WHO COUNTRY COOPERATION STRATEGY

2013 – 2014

REPUBLIC OF SOUTH AFRICA

World Health Organization
WHO COUNTRY COOPERATION STRATEGY

2013 – 2014

REPUBLIC OF SOUTH AFRICA

May 2013
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### ABBREVIATIONS

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AEFI</td>
<td>Adverse Events Following Immunization</td>
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<tr>
<td>AFRO</td>
<td>African Region Office of the WHO</td>
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<tr>
<td>AFCON</td>
<td>African Cup of Nations</td>
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<tr>
<td>AFP</td>
<td>Acute Flaccid Paralysis</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APPs</td>
<td>Annual Performance Plans</td>
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<tr>
<td>ARF</td>
<td>African Renaissance and International Co-operation Fund</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
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<tr>
<td>ARVs</td>
<td>Anti-Retroviral Drugs</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
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<tr>
<td>BRICS</td>
<td>Brazil, Russia, India, China and South Africa</td>
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<tr>
<td>CCMT</td>
<td>Comprehensive Care Management Treatment</td>
</tr>
<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
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<tr>
<td>CFCs</td>
<td>Chlorofluorocarbons</td>
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<tr>
<td>CHWs</td>
<td>Community Health Workers</td>
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<tr>
<td>CoP17</td>
<td>17th Climate Change Conference of Parties</td>
</tr>
<tr>
<td>COTHI</td>
<td>Center for Opportunistic, Tropical and Hospital Infections</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>CROs</td>
<td>Contract Research Organizations</td>
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<tr>
<td>CVI</td>
<td>Center for Vaccines and Immunology</td>
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<tr>
<td>DCST</td>
<td>District Clinic Specialist Teams</td>
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<tr>
<td>DDT</td>
<td>Dichlorodiphenyltrichloroethane</td>
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<tr>
<td>DEA</td>
<td>Department of Environmental Affairs</td>
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<tr>
<td>DFID</td>
<td>Department of International Development</td>
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<tr>
<td>DHMIS</td>
<td>District Health Management Information System</td>
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<tr>
<td>DIRCO</td>
<td>Department of International Relations and Cooperation</td>
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<tr>
<td>DQS</td>
<td>Data quality self-assessment</td>
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<tr>
<td>DRS</td>
<td>Drug Resistance Survey</td>
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<tr>
<td>DR-TB</td>
<td>Drug-Resistant Tuberculosis</td>
</tr>
<tr>
<td>DST</td>
<td>Department of Science and Technology</td>
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<td>DTI</td>
<td>Department of Trade and Industry</td>
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<tr>
<td>EML</td>
<td>Essential Medicines List</td>
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<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>FAO</td>
<td>Food and Agricultural Organization</td>
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<tr>
<td>FOCAC</td>
<td>Forum on China-Africa Co-operation</td>
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<tr>
<td>FOSAD</td>
<td>Forum of South African Director Generals</td>
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<tr>
<td>FPGH</td>
<td>Foreign Policy and Global Health Initiative</td>
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<tr>
<td>GCP</td>
<td>Good Clinical Practice</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GIZ</td>
<td>German International Cooperation</td>
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<tr>
<td>GoSA</td>
<td>Government of South Africa</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>GPW</td>
<td>General Program of Work</td>
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<td>GVAP</td>
<td>Global Vaccine Action Plan</td>
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<td>GXP</td>
<td>GeneXpert</td>
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<tr>
<td>HCT</td>
<td>HIV Counseling and Testing</td>
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<tr>
<td>HDACC</td>
<td>Health Data Advisory Coordination Committee</td>
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<tr>
<td>HED</td>
<td>Heavy Episodic Drinking</td>
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<tr>
<td>HIV-DR</td>
<td>HIV Drug Resistance</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPDN</td>
<td>Health Promotion and Development Network</td>
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<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>IBSA</td>
<td>India-Brazil-South Africa</td>
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<tr>
<td>ICDMM</td>
<td>Integrated Chronic Disease Management Model</td>
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<tr>
<td>ICH</td>
<td>International Conference on Harmonization</td>
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<td>IDSRR</td>
<td>Integrated Diseases Surveillance and Response Strategy</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<td>IPT</td>
<td>Isoniazid Preventive Therapy</td>
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<td>ISHP</td>
<td>Integrated School Health Program</td>
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<tr>
<td>IST</td>
<td>Inter-Country Support Team</td>
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<td>IVD</td>
<td>Immunization and Vaccine Development</td>
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<td>MAG</td>
<td>Malaria Advisory Group</td>
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<td>MCC</td>
<td>Medicines Control Council</td>
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<td>MCV</td>
<td>Measles Containing Vaccine</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MDR-TB</td>
<td>Multi-Drug Resistant Tuberculosis</td>
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<tr>
<td>MEC</td>
<td>Members of Executive Council</td>
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<td>MNORT</td>
<td>Multi-sectoral National Outbreak Response Team</td>
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<tr>
<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<td>MTSF</td>
<td>Medium Term Strategic Framework</td>
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<tr>
<td>NC-001</td>
<td>New Combination 1</td>
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<td>NCC</td>
<td>National Certification Committee (for Polio)</td>
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<td>NCDs</td>
<td>Non-communicable Disease Conditions</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<tr>
<td>NDP</td>
<td>National Development Plan</td>
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<td>NHI</td>
<td>National Health Insurance</td>
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<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<td>NHLS</td>
<td>National Health Laboratory Services</td>
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<td>NICD</td>
<td>National Institute of Communicable Diseases</td>
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<tr>
<td>NiMART</td>
<td>Nurse Initiated Management of Anti-Retroviral Treatment</td>
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<tr>
<td>NNT</td>
<td>Neo-Natal Tetanus</td>
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<tr>
<td>NPEC</td>
<td>National Polio Expert Committee</td>
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<td>NRA</td>
<td>National Regulatory Authority</td>
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<td>NSDAs</td>
<td>Negotiated Service Delivery Agreements</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>NTDs</td>
<td>Neglected Tropical Diseases</td>
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COUNTRY COOPERATION STRATEGY 2013-2014
NVP  Nevirapine
OECD  Organization for Co-operation and Development
OHSC  Office of Health Standards Compliance
PCC  President’s Coordinating Council
PCV  Pneumococcal Conjugate Vaccine
PEPFAR  United States President’s Emergency Plan for AIDS Relief
PHC  Primary Health Care
PICT  Provider Initiated Counseling and Testing
PIF  Premier’s Inter-governmental Forum
PLHIV  People Living with HIV
PMTCT  Prevention of Mother-to-Child Transmission
R&D  Research and Development
RAF  Road Accident Fund
RED  Reach Every District
RTMC  Road Traffic Management Corporation
SACU  Southern African Customs Union
SADC  Southern African Development Community
SADPA  South African Development Partnership Agency
SAHPRA  South African Health Products Regulatory Authority
SALGA  South African Local Government Association
SAMEC  South African Malaria Elimination Committee
SANAC  South African National AIDS Council
SANHANES  South African National Health and Nutrition Examination Survey
SAVIC  South African Vaccine and Immunization Center
SOP  Standard Operating Procedures
STIs  Sexually Transmitted Infections
TB  Tuberculosis
UHC  Universal Health Coverage
UN  United Nations
UNAIDS  Joint United Nations Program on HIV/AIDS
UNCT  United Nations Country Team
UNDP  United Nations Development Program
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
UNISA  University of South Africa
UNJT  United Nations Joint Team
UNSCF  United Nations Strategic Cooperation Framework
USAID  US Agency for International Development
VAT  Value-Added Tax
VCT  Voluntary Counseling and Testing
WHA  World Health Assembly
WHO-CC  World Health Organization Collaborating Center
WHO  World Health Organization
WISN  Work Load Indicator for Staffing Needs
WITS  University of Witwatersrand
XDR-TB  Extensively Drug-Resistant Tuberculosis
EXECUTIVE SUMMARY

South Africa is a dynamic and complex country. A middle-income nation that has dedicated substantial resources to health and human capital investments, it has a progressive Constitution and vibrant civil society. The Government of South Africa has embedded international health goals into their national strategies and plans.

*Universal health coverage is a right enshrined in the South African Constitution.*

National Health Insurance is the central means by which the government aims to achieve universal coverage, under the principles of social solidarity and equity. To implement national health insurance, the government is pushing forward with a revitalization of health service delivery, changes in financing and management, and the provision of a comprehensive package of care through an approach of primary health care re-engineering. An important challenge is overcoming the inequities of the current health system. It is anticipated that National Health Insurance will restrain private health care cost escalation and improve access to quality services for the majority of the population. This will be done through improvements in service quality and human resources for primary care, while capacities for health purchasing and alternative provider payment mechanisms are established to ensure value for health spending. Access to quality medical products is also a major component of the reform agenda, and it is envisaged that the national regulatory authority will be strengthened.

*Life expectancy has increased due to innovations and rapid scale-up of HIV/AIDS and tuberculosis treatment and care, and expanded access to immunizations.*

Life expectancy in South Africa has been driven primarily by the HIV/AIDs and tuberculosis epidemics, and the strength of the national response. Success in expanding treatment and care for HIV and TB patients has contributed to increases in life expectancy from 54 years in 2005 to 60 years in 2011. The numbers of new HIV infections have been reduced to some 351,000 annually. Two in three HIV patients also have tuberculosis. South Africa has one of the highest tuberculosis incidence rates in the world, and contributes to 17% of the global burden of multidrug resistant tuberculosis. Progress in maternal and child health continues to be hindered by the HIV and tuberculosis epidemics, and the performance of the health system. Efforts to accelerate prevention interventions are underway, including the prevention of maternal to child transmission. Important reductions have occurred in under-five and infant mortality, which stand at 42 and 30 per 1000 live births by 2011, respectively, although these rates are higher in comparison with other countries of similar socioeconomic status. Maternal mortality ratios remain high, at 310 deaths per 100,000 live births.

Immunization remains critical to improving child health. The government currently has ten antigens on its national immunization schedule, including rotavirus and Pneumococcal Conjugate Vaccine, which has markedly reduced child morbidity and mortality. South Africa reported over 80% coverage of the first dose combination Diphtheria, Pertussis and Tetanus vaccine, although wide variation in coverage exists across districts. At the same time, data quality issues should be recognized. High dropout rates for Measles
Containing Vaccines have led to major outbreaks in recent years, with high HIV prevalence as a contributing factor.

Non-communicable conditions and injuries are causing many preventable premature deaths.

A shift in the disease burden is occurring with approximately two in five deaths in South Africa attributable to non-communicable diseases. Some 40% of mortality from non-communicable conditions among men occurred before the age of 60 years - and is therefore considered premature. High levels of premature deaths have major negative impacts on families and the economy. Second to non-communicable conditions is the burden of mortality and disability from violence and injuries. In particular, a rapid increase in motor vehicles has led to increases in road traffic accidents that now account for more than one-quarter of deaths due to injuries.

For nearly two decades, tobacco use has declined in South Africa as a result of strong legislation and policies to control tobacco consumption. However, smoking rates are among the highest in the continent, averaging 20.9% for adults. Harmful alcohol consumption is the third most important risk factor contributing to non-communicable diseases, injuries, and communicable diseases. Alcohol use is a major underlying factor in injuries and road traffic accidents. Harmful and excessive alcohol consumption can also accelerate the progression of infectious diseases.

The major nutrition related problem is South Africa is overweight. More than seven in ten women above 35 years are overweight. Overweight contributes to premature death from cardiovascular diseases, diabetes, hypertension and other metabolic disorders. A contributing factor is the rapidly increasing consumption of packaged foods high in calories, saturated fats, animal proteins, sugars, and salt. In addition to the rapidly changing food environment, physical activity levels are low. Approximately half of adults are physically inactive, and two in five schoolchildren do not participate in sufficient physical activity.

The sustainable development sector has undergone many changes that have resulted in improved quality of life for South Africans. Access to improved water sources is nearly universal. However, coal is used as a source of energy for industry, and South Africa ranks as the highest greenhouse gas emitter in the continent. Climate change is one of the key priorities of Government, and mitigation is viewed as a means to ensure an internationally competitive lower carbon economy.

South Africa is an emerging global health leader.

The Government of South Africa has engaged in development cooperation since the 1960s. A unique combination of factors in South Africa – including a high disease burden, strong academic and intellectual resources, government funding to research and development, private sector investments, and an active civil society – has led to programmatic innovations and leadership in global health. South Africa’s response to major health challenges since 2009 has been notable in terms of innovation and leadership, particularly in expanding HIV and tuberculosis treatment and care. Early adoption of new tools, policies, and approaches has had a great influence on other countries’ policy decisions, particularly in Southern Africa.
As the largest economy in Africa, South Africa joined BRICS in 2010. Meetings among BRICS Health Ministers took place in 2011 and 2013. Commitments were reiterated to pushing forward progress on multiple World Health Assembly Resolutions for access to medicines, non-communicable diseases, tobacco control, mental health, International Health Regulations, research and development, and universal health coverage. The current program of joint work strives toward progress in reducing risk factors for non-communicable diseases, and advancing universal coverage, surveillance, strategic health technologies, and drug discovery and development.

South Africa is a currently a member of the WHO Executive Board and an active participant in the WHO governing bodies, which are driving the global health agenda. Representatives from South Africa participate in a wide range of WHO expert advisory panels, scientific groups, technical consultations and committees, resulting in recommendations and guidance for all WHO Member States. South Africa currently houses 13 of the 26 WHO Collaborating Centers in the WHO African region in support of WHO’s mandate and priorities. Centers under the South Africa's National Health Laboratory Service, National Institute for Communicable Diseases, play a crucial role in the WHO African region as regional reference laboratories in supporting diagnosis of pathogens causing major outbreaks, strengthening laboratory competencies, and carrying out high quality research and investigations to aid public health decision-making.

WHO is mandated by its Member States as the directing and coordinating authority in health, and WHO is the United Nations specialized agency for health.

The main comparative advantage of WHO is its mandate from 194 Member States to act as the directing and coordinating authority on international health. Through its constitution, the WHO carries out its normative function for monitoring health situations and trends globally; proposing conventions, regulations, norms, standards and guidelines; stimulating research; and advancing knowledge application. WHO is the specialized health agency of the United Nations. As guaranteed by the United Nations Charter for specialized agencies, WHO maintains autonomy and independence from the United Nations in its program of work, budget, personnel, membership, and structure, which are guided by WHO Governing Bodies. The WHO maintains its Country Cooperation Strategy as the formal agreement with the government for its cooperative programs of work.

WHO has contributed to significant health and policy achievements in South Africa between 2008 and 2012.

WHO has contributed to significant achievements between 2008 and 2012 in South Africa to advance universal health coverage, improve life expectancy, promote healthy behaviors and communities, and strengthen systems for disease surveillance and emergency response. To advance universal coverage, the WHO has worked closely on policies, strategies, and guidelines for strengthening norms and standards for human resources for health, national health insurance, essential medicines and regulation, and establishing reference laboratories.

