UNIVERSITY of the WESTERN CAPE

SoPH BULLETIN

The UWC School of Public Health Newsletter **May 2012**

Excerpts from…
THE NATIONAL HEALTH BUDGET SPEECH 2012/13
Dr Aaron Motsoaledi, Minister of Health

Dr Motsoaledi

The Health Department's outcome: "A LONG AND HEALTHY LIFE FOR ALL: We have selected four (4) out puts which must be realised on how to achieve this

We all know that life expectancy in our country has taken a serious knock as a result of the quadruple burden of disease, or the four (4) pandemics that the country is experiencing.

The four pandemics are:
- The scourge of HIV and AIDS and TB
- The unacceptably high incident of Maternal and Child Mortality
- The expanding burden of Non Communicable diseases (NCD's)
- The high incidence of violence and injury including Motor Vehicle accidents

ON HIV AND AIDS AND TB

Through combined efforts and collaborative undertaking, we launched a huge campaign to counsel and test 15 million South Africans for HIV. We have achieved this and even exceeded this target as today more than 20 million South Africans know their status.

Through this programme, we have been able to counsel and place 1, 6 million South Africans on ARV treatment. We have achieved this by increasing ARV sites from 490 in February 2010 to 3000 in April 2012. We have increased the number of nurses certified to initiate ARV treatment from 250 in February 2010 to 10 000 in April 2012. Within the same period we have conducted 320 000 on medical male circumcisions. We have reduced transmission of HIV from mother to child transmission from 8% in 2008 to 3,5% in 2011 or even to 2,5% in the case of KZN. This is a reduction of over 50%. This success allowed us to save 30 000 babies from contracting HIV from their mothers.

In order not to be complacent, we have unveiled a new National Strategic Plan or

The Department of Health receives the biggest additional allocations for health and social protection. The department receives R1 billion over the next three years for the national health insurance pilot projects and increases in primary health care visits. A further R968.3 million is provided to accommodate the increase in CD4 count threshold, to 350, for accessing antiretroviral treatment as well as the general increase in the number of patients requiring treatment; and R426.5 million over the medium term is for major hospital revitalisation infrastructure projects. An additional allocation of R450 million is made available for the upgrading of nursing colleges.

(NSP) HIV/AIDS and TB for the period 2012 – 2016. For the first time in our history we have integrated HIV and AIDS and TB in the same strategic plan. This new plan outlines a 20 year vision of the country in the fight against the double scourges of HIV/AIDS and TB. We need support and leadership to make the four (4) strategic objectives in the country's NSP a success.
These four (4) strategic objectives are:
1. Addressing the social structural drivers of HIV, STDs and TB care, prevention and support
2. Preventing new HIV/STD and TB infections
3. Sustaining health and wellness; and lastly
4. Ensuring protection of Human Rights and improving access to Justice

HIGH MATERNAL AND CHILD MORTALITY

High rates of pregnancy–related deaths, the disproportionate number of women exposed to sexual violence, with the worst incidence of all shaming the country just this past week, are a cause for concern. It is important to note that Maternal Mortality is not just the death of a women – it is the death of a woman because she dared fall pregnant! She becomes vulnerable to death because she is trying to bring new life into this World! We know that even mortality brought by HIV and AIDS, as well as Malaria, is disproportionally affecting young women of child-bearing age more than it does men. This disproportionate assault on women of child-bearing age is happening more on the continent of Africa than in any part of the World. Hence the African Union came up with a programme called CARMMA i.e Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa.

R27,6 billion for the year 2012/13, and growing to R33,9 billion over the MTEF in 2014/15

In our country we will launch this campaign on the 4th of May in Osindisweni Hospital in the Province of KZN. Members of the Portfolio Committee have been invited to this event through their Chairperson. We will outline concrete steps to reduce Maternal and Child Mortality during that event. In that event we shall further elaborate on how we shall roll-out the strategy called ESMOE i.e Essential Steps in Managing Obstetric Emergencies and the strategy called EOST or Emergency Obstetric Simulation Training.

