediate effect. Recruiting and training of dedicated people in the health system must ensure that managers are empowered and systems put in place to ensure the seamless delivery of high quality care at all levels of the health system.

While it is not possible to judge at this stage whether South Africa will indeed meet the targets set out in the Millennium Development Goals or the WSSD targets, it is clear that there has been a retrogressive tendency in the most important health status indicators of a nation: life expectancy, infant mortality rate and maternal mortality ratio. The slow realisation of the importance of developing a national strategy to combat AIDS has taken its toll and is evidenced by the increased number of children dying before the age of five, the increase in

the maternal mortality ratio and a lowering of the life expectancy after the onset of the AIDS pandemic.

A tremendous burden has been placed on the State to introduce an equitable and functional national health service in the first 10 years of democracy. The outbreak of AIDS on such a vast scale has not made it possible for the State to concentrate all its resources on the effective delivery of policies and programmes aimed at establishing a single national health system based on equity and universal access. In addition, there is large scale of poverty, which makes the public system the first port of call for the majority who cannot afford private rates.

5.8 Inequalities

There exists large gaps in efficient service delivery of high quality to the majority of Black South Africans, who, because of the high levels of poverty cannot access an adequate standard of living for themselves. This is exacerbated by insufficient funding of programmes in spite of the fact that the envelope for social spending is more than 60 per cent of the national revenue. Lack of human capacity to successfully run projects and deliver basic services has been identified as a serious problem by both government and the SAHRC, but in spite of training programmes, this still remains a major obstacle to meet the health requirements of the majority of Black South Africans.

The task of assessing whether the State is progressively achieving its goals in facilitating and fulfilling its responsibilities for universal access to health care services is a more difficult one. To assess whether the right to health is being progressively realised, the test of reasonableness as defined by Justice Yakoob requires that the measures instituted be "co-ordinated, comprehensive, coherent, balanced and flexible". The policies devised by the NDoH, which are in the main compliant with WHO goals, meet the test of reasonableness in general but there is a lack of co-ordination and uniform implementation at the provincial and local spheres of government. This may be due to the absence of an overarching national framework legislation and the resultant disparities in provincial legislation. Another factor is the slow progress of integrating services at district level.

The results of the study *Causes of Death in South Africa 1997-2001 (Statistics South Africa P0309.2)* show that the five leading underlying causes of deaths among South Africans were unspecified unnatural causes, ill-defined causes, TB, HIV and influenza and pneumonia, accounting for 40.9 per cent of deaths. The proportion of deaths due to HIV nearly doubled from 4.6 per cent in 1997 to 8.7 per cent in 2001. While the leading causes of deaths among African and coloureds were TB, HIV, influenza and pneumonia and unspecified causes, Whites and Indians tend to die of diabetes, ischaemic heart disease and cerebrovascular diseases.

While the measures instituted in this reporting period, comply with the test of "reasonableness" as defined by Justice Yakoob, it can be said that this is not true

for the AIDS policy which fact was attested to by the judgment in the TAC case which was referred to in the Introduction. In *Grootboom* case, Justice Yakoob stated that measures are deemed unreasonable if not implemented reasonably and do not take into account those in dire need. There still remain huge gaps between policy and effective implementation in many areas of quality care service delivery, disparities along class lines, urban and rural divides, between provinces and amongst "race" groups. In short, the road towards equity seems long and arduous.

The health needs of vulnerable groups such as the indigent, people living with AIDS and children orphaned by AIDS remain a major challenge to the health system whose needs have not been sufficiently addressed in terms of constitutional provions and international human rights requirements.

The enjoyment of the right to health by all is hampered by the legacy of unequal distribution of wealth, poverty, underdevelopment and HIV/AIDS – adverse factors that impede the delivery of quality care and equal access for all. It is hoped that the health care delivery will improve for the majority of South Africans in the short term and that ARVs are made available to all as soon as possible to stem the tide of the pandemic which is not only killing millions of people but will impact negatively on the development goals of the nation and raise serious security issues as well.

1 Government of the Republic of South Africa vs Grootboom 2001(1) SA 46 (CC).

2 The National Department of Health is responsible for policy formulation and setting guidelines, norms and standards which the provincial and local spheres of government are mandated to implement.

3 *The Universal Declaration of Human Rights*, (1948) article 25. which states that "Everyone has the right to an adequate standard of living for the health and well-being of himself and of his family…

4 The "right to health care services" as provided for by the South African Bill of Rights does not encompass the scope of the "right to health" as defined by the UDHR, the WHO and article 12 of the ICESCR. However, the other determinants of health are provided for in the Constitution such as the right to adequate housing, food, education, social security, and land.

5 Overall health standards are improved by public health protection which are maintained by high standards of sanitation and a healthy environment. The right to a healthy environment is treated in the Environmental Rights report in this series.