WHO’s work towards improving life expectancy during 2008 to 2012 focused on normative work in the prevention and control of HIV/AIDS and tuberculosis. This work included advancing systems for drug resistant HIV and tuberculosis, improving quality and clinical
outcomes, developing clinical guidelines, engaging non-governmental organizations in
service delivery, supporting research to understand the nature of the epidemics in South
Africa, improving data quality, and monitoring and evaluation. WHO also supported work
towards malaria elimination and advanced cross-border health initiatives. WHO carried
out extensive work in building human and institutional capacity for expanding access to
immunizations, including strengthening surveillance for measles, acute flaccid paralysis,
neonatal tetanus and adverse events following immunization. WHO provided special
support to under-performing districts, and strengthened health systems capacities for new
immunization products.

In promoting healthy behaviors and communities, WHO participated in non-
communicable disease policies, strategies and guidelines, the implementation of global
and national commitments under the WHO Framework Convention for Tobacco Control,
the Decade of Action for Road Safety, Action Plans for Non Communicable Disease
Prevention and Control, and Mental Health Action Plans.

WHO provided support to outbreak response and strategic documents, including yellow
fever policies, meningococcal disease treatment guidelines, influenza treatment
guidelines, influenza vaccination policies, and travel advisories for mass events such as the
2010 World Cup and the 2013 African Cup of Nations. In 2010, the WHO supported
national preparedness for receiving and deploying Pandemic Influenza A Vaccines,
including a WHO donation of 3.5 million doses. WHO continues to strengthen core country
capacities to implement the International Health Regulations. WHO adapted, trained and
implemented the WHO food safety norms and standards to ensure food safety at World
Cup events. WHO worked with the government to introduce the Global Food Defense
Strategy that resulted in the National Food Defense Strategy. In addition, a major
program of work is ongoing strengthening of surveillance systems across all communicable
disease programs.

This Country Cooperation Strategy sets forth four strategic priorities for WHO
collaborative work in South Africa for 2013-2014.

Four strategic directions for WHO Cooperation in South Africa are set forth based on a
situation analysis; health needs and demands; the changing environment in South Africa
as a middle-income country expanding on its own development cooperation; and the
comparative advantage, role, and mandate of the WHO as the UN specialized agency in
health. The four strategic priorities for 2013-2014 are to:

1. **Promote Universal Health Coverage and financial risk protection for all South
   Africans, through support to strengthening health systems.** This work will be carried
   out through:

   - Supporting the implementation of National Health Insurance to achieve access and
     financial protection.
   - Strengthening the national regulatory authority to ensure access to safe quality
     medical products.
   - Supporting sufficient numbers and distribution of human resources for health to
     promote access and quality in service delivery.
2. **Accelerate gains in life expectancy through focused programs to reduce the burden of HIV/AIDS and tuberculosis, and to expand access to immunization.** This work will be carried out through:

- Strengthening capacity for scaling-up HIV prevention, treatment and care to achieve the goal of no new HIV infections and no AIDS-related deaths.
- Improving the prevention and treatment of tuberculosis and multi-drug resistance tuberculosis to substantially reduce incidence, prevalence, and case fatality rates.
- Promoting access to existing and new immunization products to reduce child morbidity and mortality rates.

3. **Advance cost-effective measures that enable people to live in a healthy environment and make behavioral choices that promote longer healthier lives.** This work will be carried out through:

- Focusing on cost-effective measures to achieve global and national commitments for non-communicable disease prevention and control
- Supporting the fulfilment of commitments under the WHO Framework Convention on Tobacco Control and reducing the harmful use of alcohol.
- Advancing work to promote healthy dietary choices and exercise, and reduce overweight.

4. **Support South Africa’s contribution and leadership to achieve global and regional health goals.** This work will be advanced through:

- Accelerating programs to reduce South Africa’s contribution to the global and regional burden of disease, and documentation of innovations for replication elsewhere.
- Promoting the elimination and eradication of specific diseases to advance global public health.
- Strengthening core capacities for the implementation of International Health Regulations, and for emergency preparedness
- Promoting the implementation of the Libreville Declaration for environment and health.

**Successful implementation of the four strategic priorities will require changes in WHO’s approach and organization.**

The implementation of the four strategic priorities set forth in this extension plan will build on existing strong collaborations and good relationships with government counterparts and other major partners and stakeholders. The strategic priorities for 2013-2014 will expand on work carried out during the previous Country Cooperation Strategy, with a stronger emphasis on South Africa’s role in global health. However, successful implementation will have major implications for the WHO secretariat, in terms of a shift in technical approaches and focus, in strengthening and expanding relationships with partners, and in improving the effectiveness of the WHO response.

Implementation will require maintaining focused programs of work in communicable disease prevention and control, and providing stronger support to health systems strengthening and non-communicable disease policies and strategies, and South Africa’s global health contributions. It will also require establishing strong linkages between WHO activities and measurable impact within the results chain, by ensuring high quality
technical support and strengthening individual capacities and institutions. This implies that WHO will focus on fulfilling its established six core functions, including leadership, shaping the research agenda, setting norms and standards and promoting their implementation; articulating evidence-based policy options; providing technical support and building sustainable capacity; and monitoring the health situation and assessing health trends.

This program of work requires multi-sectoral actions, and linkages and technical relationships with a range of government departments, partners and stakeholders. WHO will support effective multi-sectoral and multidisciplinary collaborations, promote engagement and facilitate the involvement in collaborative work among relevant government departments, non-governmental and civil society agencies, and private sector. Partnerships with other UN agencies will be strengthened.

Moreover, the implementation of the four strategic priorities requires improving the effectiveness of the WHO response. Technical professionals are the principle resource of the WHO. The implementation of these strategic priorities has important implications for the WHO Secretariat at all levels – including the staff at the South African Country Office, the African Regional Office, the Inter-Country Support Unit, and Headquarters in Geneva. Alignment at all three levels of the organization is needed to effectively harness technical support and make measurable progress in the four strategic priorities.

The Country Office needs to better communicate what the organization is doing to improve health and welfare in South Africa. The office will develop and implement its communications strategy, develop information products for dissemination online and to the media, revamp its website and update it regularly, and generally improve documentation and dissemination of our activities and products. Lastly, under WHO reform, there is renewed emphasis on efficiencies in management and administration. Efforts will be made to further strengthen the country support unit for the office, streamline administration, strengthen financial management and procurement, improve human resources management and performance, and carry out other essential office functions to perform more efficiently and effectively.
FOREWORD AND ACKNOWLEDGMENTS


In particular, this strategy aims to align WHO’s work with the national health planning cycles and priorities. Thus, the current strategy focuses on 2013-2014, before a new five-year strategy plan is undertaken in 2014. The strategy was developed in a systematic way. First, the WHO carried out an internal review of WHO activities and achievements between 2008 and 2012, and current commitments for 2013. A situational analysis of the health and development challenges in South Africa was undertaken to identify existing challenges and opportunities. The policy environment was then reviewed, using WHO’s policies and priorities set forth in WHO’s General Program of Work for 2014-2020, WHO’s global and regional resolutions, and the existing health policies of the Government of South Africa. A special chapter was commissioned on South Africa’s contribution to regional and global health. Lastly, a consultation process was undertaken between WHO and our partners in the Government of South Africa, as well as the development partners in South Africa.

Many people were involved in the preparation of the strategy. The process was led by the WHO Representative for South Africa, Dr Sarah L Barber, under the guidance and support of Dr Luis Gomes Sambo, Regional Director of the African Regional Office, and Director-General of Health, Ms Precious Matsoso, National Department of Health, South Africa. The writing and technical analysis was done primarily by WHO professional staff in the Country Office, with the support of WHO technical staff in the Intercountry Support Team in Harare and in the African Regional Office in Brazzaville. We gratefully acknowledge the participation and valuable contributions of our technical partners and collaborators in the National Department of Health, Department of International Relations and Cooperation, other government agencies, centers of excellence, bilateral and multilateral agencies, civil society, and other stakeholders. We hope that this strategy provides a strong technical direction and focus for WHO’s programs in South Africa, to contribute to national health goals.

May 2013
1.1. Social and economic development

South Africa is a dynamic and complex country of 51.77 million people, with a median age of 25 years.\(^1\) It is a middle-income nation, where average annual household income more than doubled between 2001 and 2011, to R 103,204 (US$ 12,901).\(^2\) Annual economic growth rates are expected to reach 2.7% in 2013 and 3.8% in 2015.\(^3\) A progressive Constitution is in place, which provides protection for human rights. A free press and vibrant civil society enables open debates on governance and social issues. Multi-party elections are held regularly, and there is a separation of powers across the legislative, executive, and judicial branches of government. Health, education, and social services are expanding their reach, and the government has committed to increased public health spending in 2013.\(^4\)

At the same time, important challenges remain. Unemployment rates reached 35.9% by the end of 2012, including people who stopped looking for work.\(^5\) Youth are the most affected, and this is attributed to educational standards that are not well-matched to the skills needed in the labor market. Thus high rates of unemployment exist alongside high vacancies in skilled and professional sectors – including, for example, medical and nursing jobs in the public sector. In 2008, nearly one in two South Africans lived on less than US$ 2 per day, and income inequality remains high.\(^6\) Uneven access to basic services, such as health, education, housing and sanitation are one source of this inequality. Protests about basic public service delivery (health, housing, water, and sanitation, among other issues) have increased in recent years. Violence is becoming institutionalized as a legitimate means to express grievances and demand action.

A rapid shift is occurring in the burden of disease, with increasing numbers of deaths and disability resulting from non-communicable diseases (NCDs). Some two in five deaths from NCDs occur prematurely, with major negative impacts on families and the community. After NCDs is the burden of mortality and disability from violence and injuries.\(^7\) Interpersonal violence accounts for just under half of all injury deaths.\(^8\) Access to firearms and alcohol consumption are important contributing factors. Gender violence and inequality are pervasive, with high rates of poverty among women.\(^9\) Up to one half of men report having been physically violent to their partners, and half of women homicide victims are killed by intimate partners.\(^10\) Children are also the victims of violence, and assault in schools also been reported.

The Government of South Africa (GoSA) has committed to the achievement of international goals and commitments, including the Millennium Development Goals (MDGs), and embedded these targets into the National Development Plan for 2030, the National Service Delivery Agreements 2010-2014, the Medium Term Strategic Framework (2009-2014)/s 10-point plan as well as disease specific strategies and plans. Table 1
illustrates the progress on selected international health goals and targets. Important challenges remain for both communicable and non-communicable disease control.

Table 1. Progress on selected international health-related indicators, South Africa

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<tbody>
<tr>
<td>Child mortality rate per 1000 live births</td>
<td>42</td>
<td>2011</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>Maternal Mortality Ratio (MMR) per 100,000 live births</td>
<td>310</td>
<td>2008</td>
<td>270</td>
<td>38</td>
</tr>
<tr>
<td>HIV prevalence, women 15-24 years</td>
<td>8.9</td>
<td>2008</td>
<td>4.4</td>
<td>&lt;9.3</td>
</tr>
<tr>
<td>TB incidence, all forms (per 100,000 people)</td>
<td>993</td>
<td>2011</td>
<td>491</td>
<td>&lt;253</td>
</tr>
<tr>
<td>Malaria incidence (per 1000 population)</td>
<td>0.58</td>
<td>2011</td>
<td>&lt;0.45</td>
<td>Elimination</td>
</tr>
<tr>
<td>Smoking prevalence among adult men</td>
<td>34</td>
<td>2010</td>
<td>20% reduction (2020)</td>
<td>30% reduction (2020)</td>
</tr>
<tr>
<td>Salt intake per person (grams per day)</td>
<td>8.1</td>
<td>2005</td>
<td>&lt;5</td>
<td>30% reduction (2020)</td>
</tr>
<tr>
<td>Population using improved drinking water source (%)</td>
<td>92%</td>
<td>2009</td>
<td>100</td>
<td>81%</td>
</tr>
<tr>
<td>CO2 emissions: million metric ton (total)</td>
<td>433,527</td>
<td>2007</td>
<td>34% reduction (2020)</td>
<td>Country specific</td>
</tr>
</tbody>
</table>

All government programs are developed on the basis of legislation made by Parliament. The majority bases its input on the policies made at party conferences. The Cabinet meets annually to develop goals and plans and assess progress. After the cabinet determines the goals, the Forum of South African Director Generals (FOSAD) sets forward clear implementation plans. The plans are presented to Cabinet and Parliament in the budget vote for that ministry. The Treasury uses these plans as the basis for their medium term expenditure framework (MTEF).

The President and Cabinet are responsible for overall monitoring. The President's Coordinating Council (PCC) is the national coordinating policy body, consisting of the President, the Deputy President, other Ministers, the Premiers (heads of the provincial governments), and the South African Local Government Association (SALGA). Inter-governmental Forums exist where Ministers meet with the provincial ministers, Members of Executive Council (MECs), and SALGA. In the provinces, the Premier's Inter-governmental Forum (PIF) is the coordinating body, and includes MECs, and mayors from the cities and districts.

1.2. Achieving Universal Health Coverage

Universal health coverage (UHC) is a right enshrined in the South African Constitution. In recognition of the need to support people in overcoming inequalities and achieving the right to health and social services, the President's Office set forth its medium-term
priorities and commitment to 12 National Development Outcomes for 2010-2014. Negotiated Service Delivery Agreements (NSDAs) have been developed between the Presidency and the related ministries to detail interventions for each of the 12 Outcomes. The National Department of Health (NDOH) leads the NSDA to achieve Outcome 2, “A long and healthy life for all South Africans,” and its four specific outputs: increasing life expectancy, reducing maternal and child mortality rates, combating HIV/AIDS and tuberculosis, and strengthening the effectiveness of the health system.

In 2012, the government published the National Development Plan (NDP) 2030: “Our future - make it work,” which presents the long-term vision for the country. It aims to address nine major challenges, among which include a high burden of disease and weak public health system. The plan sets forward 15 objectives for 2030 accompanied by concrete actions. Among these objectives includes “Health Care For All,” with the specific aims of increased life expectancy at birth to 70 years; improved TB prevention and cure; reduced maternal, infant and child mortality; reduced prevalence of non-communicable chronic diseases; reduced injury, accidents and violence by 50 percent from 2010 levels; the deployment of primary healthcare teams; access to equal standard of care, regardless of their income; and filling posts with skilled, committed and competent individuals.

Within the health sector, the Medium Term Strategic Framework (MTSF) 2009-2014 sets forward a 10-point plan. The plan includes an emphasis on strategic leadership and a social compact for health, the National Health Insurance system, the quality of health services, financial and district management, human resources planning and management, and revitalization of physical infrastructure. In addition, the plan promotes the acceleration of the HIV and AIDS and Sexually Transmitted Infections (STI) National Strategic Plan; health promotion for non-communicable diseases, risk factors, maternal and child health, and immunization; review of the medicines policy to achieve zero stock-outs; and strengthening research. The Annual Performance Plans (APPs) of the DOH are the operationalization of the NSDA and the MTSF. The APPs are linked to the budget cycles and the Medium Term Expenditure Framework.