ON NON-COMMUNICABLE DISEASES

Until very recently, the issue of Non-Communicable Diseases was less spoken about in the public arena. NCDs as the name implies, are not transmitted from one person to the other by a germ or a biological agent. They are not only biomedical, but are by and large diseases of life style. They are divided mostly into four (4) categories and have four (4) identifiable risk factors. You may then memorise them as diseases of 4X4 i.e. four (4) categories of diseases with four (4) risk factors.
The categories are:
a. High blood pressure and other diseases of the heart and blood Vessels
b. Diabetes mellitus and a few other metabolic disorders
c. Chronic respiratory diseases like asthma.
d. Cancers
We would like to add mental disease as falling within these categories.

The four (4) risks factors are:
a. Smoking
b. Harmful use of alcohol
c. Unhealthy eating behaviour or poor diet
d. Continued lack of physical activity

ON IMPROVING THE EFFICIENCY AND EFFECTIVENESS OF THE HEALTHCARE SYSTEM

In recent days, whenever South Africans talk about Health, they are mostly referring to the efficiency and effectiveness of the healthcare system. We have identified 5 activity areas or rather 5 programmes:

· The first is the improvement of infrastructure
· The second is the planning, the development and the management of Human Resources for Health
· The third is quality of care in our public health institutions
· The fourth is the re-engineering of the primary healthcare
· The fifth is the cost of healthcare in our country

The much talked about NHI falls largely within this last category programme.

ON NATIONAL HEALTH INSURANCE (NHI)

There is no way the efficiency and effectiveness of the healthcare system can ever be realised without dealing with the cost of healthcare and healthcare financing. There are people who wrongly believe that the concept of healthcare financing, as envisaged in NHI, is a pipe dream concocted by the ANC. I wish to advise them that NHI is not a unique South African concept. The World Health Organisation is actively promoting this concept and describes it as Universal Health Coverage. Universal Health Coverage is a system that does not discriminate against any citizen of a country.

We have reached a point of no return on this issue of Universal Coverage through NHI. On the 22nd of March 2012, I announced the names of NHI pilot Districts that will form part of the 10 sites. The Districts are: Dr K. Kaunda in the North West Province, Pixley ka Seme in Northern Cape, Thabo Mofutsanyane in the Free State, Eden in Western Cape, OR Tambo in Eastern Cape, Gert Sibande in Mpumalanga, Vhembe in Limpopo, Umzinyathi and Umgungundlovu in KZN and Tshwane District in Gauteng. R1 billion has been allocated over the MTEF for purposes of supporting the pilots. There are two (2) pre-conditions which the country must meet for successful implementation of NHI.

The first pre-condition is that the quality of healthcare in the public service must improve tremendously and hence public healthcare needs to be overhauled. This overhaul is not negotiable. The second pre-condition was that the pricing in the private health sector must be regulated!

The budget included new allocations of R97.6 million for 2012/13, R618,4 million for 2013/14 and R1,9 billion for 2014/15. The allocations include the following:

· Ten million per annum for the forensic laboratories to purchase equipment and appoint staff to address backlogs. We have recently appointed 70 unemployed graduates with Degrees in Chemistry, Bio-Chemistry and Chemical Engineering, to improve the performance and turnaround of our forensic laboratories

· R9 million, R10.3 million and R11 million to establish a unit to monitor and support provincial finances and improve audit outcomes. As part of the support to the provinces to improve the audit outcomes, the Department has appointed 100 unemployment graduates with BCom Degrees to undergo an internship programme.

The Department is requesting this honourable house to support the allocation for Vote 16 (National Department of Health) amounting to R27,6 billion for the year 2012/13, and growing to R33,9 billion over the MTEF in 2014/15.

Summary of Budget Allocations

Health

Budget summary

R thousand	2012/13 Total to be appropriated	Current payments	Transfers and subsidies	Payments for capital assets	2013/14 Total	2014/15 Total
MTEF allocation						
Administration	357 852	350 944	479	6 429	382 143	397 623
National Health Insurance, Health Planning and Systems Enablement	315 521	162 868	150 462	2 191	526 332	670 166
HIV and AIDS, TB, Maternal and Child Health	9 292 548	340 875	8 950 221	1 452	11 081 238	12 816 303
Primary Health Care Services	87 420	83 997	2 164	1 259	92 925	97 093
Hospitals, Tertiary Health Services and Human Resource Development	16 927 870	135 157	16 778 762	13 951	18 016 512	19 232 174
Health Regulation and Compliance Management	575 807	192 561	379 808	3 438	614 449	645 223
Total expenditure estimates	**27 557 018**	**1 266 402**	**26 261 896**	**28 720**	**30 713 599**	**33 858 582**

http://www.treasury.gov.za/documents/national%20budget/2012/enebooklets/default.aspx

Overview of the Strategy for Health: 2008/09 – 2014/15

Outcomes based approach

Government has identified and adopted a set of priorities to guide the development and implementation of programmes and interventions aimed at 12 national outcomes. The health sector is responsible for contributing to a long and healthy life for all South Africans (outcome 2).

