ANC NATIONAL GENERAL COUNCIL 2010
ADDITIONAL DISCUSSION DOCUMENTS

ANC NATIONAL GENERAL COUNCIL

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TOWARDS 100 YEARS OF SELFLESS STRUGGLE

Working together to create a national democratic society

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NATIONAL HEALTH INSURANCE

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I   INTRODUCTION

1. The ANC 52nd National Conference has identified education and health as key priorities of the ANC government in the next years. The following Conference Resolutions have relevance:

Polokwane Resolution 53:

"Reaffirm the implementation of the National Health Insurance System by further strengthening the public health care system and ensuring adequate provision of funding".

Polokwane Resolution 55:

"Government should intervene in the high cost of health provision".

Polokwane Resolution 56:

"There should be health cover for Veterans of the struggle".

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2. Following the 52nd National Conference, the NEC established an NEC Sub-Committee on Education and Health that subsequently conducted a diagnostic process of analysing the key challenges facing the health sectors. The result of this process led to the development of the Road Map for Health, which was handed over to the Department of Health. To realise better health services to all our people and better health outcomes, the 2009 Election Manifesto identified health and education as one of the five priorities of the ANC. The 2009 Election Manifesto outlined practical steps to be taken by the ANC in its fourth term of government and makes it clear that NHI which help reduce inequalities in our health system will constitute part of the priorities of ANC administration for the fourth term. The Manifesto states that government will:

    "Introduce the National Health Insurance System (NHI) system, which will be phased in over the next five years. NHI will be publicly funded and publicly administered and will provide the right of all to access quality health care, which will be free at the point of service. People will have a choice of which service provider to use within a district".

3. The other practical steps also include the stepping up the fight against HIV and Aids and other diseases; improving quality of care, public facilities; health information and planning systems; boosting human resources; reducing the cost of drugs and active promotion of healthy lifestyles. The Road Map for Health was also translated into Governments Ten-Point Plan for the Health Sector:

    -   To create provision of strategic leadership and creation of social Comparers better health outcomes.

    -   Implementation of national Health insurance.

    -   Improving the quality of health services.

    -   Health overhauling the health care systems and improve its management this will be done in to broad areas (i) revitalization the primary health care system in order to steer away from the present destructive and very costly curative health system to a more preventative and promotive health care system, (ii) the review of the efficiency and management of health system.

    -   Improved human resource planning, development and management.

- Revitalization of infrastructure (a) development of PPPs to rebuild the rehabilitated tertiary hospital' (b) build and revitalize primary health infrastructure; (c) review and reorientation of health technology; (d) strengthening ICT and health information systems.

- Accelerate the implementation of HIV and AIDS sexually transmitted infection NSP 2007 to 2011 and increase focus on TB and other communicable diseases.

- Mass mobilize for better health for the population.

- Review of drug policy.

- Strengthen research and development.

4. Implementation of the NHI is part of the Governments Ten-Point Plan for health reform and is also contained in the Government's Programme of Action. The NEC January 8th Statements made since the resolution on NHI was passed in the 2007 Polokwane Conference have consistently reiterated the determination of the ANC to implement NHI, to address the inequities in the distribution of funding and provision of health care between the public and private sectors and the need to improve the quality of health care. In the 2010 January 8 statement, it was stated that:

"*The implementation of NHI will go a long way in addressing the inequalities that still persist in our health system, especially in the skewed distribution of funding and human resources between the public and private sectors. It is an established fact that the current command of health resources by the private health sector, which serves a minority section of the population, has been to the detriment of the public sector on which the vast majority of South Africans depend. The ANC government is determined to press ahead with the implementation of NHI this year and will ensure that all stakeholders are consulted before the passing of NHI legislation.*"

5. The State of the Nation Address in 2010 indicated that the government will introduce a National Health Insurance system in a phased manner and that this should be coupled with improvement of the health care.