National Health Insurance (NHI)

National Health Insurance (NHI) is the central means by which the government aims to achieve universal health coverage, under the principles of social solidarity and equity. NHI is proposed as a publicly funded, tax-based system. Enrollment will be mandatory, with cross-subsidies for the unemployed. NHI and the re-engineering of primary health care are being phased in over 14 years to enable equal access to affordable quality healthcare. To implement NHI, the government is pushing forward a revitalization of public health service delivery, changes in the financing and management of the public health system, the provision of a comprehensive package of care for all, and primary health care reengineering. There are 11 NHI pilot districts (out of 52) with focusing on primary care, public health service delivery, and referral systems. The purpose of the pilots is to assess key conditions and assumptions before scaling up, including the ability of districts to assume their responsibilities under a purchaser-provider split, the viability of engaging the private sector in service delivery, and actual costs of implementation.

Total health spending is relatively high, amounting to 8.5% of GDP or US$ 689 per person in 2011. Nearly half (48%) of these resources are from general government expenditures,
which are primarily allocated to government departments at central, provincial, and local levels. The vast majority of these funds is collected by the central government, and thus the national government exercises considerable influence in how public funds are spent at all levels of the system. Public spending on health is expected to increase with the expansion in insurance coverage funded through a mix of income taxes, value-added taxes (VAT), and increases in excises on tobacco and alcohol. Private insurance accounts for 43% of total expenditures, and this covers about 16% of the population.

An important challenge is overcoming the inequities and inefficiencies of the current health system. Evidence suggests that inequalities are increasing in recent years with access to health care inhibited by poor quality in the public sector and high medical cost inflation in the private sector. It is anticipated that the NHI will restrain private health care cost escalation and improve access to quality services for the majority of the population, primarily through the establishment of a central authority, the National Health Insurance Fund (NHIF) that would pool public and private funds and take a more active purchasing role at prices controlled by the central authority.

A plan is currently under development to specify the implementation steps for NHI. This includes establishing the National Health Insurance Fund (NHIF) scheduled to start in 2014, which will pool funds. At the same time, it is recognized that the primary care level should be strengthened in terms of service quality and management, while capacities for health purchasing and alternative provider payment mechanisms are established.

Service delivery and human resources

A central part of NHI implementation is strengthening public health service quality. The DOH is pushing ahead with the three streams of Primary Health Care (PHC) re-engineering for the health system: 54 District Clinical Specialist Teams (DCST); PHC teams with a professional nurse supported by four community health workers (CHWs) assigned to over 4,000 electoral wards; and integrated school health services. In the latter, a nurse is assigned to a group of schools to ensure physical, mental and social wellbeing, and maximize learning capabilities.

The quantity and distribution of skilled human resources remains an important challenge, with imbalances towards the private sector and urban areas. Difficulties remain in attracting and retaining qualified staff in the public health sector, and there has been no significant increase in the production of doctors and nurses over the past 15 years. This has resulted in difficulties in filling posts- for example, vacancy rates for doctors in the public sector in Limpopo is 84%, and for nurses in Eastern Cape, 67%. In response, the government has launched a series of programs to increase the numbers of qualified health staff, including an Academy for Leadership and Management in Health Care; a national health scholars program targeting 1000 doctorates in the health sciences over 10 years; targeted admissions policies for medical education; and large-scale training of health workers overseas and domestically. In addition, the nursing strategy promotes leadership and governance, training, ethics and professionalism for nurses and midwives.

In 2013, strengthened quality control and regulation will be implemented through the Office of Health Standards Compliance (OHSC), to be established by 2015/6, which will monitor compliance with quality standards. All 3880 public health facilities have already
been audited to assess compliance with existing standards and norms, including availability of medicines and staff. In addition, facility improvement teams have been deployed in the NHI pilot districts to support quality improvements.

**Medicines, Vaccines, and Diagnostics**

Access to quality medical products is also a major component of the NHI. It was estimated that pharmaceutical expenditures amounted to 14.5% of total health expenditures in 2006. A national medicines policy was established in 1996, and systems exist for establishing the essential medicines list (EML) and allowing for generic substitution. Various regulations related to transparent medicines pricing system (2010-11) were put forth to control medicines pricing in the private sector, including methods for benchmarking for originator products, and caps on mark-ups at various stages of the distribution system. In 2012, the Government has proposed caps on dispensing fees for medicines, as a part of reducing the cost of medicines and controlling health care costs. Pharmaco-economic evaluation is now recommended to assess new medicines in parallel with new drug registration to demonstrate that new drugs offer “value-for-money” in comparison with the existing standard of care.

The national regulatory authority (NRA), the Medicines Control Council (MCC), was created in 1965. To strengthen the NRA, in 2008, the Medicines and Related Substances Amendment Bill established the South African Health Products Regulatory Authority (SAHPRA), to operate independently of the NDOH, led by a Chief Executive Officer (CEO), with the authority to appoint and supervise staff, and relevant technical committees. It is envisaged that the SAHPRA will be in place in 2014, with a broad scope including regulation of foodstuffs and cosmetics, and medical devices, including in vitro diagnostic tests.

**Monitoring and evaluation, information systems, and research**

Monitoring and evaluation is embedded into the planning and budgeting cycles, and the system sets forth quarterly monitoring of APPs; the planning, monitoring, reporting; and how the planning cycle links annual performance reports with the APPs. In addition, a national policy for the District Health Management Information System (DHMIS) has been published in 2011. Despite the data flow policy, timely data availability for program management remains problematic. A special Health Data Advisory Coordination Committee (HDACC) acts as an external advisory body that focuses on the sources, quality and detailed requirements for the high level indicators specified in the NSDA. The South African National Health and Nutrition Examination Survey (SANHANES) has recently been launched as a prospective cohort study, which aims to collect representative data on health and nutritional status to inform national policies.

In 2011, a National Health Research Committee Summit was convened to set seven priorities for health research in South Africa. The summit proposed increased funding for health research to 2.0% of the national health budget; training a new generation of health researchers through a national health scholars program; strengthened health research infrastructure with a focus on primary care; and strengthened national regulatory framework for health research. The summit also proposed priority research projects to achieve the national goal of increasing life expectancy; a mechanism for translating
research findings into practice; and a system for evidence-based planning and monitoring, and assessment of the effectiveness of health research system on the burden of disease.

1.3. Improving life expectancy

### HIV/AIDS

Life expectancy in South Africa has been driven primarily by the HIV/AIDS epidemic, and the strength of the national response. The success in expanding anti-retroviral therapies (ART) has contributed to increases in life expectancy from 54 years in 2005 to 60 years in 2011.49 However, HIV remains a critical problem, with 5.6 million people living with HIV and 351,000 new infections annually, driven largely by sexual transmission. Since 2008, HIV prevalence among pregnant women and adults has remained stable at 29.5% and 17%,50 respectively. A major emerging challenge is the emergence of HIV drug resistance (HIV-DR). Moderate levels (5% to 15%) of transmitted HIV drug resistance (HIV-DR) have been reported based on consecutive surveys since 2008 in KwaZulu Natal.51

Over the past five years, the government has made substantial investments in policies and programs to expand HIV prevention, treatment, care and support. By 2012, more than 1.9 million of People Living with HIV (PLHIV) initiated ART, which constitutes two-thirds of those targeted to receive treatment.52 The NDOH intends to increase the number of patients on ARVs by 500,000 annually.53 More recently, the government expanded treatment through the use of nurses to initiate and/or manage follow-up of anti-retroviral treatment, to facilitate decentralization and enhance access to care.

To overcome the critical problem of lack of knowledge about HIV status and discrimination, the government launched a campaign to “know your status” and initiate Provider Initiated Counseling and Testing (PICT). This resulted in 13.3 million people undergoing HIV testing by end of 2011, among which a substantial proportion tested HIV positive and initiated treatment.

The success in expanding treatment and care has led to more people living with HIV.54 Thus, the government is intensifying its efforts to expand prevention interventions, including scale-up of male circumcision. In 2012, over half of South African men (55.5%) were circumcised compared with 42.6% in 2009.55 The NDOH targets at least 600,000 additional male circumcisions by 2013/4.56 Male and female condom distribution has been accelerated, with 68% of people using condoms at first sex in 2012. In addition, programs to Prevent Maternal To Child Transmission (PMTCT) have led to declines in HIV transmission from mother to child from 3.5% in 2010 to 2.7% in 2011, with the target of <2% by 2015/6.57

### Tuberculosis (TB)

Despite the decline in notified cases since 2008, South Africa has one of the highest TB incidence rates in the world (993 cases per 100,000 population).58 More than 389 thousand new cases of TB were reported in 2011. Case detection rates increased between 2007 and 2009, and currently stand at 69%. Treatment success rates have increased to 79% by end-2011, and the NDOH has committed to reach the WHO target of 85% by 2015/6.59
An important challenge is high TB/HIV co-infection rates (65%), and the growing problem of drug resistant TB (including multi-drug resistant (MDR-TB) and extensively drug resistant TB (XDR-TB)). In 2011, 10,085 MDR-TB cases were recorded, contributing 17% of the total global burden of MDR-TB and over 90% of the regional burden.

Diagnostic capacity has been strengthened by increasing coverage of Xpert® MTB/RIF (GeneXpert) across the provinces. The NDOH intends to carry out 800,000 tests using GeneXpert during 2013/14, and 1 million by 2015/16. Challenges remain in childhood TB diagnosis, and data quality and management. Improved versions of the Electronic TB Register and Standard Operating Procedures for TB data management are expected to improve data management. To better understand the epidemic, South Africa is carrying out large-scale surveys, including a Drug Resistance Survey (DRS), and preparations are underway for a prevalence survey by 2015.

Malaria and neglected tropical diseases

Approximately 10% of the population (5.1 million people) is at risk of contracting malaria where local transmission is endemic, including 2.1 million in Limpopo, 1.6 million in Mpumalanga, and 1.4 million in KwaZulu Natal. South Africa has committed to malaria elimination by 2018, defined as zero local malaria transmission. A major challenge is accurately classifying cases into local and imported, because of migrant population movement.

The most important neglected tropical diseases (NTDs) are soil-transmitted helminthes (STH), schistosomiasis, and leprosy. Prevalence of common roundworms and whipworms range from >70% around the coast to <10% in high-altitude, mountainous areas. Hookworm prevalence in children is estimated at 100% near the Mozambique border, and 40% in the extreme south of KwaZulu-Natal. In addition, some 4.5 million people, mainly in settings of rural poverty, are in need of treatment for schistosomiasis. Leprosy prevalence is below 1 per 10,000 population, the cut-off point for defining leprosy as a public health problem, although some communities may have higher prevalence rates.

Maternal and child health and immunization

Progress in maternal and child health continues to be hindered by the HIV and TB epidemics, and weak performance of the health system. Maternal mortality ratios remain high, at 310 deaths per 100,000 live births. Important reductions have occurred in under-5 and infant mortality, although rates are higher in comparison with other countries of similar socioeconomic status (42 and 3000 per 1000 live births, respectively). Recent policy changes have the potential to further accelerate improvements. These include the universal coverage of PMTCT in public health facilities, the aggressive HIV testing and counseling programs – particularly for pregnant women – and the changes in the HIV treatment threshold for pregnant women. The government has also emphasized exclusive breastfeeding and the prevention of unwanted pregnancies among youth.

Immunization remains key activity to improve child health and contribute to the MDGs. The NDOH currently has 10 antigens on its national immunization schedule, including rotavirus and Pneumococcal Conjugate Vaccine (PCV) introduced in 2009, which has markedly reduced the morbidity and mortality due to rotavirus diarrhea as well as invasive
pneumococcal disease. South Africa reported over 80% coverage of DPT1 containing vaccine (DTaP-IPV/HIB) for the past 5 years, which indicates good access although wide variation in coverage exists across districts. The DTaP-IPV/HIB 1-3 Drop Out Rate (DOR) is 1.3% at national level, indicating high utilization of immunization services. At the same time, data quality issues (such as over-reporting, under-reporting and unclear denominators) should be recognized. As a result, the NDOH administrative coverage rates are quite different from the WHO-UNICEF estimates. For example, WHO-UNICEF reported DPT1 vaccine coverage rates of 77% compared with 99.8% administrative coverage rates in 2011. These discrepancies together with the data quality issues point to the need for an immunization coverage survey to verify coverage levels.

The DOR for Measles Containing Vaccine (MCV) is over 10% between the first and second dose. There were two major outbreaks of measles (2003/2004 and 2009/2010); and these can be attributed to this accumulation of susceptible people due to low coverage with the first and the second doses of MCV. Other contributing factors are high population density and high HIV prevalence. This represents a major challenge to achieving the measles elimination target for the WHO AFRO region in 2020.

1.4. Promoting healthy behaviors

Non-communicable disease burden

The disease burden in South Africa is shifting, and approximately 2 out of 5 deaths in South Africa in 2008 were attributable to non-communicable disease conditions (NCDs), including cardiovascular diseases, cancers, chronic respiratory conditions, and diabetes. Hypertension affects 42.2% of the adult population, 10.6% suffered from elevated blood glucose, and 34.0% have high cholesterol. It is estimated that 40% of NCD mortality among men, and 29% among women occurred before the age of 60 years and are therefore considered premature. High levels of premature mortality contribute to reduced life expectancy and have major negative impacts on families and the economy.

Violence and injuries are another leading cause of death and lost disability-adjusted life years in South Africa. Every year intentional and unintentional injuries due to violence, traffic crashes, burns, falls or drowning are responsible for 9% of all deaths and 16% of all disabilities. The death rate from injury and violence in South Africa is 157.8 per 100,000, nearly twice the global average. Intentional injuries are attributed to high rates of interpersonal violence (46% of all injury deaths). The prevalence for a mental health condition has been estimated at 30.3% (2004), with about 1.7 people in 10 stating that they had experienced a mood disorder, anxiety, or substance abuse in the previous year. The rapid increase in the number of motor vehicles has led to increased road traffic injuries that now account for more than one-quarter of death due to injuries (26%). Consumption of alcohol is strongly associated with traffic mortality. More than one in four (25.9%) South Africans report having driven a motor vehicle after drinking alcohol. Excessive blood alcohol concentrations above the legal limit were reported in accidents that resulted in deaths among 46.5% of drivers and more than half of pedestrians. In addition, only 15.3% of passengers report wearing seat belts.
Tobacco and alcohol

For nearly two decades, tobacco use has declined in South Africa as a result of legislation and policies to control tobacco consumption – first put into place in 1993. South Africa ratified the Framework Convention on Tobacco Control (FCTC) in 2005. However, smoking rates are among the highest in the continent, averaging 20.9% for adults, and 33.9% of adult men. More than one in five male and one in 10 female students have smoked. Tobacco use causes approximately 8-9% of deaths, or about 44,000 deaths per year.

Harmful alcohol consumption is the third most important risk factor contributing to non-communicable diseases, injuries, and communicable diseases. Alcohol use is a major underlying factor in homicides, violence and rape, road traffic deaths, suicides, and other unintentional injuries across South Africa. Harmful and excessive alcohol consumption also contributes to non-communicable conditions, including cardiovascular diseases, cirrhosis of the liver, and cancers. Alcohol consumption during pregnancy is responsible for high rates of fetal alcohol syndrome in some communities. In addition, alcohol use can accelerate the transmission or progression of infectious diseases through lower treatment adherence and weakening of the immune system.