A negotiated service delivery agreement to give effect to this has been signed between the Minister of Health and the President. The agreement covers for areas of output: increasing life expectancy, reducing maternal and child mortality, combating HIV and AIDS and tuberculosis, and enhancing the effectiveness of the health system. The agreement is one of the key policy priorities informing programmes and activities for the Department of Health.

The agreement is complemented by the health sector 10-point plan for 2009-2014, the overarching policy framework providing vision and stewardship for the health sector. Overhauling the health system to make it more responsive to the expectations of the population is an essential part of the re-engineered health sector. The plan and the service delivery agreement guide the national and provincial departments in delivering the desired outputs and outcomes, and progressing towards the realisation of the millennium development goals.

Transforming the health sector and the primary health care system

Transforming the health sector will specifically involve: improving the quality and management of health services; and reducing the burden of disease, focusing particularly on women and children who bear the brunt of the burden of disease. Other important interventions include intersectoral collaboration with government departments responsible for key determinants of health such as education, water, sanitation and housing, as well as community participation and partnerships with civil society and the private sector.

South Africa has historically had a fragmented health care system that focused on the curative approach. The process of re-engineering the primary health care system has been initiated, aimed at positioning it as the mainstay of the health sector in responding to the

quadruple burden of disease, that is non-communicable diseases, communicable diseases, HIV and AIDS, and injuries. The new approach attempts to refocus from a mainly curative approach to a more preventative one that promotes health. This approach is rooted in a three tiered model involving ward based primary health care, school health services, and district based clinical specialist teams.

National health insurance

The restructuring of primary health care and the health system reform are intended to improve the quality of care and prepare the health system for national health insurance. The department has produced a green paper on national health insurance and intends to pilot the implementation of the national health insurance over the medium term. The national health insurance will be implemented over a 14-year period, starting in 2012. In preparation for implementation, the department has taken steps to strengthen the health system to make it ready for the transition to the national health insurance. These include an audit of more than 4 000 public sector facilities, infrastructure upgrades, quality improvement activities and targeted interventions to fill gaps in human resources, such as increasing the number of doctors trained and recruiting mid-level workers in clinical and health management areas that have been identified as critical gaps New grants and changes to the budget structure Changes to the department's budget structure include expanding the previous, Health Planning and Systems Enablement programme to include the development of the national health insurance, which will now become the National Health Insurance, Health Planning and Systems Enablement programme.

Two new conditional grants, the national health insurance grant and the nursing colleges grant, become operational in 2012/13. The forensic pathology grant ended in 2011/12 and has been phased into provincial funding streams from 2012/13.

Focus over the medium term

Significant progress is and has been made in increasing life expectancy (output 1), decreasing child and maternal mortality rates (output 2), and combating HIV and AIDS and sexually transmitted infections and decreasing the burden of disease from tuberculosis (output 3) in the negotiated service delivery agreement. The focus over the medium term will be on addressing major challenges in enhancing the performance and effectiveness of the health system (output 4). The department will thus place emphasis on infrastructure, human resources, improving the quality of care, re-engineering service delivery towards primary health care and curtailing exorbitant health care costs. These measures should have a significant impact on the entire health sector, and not only the public sector. The successful implementation of these programmes and targeted interventions will lay the foundation for a transformed, unitary health system, which is required to successfully implement national health insurance and improve the responsiveness of the health system and better meet the expectations of citizens.

Expenditure trends

Expenditure grew from R16.4 billion in 2008/09 to R26 billion in 2011/12, at an average annual rate of 16.5 per cent, and is expected to increase over the medium term to R33.9 billion, at an average annual rate of 9.2 per cent. The increase in both periods is driven largely by transfers to provinces, with the largest areas of spending comprising conditional grants to provinces in the HIV/AIDS, TB, Maternal and Child Health, and Hospitals, Tertiary Health Services and Human Resource Development programmes. Increasing from R117.4 million to R670.2 million over the medium term, at an average annual rate of 78.7 per cent, the National Health Insurance, Health Planning and Systems Enablement programme is expected to have the highest percentage growth due to a new conditional grant introduced in 2012/13 for the national health insurance scheme.