6 See the *4th Economic & Social Rights Report 2000/2002* of the South African Human Rights Commission for a discussion of "progressive realisation" and "available resources".

7 *Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights* para 21.

8 The Bill of Rights provides for economic, social and cultural rights as well as civil and political rights against which the right to health care must be read. See Chapter Two of the Constitution.

9 *Vienna Declaration and Programme of Action* http://www.unhchr.ch/huridocda/huridoca.nsf/A.CONF.157.23.En?OpenDocument1993. Accessed November, 2003.

10 *General Comment No. 14 of* Committee of ESCR (2000) para 12.

11 *The Convention on the Elimination of All Forms of Discrimination Against Women* (1977) articles 12, 14,16.

12 *The Convention on the Rights of the Child* (1989) articles 6, 23, 24 and similar provisions in the *African Convention on the Rights of the Child* (1960).

13 The Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, adopted by the African Heads of State in April 2001; and the Ungass Declaration of Commitment on HIV/AIDS which was endorsed by the Special General Assembly Session in June 2001.

14 The Standard Minimum Rules for the Treatment of Prisoners (1957) sets outs minimum health rights of detainees and prisoners. According to the UN's Basic Principles for the Treatment of Prisoners (1990), "prisoners shall have access to health services available in the country without discrimination on the grounds of their legal status. The WHO's Guidelines on HIV Infection and AIDS in Prison (1993) provides standards for dealing with HIV/AIDS in prisons.

15 *The Declaration on the Human Rights of Non-Nationals* (1985) article 8.

16 *General Comment No. 14 of* Committee of ESCR, (2000) para 44(3).

17 Minister of Health vs Treatment Action Campaign para 34

18 UN Doc.A/37/40 para 5.

19 Berger, J; Hassan, F; Heywood, M (eds.) (2003). The Price of Life. Johannesburg: AIDS Law Project and Treatment Action Campaign. 19-21.

20 In the TAC case, the Court stated that the "rights in the Constitution should not be construed as entitling everyone to demand that the minimum care be provided to them" and based its judgement on the basis of "reasonable" measures and implementation plans. See the 4th ESR Report for full details.

21 *General Comment No. 14 of* Committee of ESCR, (2000) para 56.

22 http://hdr.undp.org/reports/view_reports.cfm

23 http://www.un.org/millenniumgoals/

24 It is estimated that there are six million people infected with HIV/AIDS out of a total population of about 40 million in South Africa and there are 600 AIDs-related deaths every day.

25 HIV/AIDS affects the nation's health system (overburdening it with patients), its social security system (increasing numbers of child-headed households, AIDS orphans etc.) and ultimately it affects the nation's budget as money meant for development is utilised to combat and contain the pandemic.

26 http://www.who.int/mediacentre/events/HSD_Plaq_02.8_def1.pdf

27 See chapter on Health in the 4th ESR Report where these plans were outlined in detail.

28 The Integrated Nutrition Programme is discussed in the report dealing with the Right to Food in this series.

29 The National Department of Health failed to submit a report to the SAHRC on time. However, when a submission was made, their report was incomplete and much of the information requested was not supplied. Other sources of information were consulted to compile this report. For a description of existing policies and projects refer to the 4th Economic and Social Rights Report 2000/2002. Some further information was provided as a response to the second draft report in March 2004.

30 *The South African Year Book 200203.*2003 Government Communication and Information System , Pretoria.

31 The NDoH, ECDoH, KZNDoH, FSDoH, NCDoH & WCDoH did not report on this programme, or provide any statistics for the maternal mortality ratio.

32 South Africa Yearbook 2002/03 GCIS, Pretoria, 356

33 The figures for the maternal mortality ratio taken from different sources vary considirebly i.e from the Reports to the SAHRC provided by provinicial departments of health, their Annual Reports and the figures in theSecond Report on Confidential Enquiries into Maternal Deaths in South Africa: 199-2001. The absence of reliable statistics makes it difficult for the Commission to assess the progress made in programmes. It also leads us to wonder how interventions can be made by health departments if they do not have reliable data?

34 South Africa Yearbook 2002/03 GCIS, Pretoria, 350

35 The NDoH's Annual Report does not identify any problems in the delivery of IMCI, nor is there a provincial breakdown of the survey.

36 KwaZulu-Natal Department of Health Annual Report 2002/2003. KZN Department of Health, Pietermaritzburg. 36.

37 Health Systems Trust 2002.Health and Related Indicators *p433-39*
http://new.hst.org.za/indic/indic.php/82/?mode=data Accessed 3/03/2004

38 *Department of Health Annual Report 2002/2003*(2003) p22 Pretoria.

39 The NDoH did not elaborate which indicators were used nor on the outcomes of the process of integration between provincial and municipal services.