South Africa is among the top five countries globally for its risky patterns of alcohol drinking, and the highest in Africa. Some 51% of men and 79% of women report abstaining from alcohol consumption. Those who drink alcohol, therefore, consume very high amounts. Among those who consume alcohol, the prevalence of heavy episodic drinking (HED) was reported as 48.1% among men and 41.2% among women.

Diet and physical activity

The major nutrition related problem is South Africa is overweight and obesity. More than 72% of women above 35 years old are overweight or obese, and more than half of men 45 to 65 years of age are overweight. Among youth aged 15 to 24 years, 38% of females and 13% of males are overweight or obese, thus at risk of a lifetime of weight related health problems. In 2000, 7% of total deaths (36,504) were attributed to overweight and obesity, which cause premature death from cardiovascular diseases, diabetes, hypertension and other metabolic disorders.

A contributing factor is the change in dietary patterns over time, with rapidly increased intake of packaged foods high in calories, saturated fats, animal proteins, sugars, and salt. Salt consumption is estimated at 8.1 grams per person per day, compared with WHO’s recommendation of 5 grams. Consumption of soft drinks averages 254 liters per person per year – nearly three times the global average. Large commercial multinational and national companies dominate, with ten large companies accounting for 51.8% of packaged food sales, and 57% of fast food outlets. Four major supermarket chains dominate retail sales. Food marketing campaigns - particularly television advertising - are ubiquitous, and aggressive marketing of food and beverages to children is not yet prohibited.

In addition to the rapidly changing food environment, physical activity levels are low. In 2003 48% of adult men and 63% of adult women were considered physically inactive. In 2010 38% (nearly 4 in 10) school children did not participate in sufficient physical activity, and more than one-third of boys and 43% of girls were considered sedentary.
Environmental Health

The sustainable development sector has undergone many changes that have resulted in improved quality of life for South Africans. Access to improved water sources increased from 61 to 92% between 1996 and 2009; and access to improved sanitation increased from 59% to 72%. South Africa’s air quality is considered relatively good, but hot spots exist where air quality is poor. Coal is used as a cheap source of energy for industry, and thus South Africa ranks the highest greenhouse gas emitter in the continent accounting for about 65% of Africa’s emissions. Projects have been developed to reduce CO2 emissions by 21 million tons. South Africa has almost completely phased out the use of ozone depleting substances such as chlorofluorocarbons (CFCs) and carbon tetrachloride. Climate change is one of the key priorities of Government, as demonstrated with the adoption of the White Paper on National Climate Change Response prior to the 17th Climate Change Conference of Parties (COP17) in 2011. The government views climate change mitigation as a means to ensure an internationally competitive lower carbon economy.

1.5. Surveillance and emergency preparedness

Major public health risks can rapidly spread through travel and trade. Since 2008, major public health events in South Africa include an outbreak of Lujo hemorrhagic fever and a Rift Valley fever outbreak. A cholera outbreak in 2008 and 2009 resulted in 12,706 cases and 65 deaths. Pandemic influenza A (H1N1) was introduced into South Africa in 2009, and ultimately resulted in 2,640 cases and 93 deaths. A measles outbreak of more than 18,000 laboratory confirmed cases occurred across all provinces in 2009 and 2010.

This situation has called for extraordinary global consensus on international health reporting to prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international trade. In 2007, the International Health Regulations (IHR) went into force, agreed upon by all WHO member states. The IHR is a legally binding requirement for Member States to strengthen core capacities for disease surveillance and reporting of public health events for global public health security.

The legal framework for implementation of IHR in South Africa is in process. The IHR requires that the notification system be modified to include events of public health importance – and not only diseases – as is currently the case. As part of the implementation of the IHR, a national assessment was carried out in 2008-2009 in South Africa. Currently designation and assessment of the points of entry into the country (24 ports, airports and land crossings) are almost complete. Some of the issues and challenges include a lack of designated points of entry and staff training; implementation of the Integrated Diseases Surveillance and Response Strategy (IDSR). Since 2010, an annual IHR comprehensive monitoring report has been submitted to the WHO.

Flooding, fires and other accidents are frequent events that require community preparedness and response. Floods occurred in Limpopo, Mpumalanga, the Free State, Gauteng and North West provinces in 2011 and 2013. Fire outbreaks are reported frequently nationwide in informal settlements that housed millions of poor people. The National Disaster Management Act 57 of 2002 provides a policy framework for addressing these needs.
2.1. Development cooperation and modalities

The Government of South Africa (GoSA) has engaged in development cooperation since the 1960s. After 1994, these partnerships focused on maintaining stability, and promoting social and economic change. In 2001, the African Renaissance and International Cooperation Fund (ARF) was established to promote South-South cooperation, good governance; conflict prevention and resolution, socioeconomic development and integration; and to provide humanitarian assistance. With a few exceptions, assistance from South Africa is dedicated almost entirely to other African nations. In 2011/12, the GoSA reported that assistance through the ARF was valued at R 271 million (US$ 51 million). A large part of these resources was dedicated to electoral assistance and humanitarian missions.

It is estimated that ARF represents between one-third and one-half of the GoSA’s development cooperation. Other channels of cooperation include the Southern African Customs Union (SACU) established in 1910, with the goal of providing a financial safety net in the event of a decline in export earnings for RSA’s neighbors. Other government bodies (Defence and Education) as well as provincial governments also channel development funds. In addition, the GoSA contributes to regional and international organizations (WHO and other United Nations agencies, the African Union (AU), the Southern African Development Community (SADC), Global Fund, GAVI and others), as well as the India-Brazil-South Africa (IBSA) Poverty Alleviation Fund. In 2009, the GoSA proposed to replace ARF with the South African Development Partnership Agency (SADPA) with a stronger coordination function.

2.2. BRICS, trilateral and bilateral collaborations

South Africa joined the grouping of Brazil, Russia, India, China, and South Africa (BRICS) in 2010. While its economy is significantly smaller than its counterparts, South Africa remains the largest economy in Africa, the only African member of the Group of 20 (G-20), and observers in the Group of Eight (G-8). The BRICS Heads of States meetings have occurred annually since 2009, and most recently in 2013 in Durban, South Africa. Durban’s eThekwini Declaration announced a BRICS-led development bank to meet infrastructure needs, and to serve other emerging markets and developing countries. The Delhi Declaration issued during the 4th BRICS Heads of States Meeting in 2012 committed for regular meetings of BRICS Health Ministers to jointly address common goals, including universal access to health technologies and exchanges between young scientists in pharmaceuticals and health, among other areas.

Meetings among BRICS Health Ministers took place in Beijing in 2011, and in New Delhi in 2013. The 2011 Beijing Declaration emphasized commitments to World Health
Assembly (WHA) Resolutions on the Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21 and WHA62.16). The 2013 Delhi Communiqué reiterated this commitment, emphasizing access to medicines for HIV/AIDS and TB. It also emphasized support to another set of WHA resolutions, including non-communicable diseases (WHA 62.11, 2011), the WHO Framework Convention on Tobacco Control (FCTC), Comprehensive Mental Health Action Plan (WHA 65.4), the International Health Regulations (IHRs), the WHO Consultative Working Group on Research and Development, the resolution on universal health coverage, and the health Millennium Development Goals (MDGs). Both meetings discussed the importance of WHO’s future financing. For the January 2014 BRICS Health Ministers’ meeting in South Africa, the countries are expected to work toward five strategic areas: NCD risk factors, health promotion and universal coverage, surveillance, strategic health technologies, and drug discovery and development.

In addition to BRICS, the India-Brazil-South Africa (IBSA) is a trilateral cooperation initiative established in 2003, initially advocating for equity in trade and development. One of the 17 working groups established within IBSA was a health working group, including a partnership on vaccine research. Strong bilateral cooperation also exists. Brazil’s emphasis on equity has guided its exchanges of experiences with South Africa. The South African government’s program on primary health care reengineering is based on the successful model in Brazil. India and South Africa collaborate on a range of issues from higher education, mining and manufacturing to health and technology. International AIDS Vaccine Initiative (IAVI) is working with the Departments of Science and Technology (DST) in India and South Africa to partner in the development of an AIDS vaccine.

The Forum on China-Africa Co-operation (FOCAC) has met annually since 2006, and South Africa has played a leading role in this group. The African Human Resources Development Fund was set up, under which China sponsored nearly 7,000 Africans to participate in training courses in economics, defense, agriculture, medicine, education, diplomacy, and science and technology. At the fifth conference in July 2012, China committed to provide US$ 20 billion in credit to African countries for infrastructure, agriculture, manufacturing, and small enterprises; offer 18,000 scholarships; and send 1,500 medical workers to Africa, among other initiatives.

2.3. Health Research and Development

South Africa has well-established clinical infrastructure and strong academic institutions. In the belief that science and technology plays a critical role in social and economic development, the Department of Science and Technology (DST) invested US$ 2.6 billion, or 0.93% of GDP, in research and development (R&D), and committed to an increase to 2%. Motivated in part by its domestic health challenges, South Africa has established centers of excellence for R&D, including those at the University of Cape Town, University of the Witwatersrand, University of KwaZulu Natal, University of Stellenbosch, the Medical Research Council, Human Sciences Research Council, among many others. These institutions have made significant contributions to disease prevention and treatment, and control of HIV and TB drug resistance, among other areas. South Africa is notable for advancing research on novel anti-TB drug regimens to simplify treatment of drug-sensitive and drug-resistant TB, including the New Combination 1 (NC-001) and NC-002. A number of vaccine candidates are under R&D. In addition, these institutes have published
studies demonstrating the impact of male circumcision on HIV prevention, identifying neutralizing antibodies against HIV, the impact of ARVs on life expectancy, and the impact of task-shifting on HIV/AIDS patient outcomes, among other research projects. Contract Research Organizations (CROs) are active, and South Africa follows the International Conference on Harmonization (ICH) good clinical practice (GCP) guidelines.

Research is founded on the strength of South Africa’s academic institutions, which serve as regional training resources. A growing number of students are from foreign countries, accounting for 7% of enrolments at public universities. Two-thirds of international students are from the Southern African Development Community (SADC). The South African government subsidizes SADC students, whose tuition fees are the same as local students. This policy is based on the view that South Africa should contribute to the region’s human resource development.

In 2001, the DST committed more than US$ 50 million to stimulate growth in the private sector health biotechnology sector, with a focus on the production of vaccines and bio-generics, therapeutics, diagnostics and medical devices. In 2003, the Biovac Institute was established as a public–private partnership supported by the NDOH, and has received over R 200 million (US$ 25 million) to build infrastructure and expertise for vaccine manufacturing. Biovac currently imports, packages and distributes vaccines to public health facilities within South Africa, and is considering expansion to neighboring countries. Biovac has a network and academic and industry partners, and is participating in tech transfers projects of HBsAg vaccine from Cuba, pentavalent DPT + HepB + Hib vaccine from Thailand; and clinical trial material for an HIV vaccine from Italy. As a part of the Global Pandemic Influenza Action Plan, WHO is supporting Biovac in developing capacity for the production of influenza vaccines.

Many global pharmaceutical companies are based in South Africa, and pharmaceuticals are an important element of the government’s industrial strategy domestically and regionally. The South African pharmaceutical industry accounts for nearly one-quarter of pharmaceutical sales in Africa. In 2008, South Africa exported substantial amounts of pharmaceutical products to Zambia (R 169.43/US$ 21.2 m), Kenya (R 138.03/US$ 17.3 m), Nigeria (R 107.38/US$ 13.4 m), Germany (R 92.20/US$ 11.5 m), and Uganda (R 80.73/US$ 10.1 m).

2.4. Regional and Global Leadership in Health

A unique combination of factors in South Africa – including a high disease burden, strong academic and intellectual resources, government funding to R&D, private sector investments, and an active civil society – has led to programmatic innovations and leadership in global health. South Africa currently contributes a large part of the global burden of disease for a number of conditions. The HIV epidemic remains the largest globally, with an estimated 5.6 million HIV-positive people as of 2009, and HIV prevalence is one of the highest in the world at 17%. Africa has one of the highest TB incidence rates in the world (993 cases per 100,000 population), and more than 389,000 new cases reported in 2011. Most HIV/TB co-infection occurs in Sub-Saharan Africa, and rate of co-infection in South Africa are high (65%). In 2011, South Africa contributed to 17% of the total global burden of MDR-TB and over 90% of the regional burden. Rates of injury from road traffic accidents and violence are also notable in global terms. Use of tobacco, alcohol, and rates of obesity are some of the highest in the continent.
The South African response to these challenges since 2009 has been notable in terms of innovation and leadership. The GoSA has pushed ahead to reach global targets for HIV treatment and care, resulting in the largest ART program in the world, with more than 1.9 million people having initiated treatment representing about 25% of global ART coverage, and an aggressive HIV counseling and testing program that targeting annual universal testing. In addition, the GoSA has taken the lead on early adoption of initiatives to control infectious diseases, which influence uptake in other high-burden countries. The rapid adoption of Gene Xpert MTB/RIF for diagnosis of drug resistant TB is a prime example. The NDOH has procured 288 Xpert machines and over one million test cartridges, accounting for 59% of global procurement. Progress in both diagnosis and follow-up treatment for drug resistant TB is watched closely. In addition, South Africa has adopted fixed-dose combination ARVs, initiated an integrated policy for HIV/TB treatment, and led a four-country collaborative program of work to harmonize TB treatment and reduce TB among migrant workers in the mining sector. The GoSA moved quickly to introduce new vaccines, such as rotavirus into its immunization schedules, and reiterated its commitments to disease eradication and elimination, including forging ahead with the polio end-phase containment activities and the elimination of malaria. Early adoption of innovative tools, policies, and approaches has a great influence on other countries’ policy decisions, particularly in Southern Africa.

In terms of non-communicable conditions, South Africa has also provided leadership. In 1993, the government moved forward with progressive legislation to control tobacco consumption, signed and ratified the FCTC in 2005, and has since been one of the first signatories to the protocol on smuggling. The NDOH put forward progressive legislation to control alcohol abuse, including bans on advertising and promotion. It has recently implemented mandatory reductions in salt added to processed foods, and the government is now considering fiscal and tax policies to reduce the problem of obesity, particularly among children.

In addition, the private sector in South Africa has advanced some highly innovative health policies. The Healthy Food Program run by Discovery, South Africa’s largest medical aid program, offers 25% cash back on healthy food purchases. It has resulted in higher consumption of fruits, vegetables, and whole grain foods among its 260,000 members. Anglo American has championed HIV testing, treatment and care. It has achieved 80% voluntary HIV testing among its mining workers, offers free ARV treatment to HIV positive workers, and monitors the rate of HIV negative to positive conversion across its mines-awarding managers and mine workers with the lowest conversion rates.