The 2012 Budget includes new allocations of R97.6 million in 2012/13, R618.4 million in 2013/14 and R1.9 billion in 2014/15 for the following policy priorities:

- R10 million in each year to purchase equipment and appoint staff to address backlogs at the forensic chemistry laboratories
- R20 million each year for higher accommodation costs of the department's renovated head

office building
• R3 million each year for the Medical Research Council and R10 million each year for the department for annual wage increases
• R100 million, R150 million and R200 million to nursing colleges to plan and coordinate the upgrading, recapitalising and maintaining of nursing colleges following the infrastructure audit
• R834 million for the HIV and AIDS conditional grant for the rapidly growing treatment programme (lower threshold CD4 350) and to strengthen prevention programmes
• R128 million to provide for the first of five large hospital public private partnership projects under the hospital revitalisation grant
• R150 million, R350 million and R500 million to cover the cost of national health insurance pilots
• R189.2 million, R231.2 million and R216.7 million increases for the effects of wage increases in the national tertiary services grant.

Infrastructure spending

The allocation to the department includes allocations for the hospital revitalisation, health infrastructure and nursing college grants. The hospital revitalisation grant is allocated R12.9 billion over the medium term to allow provinces to plan, manage, modernise, rationalise and transform health infrastructure, health technology, and monitoring and evaluation of the health facilities in line with national policy objectives. The health infrastructure grant is allocated R5.1 billion over the MTEF period and will focus on maintaining institutions and smaller upgrading projects in primary care institutions and hospitals. The nursing colleges grant is new and is for the upgrade to provincial nursing colleges. This grant is allocated R450 million over the MTEF period.

http://www.treasury.gov.za/documents/national%20budget/2012/ene/FullENE.pdf

New Health Policy and Systems Resources Website Launched

http://www.hpsa-africa.org/

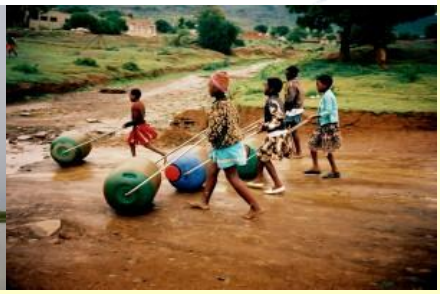
The official website for the EU-funded Consortium for Health Policy and Systems Analysis in Africa (CHEPSAA) has just been launched.

CHEPSAA, of which SOPH is a member, is working with universities in Africa and Europe to strengthen teaching, research & policy networking activities for the rapidly emerging field of health policy and systems research and analysis (HPSR+A). The new website is a CHEPSAA-flavoured collation of HPSR+A resources, pooling information from sources far wider than CHEPSAA for teachers, researchers, students, policy-makers and decision-makers. This website will be updated regularly and the resource section expanded over time. Send in your questions and suggestions and tell us what other resources are needed.

COHRED
Council on Health Research for Development

Forum 2012
COHRED / Global Forum for Health Research



Global Forum for Health Research, Cape Town, April 2012

Forum 2012 Background

***Forum 2012 focuses on a new world*:** one where long-term development aid is no longer a major feature of global interaction, solidarity and diplomacy, because low and middle income countries have found better ways to achieve health, equity and development. Everyone knows that this world will arrive some day, but no-one knows how to get there. Many different roads hold great promise, and many potential solutions are being tried and tested which may prove to be great contributions to achieving this world. While we cannot be certain about all the ingredients needed to realise this world, we can be sure about one: the capacity of any country to use research, science & technology (S&T) and innovation to improve their health, equity and development – both on their own, and in partnership with the world.

It is impossible to conceive of achieving national economic and health goals without research, S&T and innovation. Further, it is proving to be impossible to reach global development goals like the Millennium Development Goals (MDGs) without countries having the capacity to identify and address the conditions, diseases and determinants that stand in the way of health and equity.

Health and socio-economic development are two faces of the same coin. Equity is both a determinant and a result of achieving success in these two areas. The emerging economies are ideal examples, but in fact all successful modern economies have invested substantially, and over a long period of time in their own capacity to identify health and economic priorities, to prepare plans of research and innovation with which to address those priorities, and to create environments which encourage innovation. By innovation, we mean the creation of knowledge which can be translated into technology that delivers measurable health, economic and social progress.