Post-Apartheid Policies Accomplishments

6. Since 1994, the government scored several public policy successes, which include, *inter alia*, expansion of primary care, revitalisation and refurbishment of hospitals, scaling-up ART roll-out, improvements in the pharmaceutical logistics chain, medical research, maintaining and growing health professional training, and combating smoking and piloting innovative public-private partnerships. Furthermore, significant progress has been made in establishing a legislative and regulatory framework for the medical schemes industry.

7. The ANC Health Plan of 1994 was an informed transformation process which began with the integration of the fourteen [14] departments of health of the apartheid era into a single health system consisting of a central ministry and nine [9] provincial departments of health. The principle here was to create a unified national health system integrating the public and private sectors with the objective of reducing inequities and expanding access to essential health care for all.

8. Much has been achieved beyond the establishment of structures and development of policies and strategies. The focus on Primary Health Care (PHC) resulted in the re-prioritisation of budgets and resources to bring about an equitable redistribution between PHC and sophisticated curative and tertiary care. An essential PHC package was formulated which sets the norms for the provision of comprehensive primary care services. To increase access to these services, user fees for public PHC and all fees [including at hospitals] for pregnant women and children under the age of 6 years were removed.

To support the expansion of these services, 1 800 clinics and community health centers were built since 1994. Today, 95% of the population of South Africans can access health care within a five kilometer radius of their homes.

9. Hospital infrastructure was also improved significantly beginning with the Hospital Revitalization

Programme which focused on the improvement of infrastructure, equipment, management and quality of care. To date, 250 hospitals have been revitalised, and 18 new hospitals built of which three are teaching hospitals.

10. In order to remedy shortages in the number of health professionals in rural areas, the government recruited Cuban doctors in the immediate post-1994 period, introduced compulsory community service for recent medical graduates, introduced scarce skills and rural allowances for health professionals, and more recently developed a strategy for the retention of skilled workers: Occupation- Specific Salary Dispensation for certain occupational categories such as nurses, doctors and others.

11. To make medicines affordable, the State introduced a comprehensive national drug policy in 1996, one of the main pillars of which was the Essential Drug List (EDL) for the public sector. It provided for much more rational drug prescribing and the introduction of generic prescribing throughout the health system. However, there is a need to review this policy to evaluate its impact and to improve it where necessary.

12. The government also introduced many targeted health care programmes, including those focusing on women, children and diseases such as HIV/AIDS, TB, alcohol and tobacco use, malaria control, mental health and nutrition.

13. Notwithstanding these achievements, there are many challenges facing the health care system.

Public Health Sector Challenges needing Resolution

14. South Africa has a two-tiered health care system, with a large private sector serving the higher income minority, while the public sector serves the majority of the population. In 2007/8 about 43% of total health care funds in South Africa flowed via public sector financing intermediaries (primarily the national, provincial and local Departments of Health), while 57% flowed via private intermediaries. Medical schemes are the largest financing intermediaries, accounting for nearly about 44% of health care expenditure. Although medical schemes are private intermediaries, their contributing members are also funded by government through tax subsidies. Provincial health departments follow as the next largest intermediary, with 40% of all health care funds flowing via them. Households' out-of-pocket payments directly to health care providers account for a sizeable contribution, at nearly 13% of all health care expenditure.

15. Since the 1994 democratic elections there has been stagnation in funding allocations for the public health sector which together with an increasing disease burden has put the public health care system under severe pressure. In real per capita terms, government expenditure on health declined consistently from the mid 1990s until 2004, and only returned to its 1996 levels in 2005 (McIntyre et al. 2007). This was largely due to the constrained government expenditure associated with the Growth, Employment and Redistribution (GEAR) policy. Since 2005, there have been some increases in real per capita public health budgets above what was spent in 1996. According to the Medium Term Budget Policy Statement (MTBPS) released in late October 2009, the health budget is expected to increase by an average of 8.6% per annum to R101 billion in 2010/11, R109 billion in 2011/12 and R115 billion in 2012/13. Although the MTBPS also noted that inflation in August 2009 had fallen to 6.4%, it is not clear whether the MTEF increases of 8.6% will be adequate to compensate for inflation and population increases in the coming years.