2.5. Regional and Global Health Participation

The South African government has spent more than 1.3 billion rand (US$ 162.5 million) to fund its participation in the multilateral organizations over the past three years. South Africa is a member of the Foreign Policy and Global Health Initiative (FPGH), to promote health within discussions on foreign policy, analysis and practice. The group issued the Oslo Ministerial Declaration in March 2007, and they also put forward the UN General Assembly resolution on “Global health and foreign policy” in December 2012. The resolution calls on Member States to value the contribution of universal health coverage as an important cross-cutting policy issue in the international agenda and recommends that consideration be given to including universal health coverage in the discussions on the post-2015 development agenda in the context of global health challenges.
As a Member State of the WHO, South Africa is an active participant in the global and regional governing bodies driving the health agenda. South Africa was elected to the WHO Executive Board in May 2013. In addition, representatives from the South African government, academia, and civil society currently participate in a wide range of WHO expert advisory panels, scientific groups, technical consultations and committees, resulting in global and regional recommendations and guidance for all Member States. Participation from South Africa spans all categories of WHO work, including HIV/AIDS, vaccines, TB, malaria, vector control, environmental health, urban health, universal coverage, poison centers, financing, essential medicines, public health and intellectual property rights, non-communicable disease conditions and risk factors, research, public health emergencies, international health regulations, and maternal and child health, among others. South Africa is also a member of the WHO African Public Health Emergency Fund, to develop a more effective response to regional outbreaks and disasters.

The WHO Collaborating Centers (WHO-CCs) form part of international collaborative networks to conduct activities in support of WHO’s mandate and priorities. Among the 26 WHO CCs in the WHO African region, South Africa currently houses 13 WHO CCs. The WHO CCs in South Africa carry out normative work and research in areas as diverse as nursing, oral health, medicines, occupational health, communicable diseases, reproductive health, human resources, chronic diseases, injury and violence, and health technologies.

Centers under the South Africa’s National Health Laboratory Service (NHLS) National Institute of Communicable Disease (NICD) play a crucial role in the WHO African region in supporting diagnosis of pathogens causing major outbreaks, strengthening laboratory competencies, and carrying out high quality research and investigations to aid public health decision-making. The Center for HIV and STIs is a WHO Regional Laboratory for HIV drug resistance, and carries out surveillance domestically and in neighboring countries including Swaziland, Namibia, Zimbabwe and Malawi. The Center for Tuberculosis houses the regional reference laboratory for MDR-TB. The Center for Opportunistic, Tropical and Hospital Infections (COTHI) strengthens laboratory capacity regionally, carries out quality assurance for laboratories for international malaria vaccine trials and Global Vaccine Preventable Invasive Bacterial Diseases sentinel sites. The Center for Respiratory Diseases and Meningitis houses the National Influenza Centre, a regional WHO reference laboratory for influenza. The WHO Regional laboratories for polio, measles and rubella are within the Centre for Vaccines and Immunology (CVI), which provides support to WHO AFRO countries for diagnostics, testing, reagents, and external quality assessment and training. The polio lab supports seven Southern African countries for isolation of poliovirus. It also conducts confirmatory testing from other WHO AFRO national laboratories.

The South Africa Medical Research Council Tuberculosis Unit’s laboratory in Pretoria was endorsed by WHO in 1995 as the Supra National Reference Laboratory (SRL) of the SADC Region to assist countries in sub-Saharan Africa on drug resistance surveillance, EQA of drug susceptibility testing, training on TB diagnostics, and assisting the National TB Control Program.
SECTION 3

WHO’S MANDATE, ACHIEVEMENTS, AND PARTNERSHIPS

3.1. WHO Governance and Mandate

The Member States of the World Health Organization (WHO) established the organization as the leading authority in public health with the signing of its constitution in 1948.151 It goal is “the attainment by all people of the highest possible level of health.” The World Health Assembly (WHA) is the governing legislative body of the WHO, in which all 194 Member States convene annually to determine policy directions and programs of work. The Executive Board (EB) oversees the operational implementation of decisions taken by the WHA. Each of the six regions holds their Regional Committee (RC) to carry out the decisions of the WHA and EB, and develop policies on regional health concerns. In the WHO African Region, the RC consists of representation of its 47 member states. The Secretariat is comprised of international civil servants working for the Member States on day-to-day issues, and organized at three levels: Headquarters (HQ) in Geneva led by the Director General, the six Regional Organizations led by the Regional Directors (RDs), and the Country Offices led by the WHO Representatives (WRs).

The main comparative advantage of WHO is based on its mandate from Members States to act as the directing and coordinating authority on international health. Through its constitution, the WHO carries out its normative functions for monitoring health situations and trends globally; proposing conventions, regulations, norms, standards and guidelines; stimulating research; and advancing knowledge application. At the same time, WHO is mandated to carry out technical cooperation and to provide country support at the request of Member States. In the AFRO region, most Member States have country offices, with the purpose of technical cooperation based on WHO policies and programs in the context of national health development.

WHO is a United Nations (UN) specialized agency authorized to carry out responsibilities in the field of health. As guaranteed by the UN Charter, WHO maintains autonomy and independence from the UN in its program of work, budget, personnel, membership, and structure, which are guided by WHO Governing Bodies. The WHO’s Country Cooperation Strategy (CCS) is the formal agreement with the government of its cooperative programs of work.

The WHO at country level is guided by General Program of Work (GPW) approved by the WHA. The GPW for 2014-19 explicitly recognizes changes in socioeconomics, burden of disease, and the multitude of players in global health.152 The Leadership Priorities for the organization set forth under the GPW include advancing universal health coverage; supporting the health-related Millennium Development Goals; addressing the challenge of non-communicable diseases and mental health, violence and injuries and disabilities; implementing the provisions of the International Health Regulations; increasing access to essential, high-quality and affordable medical products; and addressing the social,
economic and environmental determinants of health as a means of reducing health inequities within and between countries.

Under the GPW for 2014-2019, there are six categories of work. These six categories include communicable diseases; non-communicable diseases; promoting health through the life course; health systems; preparedness, surveillance and response; and corporate services and enabling functions. Under the reform process, the GPW has taken on even greater importance in guiding WHO's work at country level. Also approved by the WHA, the budget provides the financial means to implement the program of work and carry out WHO's mandate. The projected budget for 2014/15 biennium is US$ 3.98 billion, with 52% of the allocations to communicable diseases and preparedness. The African region is projected to receive 28% of the global budget, of which 41% is allocated to preparedness (including polio eradication) and 32% to communicable diseases.

The principle resource of the organization is its technical staff. At end-2011, the Secretariat was composed of approximately 7000 permanent staff, of which 26% are in HQ, 24% are in the regional offices, and 50% are in the country offices. In mid-2012, WHO African Region had 2378 temporary and long-term staff, of which about 18% are based on the regional office in Brazzaville, Congo, and the remaining are in the sub-regional or country offices. Thus, the country offices have access to a global network of technical support at all levels of the system.

3.2. Notable Achievements between 2008 and 2012

Promoting universal health coverage

Since 2008, the WHO made several notable contributions to promoting universal health coverage for all South Africans. In terms of human resources for health (HRH), WHO provided policy guidance for several major HRH policy documents, including the Nursing Strategy for South Africa, 2008, the Human Resources for Health Strategy 2012/13-2016/17, and the revision of PHC strategy in 2008. Since 2008, WHO supported national curriculum for Clinical Associates (Mid-Level Worker) for medical doctors. WHO supported the National Nursing Compendium endorsed in 2011, and promoted the implementation of WHO global strategic directions in nursing and midwifery to improve quality of PHC service delivery. WHO participated in the National Quality Health Service delivery Conferences and awarding of the Excellent Performance Awards for performing PHC and hospital nurses.

WHO participated in planning and implementation of NIMART (Nurse initiated management of ART), including training curriculum and supervision manual for the professional nurses initiating ART. WHO country office worked in close collaboration with NDOH to clinical mentoring of health workers at district and facility levels in respect to providing quality care for ART patients following the Clinical Mentorship Guidelines for district health workers issued in 2011. WHO support provided for the initiation of the process aiming for the development of the national pharmacovigilance plan and policy, which will include toxicity monitoring of major ARVs used in South Africa, and strengthening the linkages between pharmacovigilance and clinical outcomes. In terms of information systems, WHO co-organized a high-level regional meeting in 2012, to promote civil registration and accurate vital statistics in Southern Africa, resulting in
support to strengthening national civil registration systems and developing a strategic and action plans.

The WHO participated in the Ministerial Advisory Committee for National Health Insurance (NHI) in 2011 and 2012, and provided recommendations that led to the Green Paper for NHI. WHO continues to work in collaboration with key partners to support the NHI implementation plan. WHO provided input on the service prices for private providers, and continues to support data collection for National Health Accounts for monitoring health spending.

In terms of medicines, WHO supported the phased introduction and monitoring of pneumococcal and rotavirus vaccines in 2008 and 2009. WHO also supported the laboratory accreditation processes, resulting in WHO national and reference laboratory for measles and polio labs being accredited in 2008. In terms of institutional capacity, WHO technical support was provided for the strengthening of supply and distribution of anti-TB drugs in 2008 and 2009. WHO initiated a program of work to strengthen quality standards to assess medical devices and diagnostics, and strengthen quality criteria under the national procurement programs. In addition, a joint program of work was initiated to conduct international comparisons of vaccine prices and procurement mechanisms to strengthen vaccine security. WHO selected Biovac South Africa for technology transfer for the production of influenza vaccines to promote vaccine security. WHO provided technical and financial support to the Polio and Measles Regional Reference Laboratories situated at the National Institute of Communicable Diseases (NICD).

Improving life expectancy

WHO’s work towards improving life expectancy in South Africa during 2008 to 2012 focused on the prevention and control of key communicable diseases. WHO provided technical input in the development of the National Strategic plan (NSP) for HIV/TB and STIs, 2012-2016, launched by the President in December 2011, and the Monitoring and Evaluation framework. Specifically, under HIV/AIDS, WHO took the lead in consultation to establish a national system for surveillance and monitoring of HIV drug resistance to minimize the emergence of HIV drug resistance and its negative consequences for care and treatment. WHO worked in close collaboration to initiate a framework to improve the quality of ART services and to carry out a cohort analysis for clinical outcomes. Following reported adverse effects from Nevirapine (NVP), WHO supported the NDOH in establishing a pregnancy register to monitor adverse reactions among pregnant women particularly those on ARVs. WHO participated in the update of the national ART treatment guidelines which led to access by PLHIV to life saving medications including HIV/TB co-infected patients and pregnant women. WHO participated in the strategic planning and policy development for scaling up medical male circumcision in South Africa. WHO collaborated with other partners to contribute to the revision of guidelines, especially on the HIV/TB co-infection to improve the quality of clinical management of HIV/TB co-infection.

WHO played a central role in developing the Voluntary Counseling and Testing (VCT) guidelines and policy, and implementation of the HIV Counseling and Testing (HCT), with an emphasis on ethical and human right issues that need to be observed by health workers to improve access and enrollment to ART.
Substantial WHO input was put into Tuberculosis (TB) guideline review and development. WHO facilitated the revision of Drug Resistance-TB guidelines in 2010. Subsequently, WHO supported the development and implementation of the framework for the decentralized management of MDR-TB, tools for readiness assessment and supervision of DRTB to improve the quality of MDR-TB management. WHO facilitated the revision and alignment with WHO recommendations of South Africa National TB infection Control Guideline and TB management and control guidelines in 2012. In collaboration with other partners, WHO provided input into the revision of Isoniazid Preventive Therapy (IPT) guidelines in 2012. WHO provided input in the development of Standard Operating Procedure for TB data management in 2012. In support of institutional capacity, WHO assisted to determine priorities for annual operational plan for National TB program in line with the National Strategic Plan.

WHO held a National Consultative Meeting in 2012 to engage Community Based Organization in TB activities. This joint WHO/NDOH meeting led to the establishment of a NGO consultative forum that integrates community TB activities into the work of several major civil society and non-governmental organizations. Supported the NDOH Pediatric Drug Resistance (DR) TB conference, in October 2012. WHO supported this meeting, which helped to identify gaps in the management of DR-TB among children and identified best practices for implementation. WHO is a convener of the UNTJ working group for “Keeping People Alive and well,” which provides technical oversight on One UN HIV/TB agenda, develops joint workplans, and mobilizes resources to implement activities.

In terms of TB monitoring and evaluation, WHO sits on the steering committee for the South African TB Drug Resistance TB survey in 2011/12, which will provide essential data to understand the nature of the epidemic in South Africa, for better planning and management of DR-TB programs. WHO also provided technical assistance in conducting the first “Know your epidemic synthesis” for TB in South Africa, which synthesizes programmatic, laboratory data and vital statistics in a systematic review of TB in high-risk groups. WHO also participates in the TB Drug Resistance survey and TB prevalence survey to inform planning. WHO provided technical support to the recording and reporting formats of TB and DR-TB and participated in incorporating these changes in the electronic TB register with the objective of improving the data quality at all levels of data management.

WHO facilitated training in an improved version Electronic TB Register in 2012, to ease information bottlenecks. WHO participated and provided technical support towards a combined HIV and TB programs provincial and district level supportive supervision visits through revision of assessment tools and on site administration of the tools. This contributed to the aim of delivering quality service at all levels. WHO provided normative guidance in the planning and implementation of GeneXpert roll out in 2010/11. The role out of GeneXpert contributed to improved management of TB and early diagnosis of Drug Resistant TB. WHO provided normative guidance in the development of TB component of Global Fund Round 10 proposal on TB/ HIV. This is in line with the support for resource mobilization as identified in Maputo declaration on malaria, HIV/AIDS, Tuberculosis, and other related infectious diseases. In collaboration with the United Nations Joint Team (UNTJ), a roundtable satellite session on Pediatric TB and TB in the mining sector was held at the South African TB conference in 2012. The meeting was convened to focus on TB in children, seen as a “forgotten epidemic.” The session led to collaborate work between WHO and UNICEF on TB in children.
WHO participated in the Malaria Advisory Group (MAG), to ensure that WHO standards and norms are adhered to especially for malaria free certification. This group became the South Africa Malaria Elimination Committee (SAMEC) in 2012, to provide expert guidance for malaria elimination. WHO participated in the development of the Malaria Treatment Guidelines, Quality Assurance, and Laboratory Quality Control Guidelines for malaria diagnostics to ensure alignment with WHO guidelines in 2010. WHO participated in the development of the Malaria Elimination Strategy for South Africa (Draft) as well as the M&E Plan in 2011, and costed implementation plans for each province, 2010. WHO participated in the development of malaria surveillance guidelines for elimination with support from all stakeholders including MRC, NICD, NHLS, provincial programmes, 2011-2012 based on WHO guidelines. WHO supported NDOH in reporting on the use of DDT to the Stockholm Convention, and assists in establishing thresholds for the malaria epidemic preparedness and response.

Strong efforts towards malaria elimination were made. WHO developed a series of cross border initiatives with Botswana, Zimbabwe, Swaziland, and Mozambique to prevent and control malaria, and the Lubombo Spatial Development Initiative (LSDI) is a successful cross-border initiative across Swaziland, South Africa and Mozambique, funded by Global Fund. WHO supported a comprehensive malaria program review, which resulted in recommending that South Africa is ready for elimination. WHO worked in cooperation with partners to carry out research on active case surveillance for malaria elimination in Mpumalanga. WHO also participated in schistosomiasis control program reviews between 2010 and 2011.