We strongly believe that investment in research, S&T and innovation is what makes countries great –by making them jump up the development ladder. We have the evidence to back this up. What is more, it applies as much – if not more – to countries at the bottom of the development ladder as to those at the top.

Forum 2012 is the first global forum to bring together the key actors who make research and innovation work for health, equity and development. Governments, industry, social enterprises, non-governmental organisations, researchers, media, financiers–donors–sponsors, international organisations, and others who believe that ***this*** is the way to move 'beyond aid'.

Forum 2012 is the 14th global meeting of the Global Forum for Health Research and is a service of the COHRED Group, which resulted from the merger of COHRED and the Global Forum for Health Research.

Forum 2012 Calls upon Countries to Maintain Support to Research and Innovation for Health...Development...

By Gabi Falanga

Cape Town, 26 April 2012

Forum 2012 on the theme ***Beyond Aid...Research and Innovation as key drivers for Health, Equity and Development***, was held in Cape Town, South Africa this week.

The Forum examined the prospects for a new vision of development that looked 'beyond aid', by focusing on developing capacities in low-and middle-income countries and emerging economies. This engagement probed how global collaborations can be used to support research and innovation processes that can enhance this new era of development.

Participants at Forum 2012 had the opportunity to share experiences on how to set their own priorities for research, build capacities and provide incentives for innovation. Innovation was identified as a key factor in compensating for the lack of infrastructure and resources, especially in the form of new information and communication technologies (ICTs): Virtual collaboration, sharing of data and mobile health technology, to reach rural areas, are some of the exciting possibilities.

Although governments in developing countries find it difficult to meet recommended targets for research and development spending, it is a misconception that they rely purely on international aid, as they remain the major funders of research in their countries.

Whilst building self-reliance for countries is essential, participants at Forum 2012 argued that there are benefits to collaborating with neighboring countries – such as pooling resources and knowledge. Additionally, participants called for greater cooperation between sectors within countries to drive improved health. Participants from the private sector were urged to create public private partnerships in order to share funding and knowledge.

A strong and recurring theme at Forum 2012 was the need to always ensure the involvement of communities in setting the priorities for health research.

We Need a Global Treaty on Health Research for the Poor...

David Dickson
20 April 2012

It's time to move from debate to action with new mechanisms for funding research into diseases faced by developing countries.

In the current financial and political climate, it is brave — some might say foolhardy — to propose a binding international treaty on the funding and coordination of research into health problems facing the developing world.

Nevertheless this is what the World Health Assembly (WHA), the body responsible for the policies of the WHO, is being asked to consider at its annual meeting in Geneva next month (21–26 May).

The proposal comes from the WHO's Consultative Expert Working Group on Research and Development (CEWG), which has spent the past year analysing various ways of enhancing research and development (R&D) of treatments for diseases prevalent in developing countries.

Its report, released two weeks ago (5 April), lists measures that could bridge the continuing gap between the potential that science offers for creating such treatments, and the failure of the market to provide adequate incentives to make them affordable.

Top priority, it says, is starting negotiations on a binding convention on R&D. A central idea is that governments should commit to spending 0.01 per cent of GDP on R&D that is relevant to the needs of developing countries.

It also examines possibilities for new sources of sustainable funding, in particular through taxation — for example on air travel, alcohol or financial transactions — according to each country's preference.

An uncomfortable void

Both run counter to the prevailing political winds. This is a time when foreign aid budgets are being cut in many parts of the world — Canada is the latest government to do so — due to spending constraints and in the belief that the market should be treated as the main driver of development.

But the proposal deserves support. Disease is not only an endemic problem with social implications in developing countries; it is also a financial burden, depriving them of the healthy workforce needed to reach anything like their full potential.

Read more at:
http://www.cohred.org/2012/04/we-need-a-global-treaty-on-health-research-for-the-poor/

High on the Forum 2012 agenda was the issue of women's health, although it was stressed that the focus should be on sexual and reproductive health and not simply on maternal health.