40 The figures for per capita PHC provided by the NDoH do not tally with those cited in the IGFR.

41 Refer to Guidelines for District Health Planning and Reporting under New Policies.

42 UNDP South Africa Human Development Report 2003 p 32

43 For details see the South African Human Rights Commission's Report: *Site Visits &Investigation, Eastern Cape Hospitals.* SAHRC, Johannesburg 2003. The report is based on interviews conducted by members of the Commission with Medical Superintendents, CEOs, chief nursing officers and patients.

44 Holy Cross Is one of the 18 pilot sites for the PMTC and PEP programmes.

45 The SAHRC Reported that most of the time staff members were tying up the lines with personal calls.

46 Of the two ambulances at St Elizabeth Hospital, only one was in working order.

47 Karl van Holdt "Baragwanath in Bandages" http://free.financialmail.co.za/03/1219/currents/dcurrent.htm accessed 2003.For a full report of NALEDI's study on Chris Hani Baragwanath hospital see the report titled "After apartheid decay or reconstruction? Transition in a public hospital." Karl van Holdt, Betheul Maseramul & Mike Murphy. Personal communication with Karl van Holdt.

48 SAHRC 2003. *Final Report on the Inquiry into Human Rights Violations in Farming Communities.*Johannesburg.SAHRC.

49 See 4th ESR Report, pages 98 & 99 for a description of these programmes.

50 See the chapter on the right to social security in this series.

51 NDoH's Annual Report.

52 The ECDoH and NWDoH provided information for 2000-2001.

53 The study draws no conclusion on how these children were infected, but states that possible factors to be investigated are sexual abuse and exposure to infected needles.

54 Pillay, Y; Marawa, N; Proudlock,P. "Health Legislation." South Africa *Health System Review 2002. Health System Trust, Durban. P3-12.*

55 This table is adapted from the South African Health Review: www.hst.org.za/sahr/2002/chapter1.htm

56 See 4th ESR Report. At the time of writing (October 2003) The Revised Draft Bill has been sent to the provinces and the NCOP for discussion and it is was hoped that it would be enacted before the end of 2003.

57 The White Paper on the Transformation of the Health Care System in South Africa. http://www.gov.za/whitepaper/1997/health.htm

58 The Price of Life: Hazel Tau and Others vs GloxoSmith Kline and Boehringer Ingelheim: A report on the excessive pricing complaint to South Africa's Competition Commission. July 2003. Law and Access Units of the AIDS law project and the Treatment Action Campaign.

59 Personal communication between Eric Watkinson of the SAHRC and Diane Terblanche of the Competiton Commission , 30 April, 2004.

60 See Alexandra Vennekens-Poane *Budget Information Service http://www.idasa.org.za/bis/*

61 Intergovernmental Fiscal Review 2003 Chapter on Health http://www.treasury.gov.za/documents.htm Accessed March 2004. All figures and discussion is from the IGFR unless otherwise indicated

62 About 7 million of a total population of about 45 million are covered by medical aid schemes. Private health contributions were about R5 900 per beneficiary compared to an expenditure of R911 per person in the public health sector. Clearly there is a large disparity in the quality of services accessed.

63 In this Chapter, "2002-03" is used to denote the municipal financial year which runs from 1 July - 30 June. In contrast "2002/2003" denotes the national and provincial financial year from 1 April to 31 March.

64 The Eastern Cape,Limpopo, and Mpumalanga are the historically disadvantaged provinces.

65 This decline is mainly due to the declining trend in personnel numbers and the containment of growth in remuneration in recent years.

66 Allocating a rural allowance as an incentive to attract health workers to rural areas was a recommended in the 4th Economic and Social Report.

67 Over 90 per cent of pharmacists, dentists and psychologists practice in the private sector. Health Systems Review 2002

68 Statement of the National and Provincial Governments' Expenditures at March 31 2002 and 2003, National Treasury.

69 Alexandra Vennekens-Poane. Provincial expenditure briefs for the financial year 2002/03 http://www.idasa.org.za/bis Accessed June 2003.

70 These challenges were identified in the *South African Year Book 2002/03 p 350*

71 *Initial Burden of Disease Estimates for South Africa, 2000 (2003)* wwww.mrc.ac.za/bod/bod.htm accessed February,2004

72 Causes of Death in South Africa 1997-2001 (2002) Statistics South Africa. Pretoria.

73 *4th ESR Report 2000/2002* (2003) 133.

74 A National Plan was adopted in November 2003.

75 See note59. The Competition Commission ruled in favour of the complainants.

76 At the time of writing the National Health Bill had not been promulgated into an ACT.

77 See CETIM Realisation of the Right to Health http://www.Cetim/2003/03 ic 10w4.htm Accessed 26 February, 2004.