In MCH, WHO facilitated the interpretation and incorporation of WHO Global evidence-based practices on achieving MDG targets for MDG 4 and 5, for utilization in plans, policy and strategy documents (2008-2012). WHO reviewed Global case studies of youth services models to assist in the adaptation of the Youth Friendly Services model in line with WHO guidelines (2011-2012). WHO also worked together with UNICEF to support the implementation of the rapid assessment of pediatric and adolescent ART programming nationally in 2012. WHO participated in the design and implementation of several major surveys, including the National Antenatal Sentinel HIV and Syphilis Surveys in collaboration with other development partners, the National gender audit (2009-2010). WHO developed and adapted WHO research tools and guidance documents to conduct the national gender audit for health at both the national level and in 8 provinces. WHO initiated research on the national status of adolescent pregnancy in an effort to develop the adolescent health strategy (2010).

Extensive training and capacity building in MCH was undertaken. WHO developed training materials and presentations for training workshops in selected provinces in sexual and reproductive health using WHO/UNFPA tools for family planning, cervical cancer and Human papillomavirus (HPV) guidelines, in 2008 and 2009. WHO supported the development of routine checklists in cervical cancer screening to conduct problem identification and SWOT analysis of program areas. WHO also participated in the development of standardized, integrated training materials for contraception in collaboration with partners and academic institutions using WHO Medical eligibility guidelines in 2012.

WHO carried out extensive work in building human and institutional capacity for immunization. WHO provided technical input into the revision and finalization of the
National Surveillance Manual, completed November 2012. The manual covers the procedures for conducting the surveillance of measles, acute flaccid paralysis (AFP), neonatal tetanus and adverse events following immunization. WHO provided technical support mainly in training-the-trainers in Reach Every District (RED) to assist in increasing the vaccination coverage by reaching the unreached populations in the districts, and assisting facilities with community engagement and social mobilization as part of strengthening of immunization systems. RED-train-the-trainer workshops were undertaken in 2011, and RED training was undertaken in 4 districts in 4 provinces in 2012. WHO provided technical support for the pre-, and intra-PCV drive assessment in February to May 2012, including finalization of the assessment tools, assessing implementation and trouble shooting when necessary via visits to selected health facilities in designated provinces. The coverage of the new vaccines particularly PCV had been low due to various factors such as stock outs and insufficient social mobilization. This drive aimed to intensify the availability and use of the PCV vaccine.

In terms of EPI logistics and cold chain, WHO provided support to orient the DOH EPI and pharmaceutical services team on the WHO logistics tools in 2012. WHO provided Effective Vaccine management Training to national and provincial EPI managers, cold chain and depot managers in 2012). This training was instrumental in assisting managers to estimate their cold chain requirements, forecast vaccines as well as obtain up to date information on the new developments in cold chain including the new temperature monitoring devices.

In terms of EPI data management, WHO coordinated the quarterly Data Harmonization meetings between the DOH and the National Institute of Communicable diseases (NICD) for the measles and Acute Flaccid Paralysis (AFP) databases. Technical input into the weekly review of performance of districts in measles and AFP surveillance activities and assisted with training as necessary to improve capacity. Via STOP data manager, assisted in the development of standard operating procedures for the management, cleaning and analyses of the measles and AFP datasets in 2012, and supported the DOH to initiate a weekly surveillance performance bulletin. WHO provided technical support in the conduct of data quality self-assessment (DQS) in 4 provinces, and supported the review and update of EPI monitoring charts and provided financial support for the printing of these. WHO facilitated the timely reporting of Routine Immunization, measles and AFP databases. WHO also developed and supported the implementation of the influenza vaccination campaigns and evaluation of the campaigns (2008-2012).

WHO worked in partnership with UNICEF in 2012, to provide technical input into the first EPI coverage survey to be conducted in 2013. This is a significant step by the DOH to verify the administrative coverage data, which differs from other survey data. Information from the coverage survey will be useful in guiding the program by identifying areas of underperformance.

Promoting healthy behaviors

WHO participated in the development of NCD policies, strategies and guidelines. WHO participated in the National Health Promotion Task Team to develop the NDoH Draft Integrated Health Promotion Strategy and Policy 2012-2015. As part of the Health Promotion and Development Network (HPDN), WHO promoted the concept and
operationalization of South Africa's Health Promotion Foundation. As part of the National Integrated School Health (ISHP) Task Team, WHO supported the launch the National School Health Program and pilots.

In terms of policies for health promotion, WHO actively participated in developing several draft policies, strategies, regulations and guidelines, which include the National Guidelines on Promoting Healthy Lifestyles and Guidelines on Health Promoting Schools Initiative. WHO continues its work on the Framework for addressing Social Determinants of Health. WHO participated in specific implementation tools including the ISHP M&E Instrument, ISHP template for provincial operational plans, Integrated School Health Policy, Learner Assessment Form: Foundation and Intermediate Phases, Learner Assessment Form Senior and FET Phases, School Health Week Evaluation tool, and Draft ISHP Communication Strategy.

In terms of tobacco control, WHO participated in the National Tobacco Products Control Task Team, which supported the development of regulations for implementation of the 2009 amendment to the National Tobacco Products Control Act. The team's achievements include smoke free stadia during the 2010 FIFA World Cup Tournament, and training of provincial health staff (environmental health, health promotion and communication) on the 2009 amendment of the National Tobacco Products Control Act. In 2011, WHO and NDOH convened national and international experts, to systematically review South Africa's status in implementing the WHO FCTC, and existing capacity for tobacco control work, with emphasis on the treaty provision for monitoring tobacco use and interventions, clean air legislations, cessation, health education, bans on tobacco advertising, promotion and sponsorship, and price and tax measures.

Capacity building was undertaken in 2012, among Health Promotion and Environmental Health Officers from 9 provinces in Tobacco Products Control Policy and its implementation. WHO provided technical support to NDoH and work with the National Council Against Smoking, in training workshops on the advances to the Tobacco Control Legislation in South Africa. Workshops were run in Gauteng and Western Cape provinces attended by Health Promotion Officers and Environmental Officers, representatives of a variety of health disciplines from the public and private sectors including District Health Managers, Environmental Health Officers, Health Promotion Officers, Nurses (maternal and Child Health, Occupational Health, and Schools), Community Health Committees Representatives, Traditional Healers, Academics and NGOs. WHO actively participated in developing tobacco control regulations relating to display at point of sales.

In 2011, WHO worked actively with the Departments of Transport and Health and other stakeholders to launch the Decade of Action for Road Safety in South Africa. WHO has since worked with more stakeholders in organizing and successfully holding the 2011 and 2012 National Road Safety Conferences. With the Road Traffic Management Corporation in 2010, WHO participated in the National Youth Road Safety Conference. WHO attended and participated in the National Road Safety Steering Committee, which put forward the ‘Make Roads Safe’ Initiative, Road Safety debate competition, Community Road Safety Councils Preventing Childhood Injuries: Living Safely Workshop. WHO partnered with the Road Traffic Management Corporation in 2009 leading to the successful hosting of the Road Safety Youth Convention, which discussed road safety matters and opinions on solutions to youth road safety challenges.
To advance policies and regulations for NCD prevention and control in 2010, WHO and NDoH convened joint workshops on chronic diseases and geriatrics covering the following areas: Regulations on the Compulsory Registration of Cancer, Standard Operating Procedure (SOP) Manual: Cancer Regulations, Cancer Regulations and SOPs, Rheumatic Fever / Rheumatic Heart Disease, Implementation Plan: Diabetes Declaration- achievements and future targets, Long Term Care Service Model: Implementation Framework - achievements and future targets, Older Persons Act and health related matters, and Residential Care Facility Monitoring Tool. In 2011 and 2012, on behalf of NDoH, WHO supported training of 120 health staff from Gauteng and North-West Provinces on the implementation of the Chronic Diseases Management Register.

WHO also participated in co-organizing or supporting multiple national meetings to raise awareness, generate consensus, or convene stakeholders to advance key areas of work. A few key meetings include the National Summit on Prevention and Control of Non Communicable Diseases Summit, 2011, the National Mental Health Summit in 2012, and the meeting for the Global Mental Health Action Plan 2013-2020, to develop an action plan/strategic plan based on the Declarations/ Resolutions from the 2012 National Mental Health Summit and the Mental Health Policy Framework.

Surveillance and emergency preparedness

WHO provided support to outbreak response through participation in the regular meetings of the National Multi-Sectoral Outbreak Response Team (MNORT), based at the Communicable Disease Unit of the DOH. Several subcommittees of the body are put together as the need arises to develop or review strategic documents e.g. the yellow fever policy, the influenza policy. In 2010, the WHO supported national preparedness for receiving and deploying Pandemic Influenza A (H1N1) Vaccines, including a WHO donation of 3.5 million doses.

WHO supported the development of multiple policies and guidelines for disease prevention and control, including yellow fever policy updates, meningococcal disease treatment guidelines update, influenza treatment guidelines update, influenza vaccination policy, E-Health policy, travel Health Advise document (For the 2010 World Football event). WHO conducted an assessment of the core country capacities to implement the IHR, and initiated discussions with the National DOH (NDOH) on the need to implement an IDSR strategy that will provide live information for the purpose of timely response to outbreaks and other events of public health concern.

WHO provided field support in outbreak response during the major outbreaks of cholera (2008 and 2009) and Rift Valley Fever, including outbreak response coordination, information and data management, training of provincial CDC staff in outbreak investigation, clinic staff in case management. WHO supported training of provincial (all nine provinces) staff in outbreak response, with focus on ongoing outbreaks and perceived public health risks (Viral hemorrhagic fevers, Hepatitis). In terms of International Health Regulations (IHR), WHO supported the National Focal Point (NFP) in the management of information on outbreaks and public health events, including verification of public health events within and outside South Africa. WHO held a meeting to assess 20 designated ports, airports and ground border crossings for compliance with the IHR in South Africa in 2012, including training of 10 Port Health staff in Ship Sanitation Inspection.
In terms of food safety and mass gatherings, WHO adapted, trained and implemented the WHO food safety norms and standards to ensure food safety at football World Cup events in 2010. WHO worked with the GoSA to introduce and orientate the food control unit to the Global Food defense strategy that resulted in the adoption of a national food defense strategy for the country in 2009-10. WHO engaged mass gathering specialists to support the setting up and implementation of event surveillance system for the 2010 Football World Cup and the Africa Cup of Nations (AFCON).

Strengthening surveillance systems was a major focus on work, and encompassed immunization Data Quality Surveillance (DQS), and EPI surveillance in all provinces, and polio eradication. Notably, WHO support was provided to surveillance during mass gatherings during the 2010 FIFA World Cup, and documentation of experiences for application during the 2013 African Cup of Nations. WHO support was provided to protocols for severe acute respiratory infection sentinel surveillance, systems for monthly national outbreak and response, surveillance for malaria elimination.

In terms of immunization surveillance, WHO provided ongoing technical support on AFP, measles, NNT and AEFI surveillance to all the provinces, including training in surveillance and data management, and on the updated Surveillance Manual. At the request of Provincial Departments of Health and in collaboration with the National Department of Health, WHO supported the provincial training of clinicians and other health professionals in AFP and Measles surveillance. The clinician training courses were CPD (Continuing Professional Development) accredited by the Health Professions Council of South Africa.

To advance polio eradication, WHO works in close collaboration with the NDOH EPI team to support the secretariat to the ministerial appointed Polio Committees (National Polio Expert Committee (NPEC), National Polio Certification Committee (NCC), and the National Task Force (NTF). In this capacity, WHO supported the annual report as required by the Africa Regional Certification Committee.

3.3. Major partners and stakeholders

Major bilateral development partners

Based on data from the Organization for Economic Cooperation and Development, Development Assistance Committee (DAC), total international aid flows to South Africa increased in nominal terms and reached 1.27 billion in 2011. More than half of total DAC aid flows are dedicated to health (54.1%). The vast majority of aid is from bilateral partners (82%).

Based on 2010-11 averages, the United States government is the largest donor, contributing US$ 547 million on average annually. The largest program is the CDC administered President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR is currently being phased down, under a bilateral Partnership Framework Implementation Plan since 2012, under which annual PEPFAR funding to South Africa will be reduced by half of its current levels (US$ 483.7 million) by 2017. The South African Treasury committed to funding the gap to ensure that the government meets its target of treating 3.6-million HIV patients by 2016. PEPFAR played an important role in HIV counseling and testing for millions of people in the past two years, and reducing HIV transmission from mother to child to 2.7% by 2011.
The WHO Regional Office for Africa holds Memoranda of Understanding with both US CDC and USAID, which outline comprehensive areas of cooperation with WHO in the African region. In South Africa, WHO partners closely with CDC on HIV treatment, care, support and prevention, including support to male circumcision, HIV drug resistance, production of technical guidelines, promotion of research, and supporting strong civil society. In addition, collaboration exists on public health, and disease control and prevention programs. WHO partners closely with USAID on the pediatric and adolescent ART and IMCI programs, PMTCT, TB/HIV, health systems strengthening including data management.

The second-largest donor is the EU institutions (estimated US$ 176 million annually), based on a framework for EU co-operation with South Africa, focused on achieving the National Development Plan. Areas targeted for support include strengthening the national regulatory authority strengthening, national health insurance, national health information center, human resources, training, maternal and child, and other programs to advance bilateral cooperation. The next largest DAC donors are France (US$ 136 million) and Germany (US$ 101), and the United Kingdom (US$ 60 million), based on OECD estimates. Technical collaborations with Germany exist through its development agency, GIZ, which focuses on ART, HIV prevention (male circumcision, condom use, HIV at work place). GIZ also supports some aspects of health systems development for HIV, data management, and human resources. DFID health resources in South Africa have focused on various aspects of health systems development, carried out in close consultation with the Director General for Health and delivered via contractual agencies. Areas targeted for support include strengthening the national regulatory authority, national health insurance, human resources, training, maternal and child, and other programs to advance bilateral cooperation.

The main forum for coordination among the development partners is the AIDS and Health Development Partners Forum, which bring together all major partners in the health sector. It is currently co-chaired by WHO and the German Embassy. The forum meets every few months among the development partners, quarterly with the Director General of Health, and annually with the Minister of Health. Under the forum are four technical working groups for HIV/AIDs, MCH, and health systems strengthening to advance specific areas of technical collaboration with the government and share information.

United Nations System

The United Nations Country Team (UNCT), comprised of 17 United Nations agencies, signed in early 2013 the United Nations Strategic Cooperation Framework (UNSCF) for 2013-17. The SCF provides a coordinating framework for UN funds, programs, and partnership agencies in South Africa. The SCF was developed in 2012 through an extensive consultation process, coordinated by the Department of International Relations and Cooperation (DIRCO). The SCF is based on a joint agreement of UN support to achieve the major government policies and strategies, including the National Development Plan (NDP) and the Medium Term Strategic Framework (MTSF). The SCF identified four areas of cooperation: inclusive growth and decent work; sustainable development; human capabilities; and governance and participation. The SCF also aims to support South Africa in achieving its regional and global development goals.