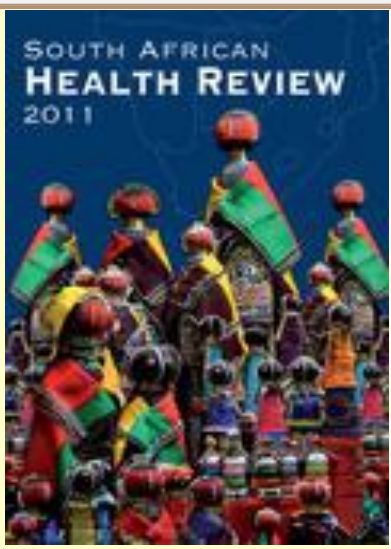
Forum 2012 was credited for an inclusive and diverse approach particularly around the presence of young people through the 'Youth in Motion' sessions. Youth in Motion is a platform for young people to have discussions and create youth networks with the goal of achieving global equity.

Tennyson Magambo spoke at the closing ceremony on behalf of Youth in Motion. He called for the increased use of ICTs and new media, and for action and social change around issues of health, equity and development. Youth in Motion is in the process of setting up a health research network portal for sharing experiences, knowledge and peer learning.
Forum 2012 was held from 24 to 26 April 2012 and jointly organised by the Council on Health Research and Development Group (The COHRED Group), and both the Department of Science and Technology and the Department of Health, of South Africa.

http://www.cohred.org/

South African HEALTH REVIEW 2011

The SAHR 2011 provides valuable policy and empirical information on a range of issues that are related to and impact on the Negotiated Service Delivery Agreement and primary health care re-engineering as envisaged by the National Department of Health (NDoH). A range of experts provide commentary on topics ranging from rural health, health technology to human resources.



SAHR 2011 also contains a section on core health issues, where developments in health information systems, financing health care, and health legislation and policy are discussed. The Review concludes with the Indicators chapter which presents a selection of the best available data on the functioning and performance of the health system.

Padarath A, English R, editors.
South African Health Review 2011. Durban: Health Systems Trust; 2011.
URL: http://www.hst.org.za/publications/south-african-health-review-2011

From the Editorial...

The years 2010 to 2011 were characterised by numerous health related legislative and policy changes which, if successfully implemented, will serve to change the prevailing South African health system irrevocably. Many of these changes are firmly embedded in the ruling party's increasing focus on the 'outcomes approach', whereby 'improving outcomes means doing things differently in order to increase the impact we have on improving the lives of citizens'.

In order for Government to collectively address its main strategic priorities, 12 outcomes – each with its own measurable outputs, sub-outputs and clear targets – were identified as areas of focus for the period 2010 to 2014. All Government Ministers subsequently signed performance agreements with the President of South Africa (SA) to show their commitment to realising these 12 Cabinet-approved outcomes.

Outcome 2, A long and healthy life for all South Africans, aimed at improving the health status of all South Africans, falls within the responsibility of the health minister; hence a Negotiated Service Delivery Agreement (NSDA) was signed by the Minister of Health (MoH) and the President in October 2010. The four NSDA strategic outputs to be achieved by the health sector are: (1) increasing life expectancy; (2) decreasing maternal and child mortality;

(3) combating HIV and AIDS and decreasing the burden of disease from TB; and (4) strengthening health system effectiveness. The NSDA links directly with the 10 Point Plan, which in turn forms the basis for the National Department of Health's (NDoH) National Strategic Plan for the period 2009-2014 to improve the performance of the South African health system. Both the NSDA and the 10 Point Plan highlight the need to improve health system functioning through improving healthcare financing; enhancing human resources for health (HRH); improving the quality of health services; strengthening overall stewardship and governance; producing better-quality data and streamlined reporting systems to support planning and decision making; and improvement of infrastructure development and health technology, including maintenance initiatives, drug policies and procurement systems, amongst others. Primary Health Care (PHC) re-engineering, a concept whereby the South African health system will be further transformed to align with the PHC approach, will underlie all interventions and activities.

Furthermore, a complete overhaul of the key components and structures of the public health system will be another major area of focus of Output 4, health systems effectiveness. The introduction of universal coverage in the form of National Health Insurance (NHI) is one of the major policy changes ushered in through the signing of the NSDA, and requires that the above mentioned policy changes be translated into practice. This 15th edition of the South African Health Review focuses on a variety of basic health system building blocks from the perspective of the NSDA and PHC re-engineering, and provides an opportunity to assess how far SA has progressed with regard to transforming its health system since 1994. It also creates an opportunity to reflect on successes, failures and missed opportunities, and sheds light on the health system's state of readiness to respond to the recent introduction of key policy reforms.