16. The trends in real per capita public spending are shown in Figure 1 below. What is of concern is that not only was public spending on health care not keeping pace with inflation or population growth, but that this occurred at precisely the time when the AIDS epidemic was imposing growing demands on public sector health services.

Figure 1: Trends in real per capita public sector spending on health care (1996 – 2008)
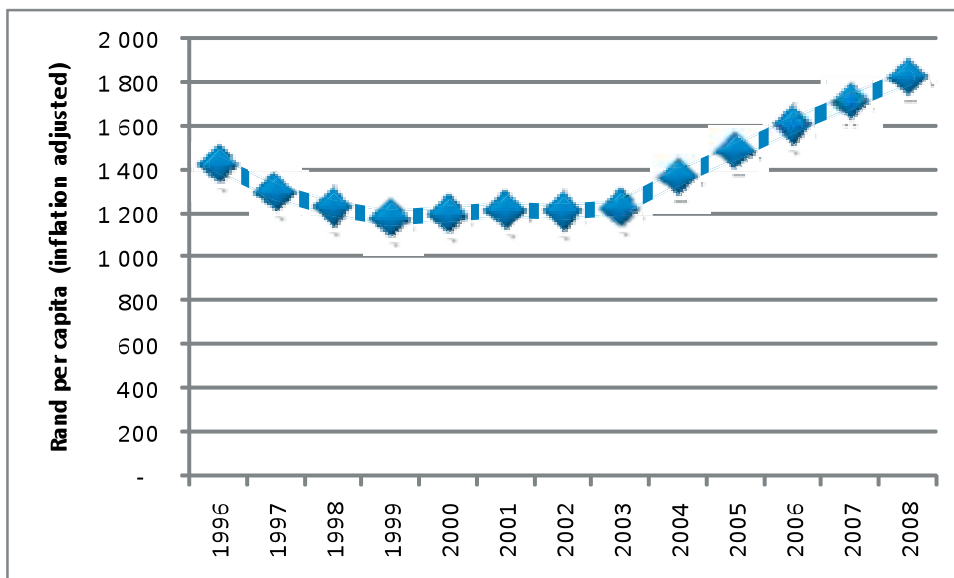
17. The impact of this decline in real per capita spending is possibly best illustrated through looking at staffing levels in the public health sector (see Figure 2). Staff salaries account for the single largest share of health care spending, and as real financial resources declined (at the same time as efforts to improve staff salaries), the number of staff employed declined dramatically (by 36,000 between 1997 and 2003). If the staff to population ratios that prevailed in 1997/98 had been sustained, we would have needed an additional 64,087 staff above those actually employed in 2007/08. If we had also taken into account the need for even more staff to adequately address the growing burden of disease, particularly due to the AIDS epidemic, we required almost eighty thousand (80 000) additional staff in the public health sector in 2007/08.