WHO is authorized under the General Assembly to act as the UN specialized agency to carry out international health work. WHO maintains autonomy and independence from
the UN in its program of work, budget, personnel, membership, structure, and
appointment of its Director General. The independence that the WHO has from the UN
system is guaranteed by the UN Charter, which authorizes WHO to carry out international
responsibilities in the field of health. Unlike the UN funds and partnership agencies, the
WHO as a specialized UN agency, maintains its Country Cooperation Strategy as the formal
agreement of WHO cooperative programs in South Africa, and is guided by its Governing
Bodies in terms of technical cooperation.

WHO’s contribution to the UNSCF is channeled through UNCT thematic clusters on
HIV/AIDS, human capabilities, and governance and participation. Aligned with its
mandate, WHO is responsible for health sector and humanitarian and disaster response,
and contributes to the joint outputs under the SCF in collaboration with other UN
agencies. It is anticipated that, with the development of the WHO CCS, WHO will focus its
collaboration on inter-sectoral actions to achieve the social determinants of health.

Other UN agencies with significant involvement in the health sector include several UN
funds (UNICEF and UNFPA), and UNAIDS. UNICEF’s operations in South Africa focus on child
survival and development, education and child friendly schools, protection for orphans and
vulnerable children, and social policy. UNICEF partners closely with WHO in several key areas,
including immunization and surveillance, social mobilization, nutrition, PMCTC, and
reproductive and child health, TB in children, and procurement. UNFPA in South Africa
focuses on reproductive health and HIV, gender, and population development. WHO
partners closely with UNFPA on HIV prevention, maternal and child health, contraceptive
and fertility policies, and cervical cancer. UNAIDS was more recently established as a
coordinating agency and advocate for HIV/AIDS. It serves as the secretariat for the United
Nation Joint Team (UNJT) in South Africa, with the role to coordinate and share information,
with no gaps and duplication of efforts which requires respect for the mandates of
individual UN agencies working on common areas in HIV/AIDS. In cooperation with the UN
team, WHO works with other agencies on a systematic review of TB among high-risk
populations, and UNDP participants in the UNTJ for governance and key populations.

WHO works with the Food and Agricultural Organization (FAO) on the animal/human
interface and the One Health Approach, which integrates surveillance and response to
zoonotic events, strengthening of foodborne event surveillance and response systems,
and capacity building for risk assessment in food safety at national and provincial levels.
WHO also maintains close collaboration with the International Organization for Migration
(IOM) for TB treatment among migrant workers, and with the World Bank on a four-
country program of work to address TB in the mining sector in South Africa, Lesotho,
Swaziland and Mozambique. The collaboration aims to achieve the SADC Heads of State
declaration in 2012 on TB in the mining sector. The WHO contribution is focused on
cross border medical referral systems and harmonized treatment regimens for TB.

Other partners

Other partners play key roles in the health sector, including the Global Fund to Fight AIDS,
Tuberculosis and Malaria (GFATM), Roll Back Malaria, and Stop TB Partnership in their
focused efforts to control HIV, TB, and malaria. Based on OECD DAC figures, the Global
Fund contributes a substantial share of development aid to South Africa, ranking as the
7th largest donor with an annual average contribution of US$ 32 million. National
disease control programs thus have incentives to follow global recommendations for prevention, treatment and care advocated through these partnerships, which can provide important evidence to feed back into the global health policy dialogue. International Private Sector Development Partners also have a significant presence in the health sector. Development assistance from the Bill and Melinda Gates Foundation has focused on HIV/AIDS, TB, operational research, and strengthening the regulatory authority. The Clinton Foundation is working on health systems strengthening, including an Annual Planning Tool to identify trends in development assistance.

National civil society organizations in the health sector play a critical role in advocating for health and care of vulnerable groups. Soul City and Love-Life have played key roles in supporting family planning campaigns, the implementation of the youth friendly services programs. In addition, they have run community-based health outreach and awareness projects to increase community awareness about primary prevention of communicable and non-communicable diseases, including alcohol and tobacco. WHO is expanding their work with community based organizations – including Save the Children South Africa, Lovelife and Catholic Health Care Association -- to extend the reach of the health system in providing community based TB care and treatment.

South Africa has a number of institutes that play central roles in disease prevention and control. The National Institute of Communicable Disease (NICD), under the National Health Laboratory Service, serves as a center of excellence and regional WHO reference laboratory. It plays a central role in diseases prevention and surveillance in the region, and specifically strengthening laboratory capacity, TB reference laboratory, HIV drug resistance early warning indicators, and malaria case management and diagnostics.

WHO collaborates with the universities and academic institutes to support evidence-based decision-making processes. This includes collaborations on a broad range of communicable diseases (including malaria information system and GIS) as well as non-communicable conditions and risk factors with University Research Council, the Medical Research Council (MRC), University of Cape Town, University of Pretoria, University of the Witwatersrand, University of KwaZulu-Natal, University of Limpopo, Walter Sisulu University, Human Science Research Council. A large number of professional and patient associations are influential in developing better health policies and programs, and ensuring broad support for policy changes. Other institutions are instrumental in developing health and health system information to strengthen evidence-based policy, including the Health Systems Trust, The South Africa Vaccine and Immunization center (SAVIC) at Medunsa Campus, and the Red Cross Society, South Africa, which carries out outbreak response, surveillance and health promotion.

Lastly, WHO works closely with a range of government departments. The Department of International Cooperation (DIRCO) plays a central role in WHO governing bodies. In Disease Prevention and Control, key departments include Veterinary Services (Department of Agriculture, Forestry and Fisheries) for Joint Animal and Human Health Collaboration on Zoonotic Diseases, and meetings of National Multi Sectoral Outbreak Response Team (MNORT); the Disaster Management Centre: disaster risk management, preparedness for disaster; and implementation of the IHR. For environmental issues, the Department of Environmental Affairs (DEA) is responsible for DDT reporting for the Stockholm Convention, Climate change adaptation. The Department of Agriculture, Forestry and
Fisheries are responsible for Chemical regulations. In the area of NCDs and prevention of risk factors such as alcohol abuse and tobacco control, key government departments including the National Department of Basic Education; National Department of Social Development; National Department of Transport; National Department of Finance; National Department of Trade and Industry; National Department of Cooperative Governance and Traditional Affairs; Government Communication and Information Services, among others.
SECTION 4

THE STRATEGIC AGENDA FOR WHO COOPERATION: 2013-2014

4.1. Four Strategic Priorities for South Africa

Four strategic priorities for WHO Cooperation in South Africa are set forth based on the situational analysis; health needs and demands; the changing environment in South Africa as a middle-income country expanding on its own development cooperation; and the comparative advantage, role, and mandate of the WHO as the UN specialized agency in health.

The four strategic priorities set forth for 2013-14 include:

Strategic Priority 1. Promote Universal Health Coverage (UHC) and financial risk protection for all South Africans, through support to strengthening health systems.

The first strategic priority is to support access to health care and risk protection under the goal of Universal Health Coverage (UHC). This work will be carried out through support to the implementation of National Health Insurance (NHI) and financing systems, strengthening the national regulatory authority to ensure quality medical products, and support to human resources for health for access to qualified health care providers.

a) Supporting the implementation of National Health Insurance (NHI) to achieve access and financial protection.

South Africa guarantees the right to health care in its Constitution. WHO has emphasized the basic principle behind UHC as universal access to services regardless of ability to pay. This requires a strong financing system and strategy to generate resources, pool funds, purchase services, and ensure value and performance. National Health Insurance (NHI) is the central means by which the government aims to achieve UHC and enable equal access to affordable quality healthcare. The government intends to complete its White Paper by 2013/4, after which regulations will be implemented. WHO will continue its work with the government in support of the phased implementation of NHI, and support the major changes required in financing and management, provider payment mechanisms, purchasing, and pricing systems.

The NHI is being piloted in selected areas before national roll-out. A key activity therefore, is monitoring and evaluation through strengthened capacity for analysis, use, validation and dissemination of data and evidence. WHO will support the use of data for accountability under the Negotiated Service Delivery Agreement (NSDA) and ongoing policy processes. In addition, a central part of NHI implementation is strengthening public health service quality. There is a need to strengthen health systems to prevent and manage both communicable and chronic non-communicable conditions, and ensure the delivery of cost-effective interventions.
b) Strengthening the national regulatory authority (NRA) to ensure access to safe quality medical products.

Access to quality medical products is also a major component of the NHI. The establishment in 2014 of the South African Health Products Regulatory Authority (SAHPRA) as a functional regulatory authority with a broad scope and mandate provides an opportunity to promote quality, safe, and efficacious medical products in South Africa and the continent.

WHO support to the SAHPRA will be forward-looking and encompass its mandate and scope of work, including regulation of medical devices and diagnostics. As a newly established entity, systems will be required in overall quality management, information technology, human resources and capacity building. Specialized technical support will be required in blood products and biologicals, medical devices and IVDs, complementary and traditional medical products, pharmaco-vigilance and safety monitoring, and financing.

Enhancing national registration and regulatory capacity will be required, to realize South Africa’s private pharmaceutical and device manufacturing potential and promote vaccine security, particularly in light of WHO’s program of technology transfer for the production of influenza vaccines with Biovac South Africa.

c) Supporting sufficient numbers and distribution of human resources for health (HRH) to promote access and quality in service delivery.

The quantity and distribution of skilled human resources remains a key challenge in health and social development. WHO will continue to support health workforce norms and standards in the NHI pilot sites and beyond, and in using the information to develop the organizational structure and project human resource requirements for production and budgeting. There is also a need to improve information and the knowledge base about the health workforce, which is currently being advanced under the Human Resources for Health (HRH) Observatory.

Strategic Priority 2. Accelerate gains in life expectancy through focused programs to reduce the burden of HIV/AIDS and TB, and to expand access to immunization.

The second strategic priority is to accelerate gains in life expectancy. This work will be carried out through focused programs of work on communicable disease conditions including strengthening capacity for scaling up HIV prevention, treatment, and care; improving the prevention and treatment of TB and MDR-TB; and promoting access to immunization to reduce infant and child mortality rates.

a) Strengthening capacity for scaling-up HIV prevention, treatment and care to achieve the vision of no new HIV infections and no AIDS-related deaths.

Life expectancy in South Africa has been driven primarily by the AIDS epidemic. The success in expanding anti-retroviral therapies (ART) has led to increases in life expectancy from 54 years in 2005 to 60 years in 2011. The success in expanding treatment and care has led to more people living with HIV. In line with WHO’s Global and Regional HIV/AIDS commitments and strategies and the goals set forth in the South African National Strategic Plan on HIV, STIs, and TB, WHO will continue to support the urgent need to
accelerate prevention interventions. This includes expanding access to Provider Initiated Counseling and Testing (PICT), male circumcision, and interventions for key populations at high-risk. Progress in maternal and child health continues to be driven by the HIV and TB epidemics, and weak performance of the health system, and WHO will work to strengthen joint efforts to reach the goal of <2% of Maternal To Child Transmission (MTCT).

However, simply getting more people on treatment is insufficient; the quality of their care is essential to ensure good clinical outcomes. WHO will support better clinical outcomes, in part through supporting a cohort analysis to monitor HIV and TB clinical outcomes. Following reported adverse effects from Nevirapine (NVP), WHO will continue to support systems to monitor adverse reactions among pregnant women particularly those on ARVs to inform decision making for reducing maternal and infant mortality. A major emerging challenge is the emergence of HIV drug resistance (HIV DR), and underlies the urgency of WHO's continued support to the national HIV drug resistance strategic plan and protocols, and an Early Warning Indicator system.

b) Improving the prevention and treatment of TB and MDR-TB to substantially reduce incidence, prevalence, and case fatality rates.

The TB program requires special support given that South Africa has one of the highest TB incidence rates in the world. WHO will strengthen surveillance, monitoring, and evaluation and timely information on progress towards national and global targets for control and evaluation of drug resistance. This will include support to the TB Drug Resistance Survey, the national TB prevalence Survey, and the TB Drug Resistance Program Review. WHO will support increased new knowledge to inform policies and strategies by supporting a systematic Review of TB among high risk populations, carrying out a trend analysis of routine data and vital statistics, retrospective analysis of laboratory data, and tuberculosis and diabetes collaborative research. Diagnostic capacity has been strengthened by increasing coverage of GeneXpert. WHO will continue to support assessments of GeneXpert implementation, and also evaluate the effect of the HIV Counseling and Testing (HCT) campaign on the TB program.

A major challenge is high TB/HIV co-infection rates, and the growing problem of drug resistant TB. WHO will continue its work to harmonize clinical guidelines to reduce TB prevalence across countries, particularly for migrant populations in the mining sector. WHO will continue to conduct clinical audits; and to develop guidelines, policies, and strategies for infection control.

WHO will continue to support Isoniazid Preventive Therapy guidelines, assist in the initiation and monitoring of Bedaquiline, and address the challenges of TB diagnosis among children. WHO will continue to support the piloting of decentralized management and nurse initiated MDR-TB and promoting the effective involvement of NGOs at community level in extending the reach of the health system. Lastly, WHO will continue its work to improve TB data quality and management.

c) Promoting access to existing and new immunization products to reduce infant and child morbidity and mortality rates.

Immunization remains a critical activity to improve child health and contribute to the MDGs. The successful inclusion of 10 antigens on the national immunization schedule has
reduced child morbidity and mortality rates.\textsuperscript{177} WHO continues to support national plans and policies to address the challenges in improving access to and utilization of existing and new immunization products, through the national comprehensive multi-year plan, a National EPI policy, the revision and finalization of the National Vaccinator’s Manual and the National Cold Chain Manual.

Maintaining routine immunization is essential. WHO continues to provide support to the Reach Every District program targeting the poorest performing districts; to improve measles second dose coverage, such as the development and standardization of defaulter tracing systems; to support in the planning and implementation of the 2013 measles and polio campaign (pre, intra and post campaign assessments); and to support the introduction of the HPV vaccine. WHO also supports systems for Effective Vaccine Management, and the training and implementation of the Vaccinator’s and Cold Chain Manual.

Major efforts are underway to accurately measure impact and address data quality including over-and under-reporting, and accurate denominators. WHO continues to support the planning and implementation of the first national EPI coverage survey in South Africa, coordinates the meetings on data harmonization, and provides training for Data Quality Self-assessment (DQS).

**Strategic Priority 3. Advance cost-effective measures that enable people to live in a healthy environment and make behavioral choices that promote longer healthier lives**

The third strategic priority is to advance policies for healthy communities and environments, which enable people to easily make behavioral choices that promote longer healthier lives. This work will be carried out through activities towards achieving the global targets and national commitments for non-communicable disease (NCD) prevention and control; supporting the fulfillment of commitments under the WHO Framework Convention on Tobacco Control (FCTC) and reducing the harmful use of alcohol; and advancing work to promote healthy diets and exercise.