The presence of relevant, appropriate and comprehensive legislative and policy frameworks is critical and necessary for the creation of an enabling environment for attainment of health and related development goals, and reflects Government's level of responsiveness and commitment to ensuring implementation of various components of related key health-related Acts

South Africa's AIDS response: the next 5 years

The Lancet

No South African is untouched by HIV/AIDS. Many are infected with the virus, whether they are aware of their status or not, many have family or friends living with HIV, and many know someone who has died from an AIDS-related disorder. From the early 1990s, it was clear that South Africa's HIV/AIDS crisis had reached epidemic proportions. But the country's response at the time was hampered by denialism, a lack of political will, and poor implementation of evidence-based programmes. Thankfully, this situation has radically changed, and South Africa has since achieved some good results in tackling HIV, such as a 50% reduction in mother-to-child transmission. But the country is still underperforming in its control efforts. The AIDS accountability country scorecard for 2008 showed that South Africa was doing worse or no better than some of its neighbours.

April 1, however, marked an important milestone in the country's response to tackling not only its HIV crisis but also its tuberculosis epidemic with the start of its new *National Strategic Plan on HIV, STIs and TB 2012—2016*. The plan has several broad goals: to reduce new HIV infections by at least 50%; to start at least 80% of eligible patients on antiretroviral treatment; to reduce the number of new tuberculosis infections and deaths by 50%; to ensure a legal framework that protects and promotes human rights to support implementation of the plan; and to reduce self-reported stigma related to HIV and tuberculosis by at least 50%. Additionally, a major strategic objective of the plan will be to address the social and cultural barriers to HIV, sexually transmitted infection, and tuberculosis prevention and care. The

plan states that key vulnerable populations (eg, women between the ages of 15 years and 24 years, people from low socioeconomic groups, and men who have sex with men) will be targeted with different but specific interventions under each goal to achieve maximum impact.
The new focus on tuberculosis in the strategy is welcome, and the plan as a whole is ambitious, which it needs to be. An estimated 5·6 million people were living with HIV/AIDS in South Africa in 2009—the highest number of people in any country. In the same year, 310 000 people in the country died of AIDS-related causes. South Africa also has one of the world's worst tuberculosis epidemics with 482 000 people living with the disorder, 70% of whom are co-infected with HIV.

Marring the start of the new strategy, however, has been the news reported in local media that South Africa's National AIDS Council (SANAC) has sacked its entire staff on the eve of the implementation of the plan. In truth, SANAC is undergoing a planned restructure involving new governance structures, a new organisational home, new tasks, and new staff. The change is much needed. SANAC was established in 2000 to provide multisectoral leadership, political oversight, and guidance to South Africa's HIV/AIDS programme. In 2007, it endorsed a *National Strategic Plan for HIV and AIDS and STIs 2007—2011* with the job of overseeing continual monitoring and assessment of all aspects of the plan. But a mid-term review of implementation of the plan identified serious problems with SANAC. The review found that the high number and lack of definition of targets, weak coordination between different implementers, and between implementers and SANAC, had seriously hampered reporting on national progress in the strategic plan. The message was stark: SANAC structures were not fit for purpose.

But reform is now underway. SANAC's new chief executive of 2 months, Fareed Abdullah, is leading the organisation's restructure, which will crucially strengthen the Monitoring and Evaluation Unit within the secretariat. Abdullah, former Africa Unit Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, is widely respected in South Africa and beyond. He led the initiative to provide azidothymidine to pregnant women in the Western Cape years before the government was forced by the Constitutional Court to provide antiretroviral treatment to prevent mother-to-child transmission of HIV in the rest of the country. Abdullah is a capable leader for SANAC.

Although the council's restructuring is likely to affect its work in the short-term, the upheaval will be short-lived. SANAC needs to weather any fallout from the changes. It must be a strong, effective organisation to provide leadership for the next era of the country's AIDS and tuberculosis response. The next 5 years will be crucial for South Africa to prove that it can not only take responsibility for its epidemics of HIV/AIDS and tuberculosis, but that it can also achieve impressive results in controlling them.

The Lancet, vol.379
Number 9824 | Apr 14, 2012; doi: 10.1016/S0140-6736(12)60578-9