**a) Focusing on cost-effective measures to achieve global and national commitments for non-communicable disease (NCD) prevention and control**

Approximately 2 in 5 deaths in South Africa are attributable to non-communicable disease conditions (NCDs). WHO has established political commitments through the Brazzaville Declaration on Non-Communicable Disease and Prevention in the WHO African Region,\textsuperscript{178} and for the first time, set out targets and indicators for monitoring progress on NCDs under the WHO Global Action Plan.\textsuperscript{179} WHO will continue to work closely with the government to support multi-sectoral collaboration and institutional arrangements required for effective prevention and control, and the implementation of evidence-based policies to achieve global and regional goals, which have been integrated into South Africa’s National NCD Strategic Plan. In addition, WHO is committed to support the government’s Mental Health Action Plan: 2013-2020,\textsuperscript{180} and linkages with the WHO Mental Health Action Plan for 2013-2020; the Strategic Framework for the Prevention of Injury in South Africa, and road safety. WHO will also support the government’s Intersectoral Framework for addressing the Social Determinants of Health, to be guided by WHO’s prior technical work.\textsuperscript{181}
b) Supporting the fulfillment of commitments under the WHO Framework Convention on Tobacco Control (FCTC) and reducing the harmful use of alcohol.

The Government of South Africa has been progressive in its approach to the control of tobacco and harmful use of alcohol. These two risk factors are important drivers of the burden of NCDs, violence and injuries. South Africa has some of the highest smoking rates and harmful use of alcohol in the continent. WHO is fully committed to supporting the government’s implementation of its commitments under the WHO Framework Convention on Tobacco Control (FCTC), including advertising bans, smoke free public places, graphic health warnings on packages, price and tax measures, cessation programs, and illicit trade. In recognition of the public health emergency presented by risky patterns of alcohol drinking in South Africa, WHO is committed to work towards advancing effective policies, including bans on alcohol advertising and promotion; warning labels on alcohol products; price and tax measures; and effective multi-sectoral collaborations for the prevention and control of the harmful use of alcohol.

c) Advancing work to promote healthy dietary choices and exercise, and reduce overweight.

The major nutrition related problem is South Africa is overweight and obesity, with more than 7 in 10 women 35 years or older and half of men 45 to 65 years overweight. The number of children that are overweight is also rising rapidly. A major contributing factor is the food environment, with greater availability, aggressive promotion, and subsequent consumption of packaged foods high in calories, saturated fats, animal proteins, sugars, and salt. Work is urgently needed to advance cost-effective evidence-based policies to control obesity and promote healthy diets, including regulations for the reduction of salt content in processed foods; nutrition pricing policies and subsidies; restrictions on advertising and promotion, particularly to children; among others. Lack of physical activity is a contributing factor. WHO is committed to capacity building on health promotion, increased knowledge and awareness concerning the importance of regular physical activity and other health promoting activities, and promotion of environments that enable physical activity. In addition, WHO is undertaking a global longitudinal study of the health of over 90,000 older people in 11 countries, including South Africa, to assess trends in healthy aging.

Strategic Priority 4. Support South Africa’s contribution and leadership to achieving global and regional health goals.

The fourth strategic priority is to support South Africa in making its contribution to advance global and regional health. This work will be advanced through accelerating programs to reduce South Africa’s contribution to the global burden of disease, identification and documentation of innovations and models for replication elsewhere, advancing the elimination and eradication of specific diseases, and strengthening core capacity for the implementation of International Health Regulations (IHR), and promoting the implementation of the Libreville Declaration for health and the environment.

a) Accelerating programs to reduce South Africa’s contribution to the global and regional burden of disease, and documentation of innovations for replication elsewhere.

South Africa contributes to a large share of the global burden of disease for HIV/AIDS and TB and MDR-TB. For MDR-TB, for example, South Africa contributed 17% of the total global
burden and over 90% of the regional burden in 2011. Thus, the WHO is committed to accelerating policies and programs conditions and risk factors where domestic efforts in improving health outcomes can have a significant impact on global health trends. These efforts include TB and MDR-TB, HIV/AIDS, risk factors, and non-communicable diseases.

Being on the front line of several major epidemics, South Africa's responses to its domestic health challenges, particularly HIV/AIDS and TB, are watched regionally and globally. Bold approaches in piloting and testing innovations have had a global impact, particularly for the treatment and prevention of HIV/AIDS. It is imperative to document and disseminate such innovations and development successes, which can serve as models for adaptation in other countries. These efforts could include innovations in HIV/AIDS treatment and care, alcohol control policies, salt reduction, and malaria elimination, among others.

Regional reference laboratories, clinical and academic institutions, and WHO-CCs in South Africa serve critical roles that must be recognized and supported to serve national, regional, and global health interests. One way to disseminate successes is to expand South Africa's involvement in WHO technical consultations, meetings, and events for sharing domestic policy successes, and fully utilizing WHO as a global organization to facilitate exchanges of experiences across regions. Another means is to fully support the BRICS Health Ministerial Forum to establish programs of collaboration.

b) Promoting the elimination and eradication of specific diseases to advance global public health.

The eradication and elimination of diseases represent a global public health good, with vast economic and social benefits. The polio end-game initiative is underway, with South Africa currently having undergone laboratory containment. WHO will continue to support the Measles Elimination Strategic Plan. Surveillance is an essential part of the work, and WHO will continue to support surveillance systems for Acute Flaccid Paralysis (AFP), surveillance for measles and neonatal tetanus (NNT) – also targeted for elimination – as well as adverse events following immunization (AEFI). WHO continues to support the institutional mechanisms for polio eradication, including the three national committees tasked with overseeing and producing the evidence and documentation for eradication, as well as the Polio and Measles Regional reference laboratories at the NICD.

WHO promotes malaria elimination, and the elimination or eradication of neglected tropical diseases (NTDs), which continue to affect substantial numbers of South Africans. WHO supports to South Africa Malaria Elimination Committee, that is advancing cross-border initiatives with Zimbabwe, Botswana and Mozambique; and carrying out a migrant survey in five provinces, and sero-epidemiological survey on malaria in low endemic areas. Support to the prevention and control of NTDs will also be provided, with a focus on soil-transmitted helminthic (STH), schistosomiasis, and leprosy. Progress will be accelerated through support to the National Master Plan for the control of NTDs, to disease specific response plans, and to the policies and programs (Including the Integrated School Health Policy) in promoting regular treatment of schoolchildren for soil transmitted helminthic infections, and prevention and treatment of other NTDs.

c) Strengthening core capacities for the implementation of International Health Regulations (IHR), and for emergency preparedness
Major public health risks can rapidly spread through travel and trade. The International Health Regulations (IHR) represent an extraordinary global consensus on international health reporting to prevent, protect against, control and respond to the international spread of disease, which commits members states to strengthen core capacities for disease surveillance and reporting of public health events to ensure global public health security.

WHO is committed to enhance capacity for surveillance and monitoring of communicable diseases of public health importance, through implementation of the IHR, improved information management on events of national and international importance, implementation of sector specific plans on attainment IHR core capacities and annual monitoring and reporting to the WHA, and implementation of Integrated Disease Surveillance and Response (IDSR).

WHO’s mandate is to improve detection, coordination and response to epidemics and other public health emergencies of international concern, through support to the coordination of national level outbreak response, continuous monitoring of public health events, and risk assessment of public health events. WHO will continue to strengthen the effective operations and response to epidemics and pandemics, through the updates of guidelines and policies to respond to emerging pathogens, and country capacity building, including the orientation of health workers on management of diseases due to dangerous and emerging pathogens.

WHO is also mandated to enhance capacity for emergency preparedness and response to reduce excess mortality in affected communities, through conducting a health sector vulnerability and risk assessment and action plans to improve resilience of health facilities and communities, and building partnerships and providing leadership in responding to emergencies.

c) Promoting the implementation of the Libreville Declaration on health and the environment.

The sustainable development sector has undergone many changes that have resulted in improved quality of life for South Africans. However, continued use of coal as a cheap source of energy for industry has resulted in South Africa as a major greenhouse gas emitter in the continent. The WHO will work closely with partners to enhance capacity to implement the Libreville Declaration on health and the environment, including undertaking a situational analysis and needs assessment on health and the environment.

4.2. Implications for implementation for the Secretariat

The implementation of the four strategic priorities set forth in this extension plan will build on existing strong collaborations and good relationships with government counterparts and other major partners and stakeholders. The strategic priorities for 2013-2014 also build on the achievements from the previous Country Cooperation Strategy, with a stronger emphasis on South Africa’s role in global health. However, successful implementation will have major implications for the WHO secretariat, in terms of a shift in technical approaches and focus, in strengthening and expanding relationships with partners, and in improving the effectiveness of the WHO response.
Specifically the implications for the secretariat include the following:

a) Maintaining a focused program of work in communicable disease prevention and control, and providing stronger support to health systems strengthening and non-communicable disease policies and strategies, and South Africa’s contributions to global health.

In response to the policy environment, this strategy proposes to maintain a focused program of work on communicable diseases prevention and control, with an emphasis on WHO global and regional resolutions, and an understanding of the contribution of other partners and stakeholders. At the same time, stronger emphasis will be placed on health systems strengthening, non-communicable disease prevention and control, and South Africa’s global health role. This will require shifts in human and financial resources according to technical priorities, and a mobilization of fresh resources for new areas of work.

b) Establishing stronger linkages between WHO activities and sustainable impact within the results chain, by ensuring high quality technical support, and strengthening individual capacities and institutions.

WHO is a technical advisory agency with a focused mandate. Given limited human and financial resources, the Secretariat needs to shift away from low-impact activities and small scale funding, and towards technical advisory support for activities that will have measurable and sustainable impact. This requires a shift from small-scale project funding in order to better utilize scarce resources, and the provision of high quality technical advice that will impact policies, programs, and long-term government investment in the health sector.

c) Emphasizing strengthening individual and institutional capacities and fulfilling WHO’s established six core functions.

The WHO is not an implementing agency. The Secretariat should not replace the work of the government but work towards systematically strengthening capacities through counterpart relationships and continuous transfer of skills and knowledge. WHO staff will need to concentrate on its comparative advantages relative to many stakeholders in the health sector, add value to ongoing efforts, and fully carry out its six core functions, including:

1. Providing leadership and engaging in partnerships for joint action;
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3. Setting norms and standards and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support, catalyzing change, and building sustainable institutional capacity; and
6. Monitoring the health situation and assessing health trends.

Advances have been made to more clearly identity the roles of WHO Secretariat at the three different levels of the organization and how they work together to deliver concrete outputs. For example, for core function number five (providing technical support, catalysing change, and building sustainable institutional capacity), the country office takes the lead through the development of the CCS, managing technical cooperation, and
monitoring international commitments. The Regional Office has the responsibility for providing and coordinating support as needed to enable these processes, and headquarters develops corporate guidance, and promotes best practice. In contrast, for core function number three, in setting technical norms and standards, the headquarters leads the process, and the country and regional offices support adaptation and provide evidence on which the norms, standards and methodologies are based. Thus the implementation of each of the core functions requires participation and mutual support at all levels of the Secretariat, including the staff at the South African Country Office (CO), the African Regional Office (AFRO), the Inter-Country Support Unit (IST), and Headquarters (HQ) in Geneva.

d) Establishing technical networks to fully utilize and harness WHO resources at all three levels of the WHO Secretariat in support of the strategic priorities, and in line with the expected deliverables at country office, regional office, and headquarters.

Technical professionals are the principle resource of the WHO. The effective implication of the four strategic priorities requires harnessing technical support at all levels of the WHO Secretariat, including the staff at the South African CO, AFRO, IST, and HQ. Similar to the core functions, roles and functions at all levels of the Secretariat have been identified for the five major technical categories of work in the Program Budget.

Effective implementation of this strategy will, therefore, build on and operationalize the responsibilities and deliverables by WHO category outlined in the Program Budget 2014-2015, which specifies roles and functions at each level of the WHO. The country office will need to systematically strengthen and expand on the WHO technical support networks across the organization to fully access the global network of technical support at all levels of the organization.

e) Strengthening and expanding relationships with partners and other stakeholders.

The program of works set forth requires multi-sectoral actions, linkages and technical relationships with a range of government departments, partners and stakeholders. WHO will support effective multi-sectoral and multidisciplinary collaborations, and promote engagement across relevant government, non-governmental organizations, civil society, and private sector and facilitate their involvement in collaborative work. Partnerships with other UN agencies will be strengthened.

f) Thinking globally: the implications of our work in South Africa on global health.

While South Africa faces its own important development challenges, the models and innovations underway are important to share and disseminate widely. The Secretariat must consider the implications of work in South Africa on regional and global health, through stronger documentation and dissemination of work and broader engagement in regional and global forums to ensure that South Africa can bring its experiences to the regional and global health community.

g) Creating a communications strategy and expanding on information products to promote WHO’s visibility and presence.
The WHO country office needs to better communicate to the public, its partners, and the media what the organization is doing to improve health and welfare. The office will develop and implement a communications strategy, develop information products for dissemination online and to the media, revamp its website and update it regularly, and generally improve documentation and dissemination of our activities and products.

h) Strengthening the enabling functions of the country office to allow for greater efficiencies and flexibilities in operations, and stronger performance.

Under WHO reform, there is renewed emphasis on efficiencies in management and administration. Efforts will be made to further strengthen the country support unit for the office, streamline administration, strengthen financial management and procurement, improve human resources management and performance, and strengthen other essential office functions to perform more efficiently and effectively.
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SECTION 1

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112 IBSA Poverty Alleviation Fund - The IBSA Poverty Alleviation Fund is another programme through which SA provides foreign assistance. Established in 2004 by India, Brazil, and South Africa, its function is to “identify replicable and scalable projects that can be disseminated to interested developing countries as examples of best practices in the fight against poverty and hunger.” Each member contributes US$1 million annually.
SECTION 3


Artemisinin Combination Therapy (ACT) is the recommended treatment for uncomplicated malaria. The recommended ACT in South Africa is Artesun-lumenfantrine. For complicated malaria, quinine is still being used but they have also included IV artesunate.


Guidelines for the treatment of malaria, 2nd edition, 2010. WHO recommend the use of ACTs, and provide guidance on drug resistance and thus clarify that mono therapy (medicines) should not be used by countries.

Draft QA/QC guidelines for malaria diagnostics in SA 2012. Prepare the microscopist at district level on how to carry out diagnosis, for both rapid test and slide microscopy. It also refers to slide microscopy as the gold standard for malaria which is recommended for malaria elimination.

Microscopy Quality Assurance Manual, 2008. Emphasis the importance of quality control and assurances for malaria. They also give direction as to how to carry out quality assurance and control including the training of microscopists.

Disease surveillance for Malaria elimination, 2012 Active case surveillance is recommended as important for malaria elimination. Foci classification, accurate reporting, use of GIS and mapping to track malaria elimination.

Medical Research Council, Malaria http://www.mrc.ac.za/pressreleases/malaria.pdf

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Draft Surveillance guidelines for malaria elimination 2012. Case classification is clearly defined into local and imported. The document also identifies the different malaria foci and the type of interventions to be carried out.

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