Figure 2: Trends in public health sector employment (1997/98-2007/08)
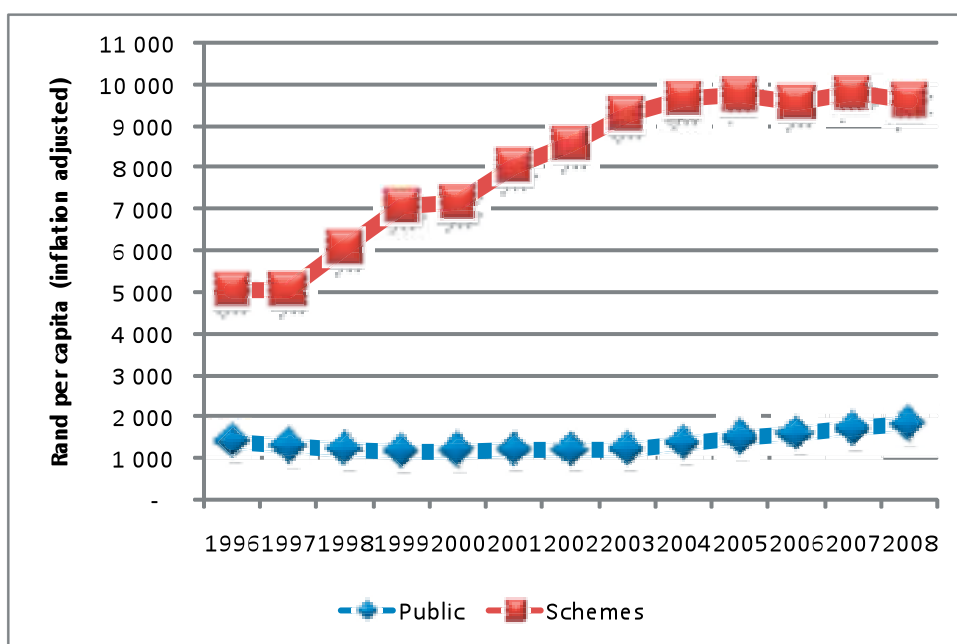
Source: Development Bank of South Africa (2008). A Roadmap of the reform of the South African health system.

Inability to treatment people with TB

18. According to the Department of Health and the WHO, South Africa is one of the 22 High Burden Countries that contribute approximately 80% of the total global burden of all TB cases. It has the seventh highest TB incidence in the world as a result of the double burden of disease, related to co-infection with HIV. South Africa has seen a rise in the incidence of tuberculosis in the adult population with a threefold increase in the numbers of people with TB from 109,000 in 1996 to 341,165 in 2006 or 269 cases of TB cases per 100,000 to 720 per 100,000 population. This has resulted in increased morbidity, mortality and poor progress towards the MDG 2015 targets.

19. Drug resistant TB arises as a result of failures of the public and private health system to adequately deal with patients who have TB. According to the Medical Research Council's Drug Resistant Surveillance, (MRC: 2001-2002), the proportion of people with extra-pulmonary TB trebled to around 15% and the proportion of people who were co-infected with HIV in 2002 was around 55%. TB patients who are HIV positive need to commence ARV's early. In addition, 900 cases of Extensive Drug Resistant TB were reported between 2004 and 2007. Although the cure rates and treatment success have gradually increased from over the last five years with 66% in 2000 to 70% in 2004, the defaulter rates remain high. This has created hurdles in achieving the targets for treatment success and cure and has increased the probability for drug resistance.

20. The most critical component in the management and eradication of TB pertains to addressing the social determinants of TB. These include poverty eradication, nutrition, housing and improvement of living and working conditions. However, effective public health, as well as clinical interventions, is also critical in ensuring adequate and effective management and eradication of TB and its complications. To this effect, the Department of Health developed the Tuberculosis Strategic Plan for South Africa 2007-2011. Financial barriers to seeking health care at the early and latent stages of TB mean that a significant number of household members are infected before diagnosis of TB is made.

Imbalances in the health sector

21. Inequities in access to health care remain a key challenge that should be addressed in a fundamental way.

22. A major access dimension that has posed problems for South Africans is that of the affordability of health services. In a population survey undertaken in 2005, 16.6% or 5.2 million people indicated that they experienced difficulties in accessing health care, including medicines (Shisana et al, 2007).

23. Furthermore, inequities in the public-private health care mix have increased. Government expenditure on health care per person dependent on the public health sector has barely kept pace with inflation, while real medical scheme expenditure per beneficiary has doubled in the past decade, with excessive cost increases in key parts of the private health sector. At the same time, despite policy efforts, public sector health services continued to face severe budget constraints and still fall significantly short of the goal of a unified, comprehensive, equitable and integrated national health system.

24. The mismatch of resources in the public and private health sectors relative to the size of the population each serves, and the inefficiencies in the use of available resources, has contributed to the very poor health status of South Africans, particularly in the lowest income population. We have far higher infant and child mortality rates and far lower life expectancy than other countries with similar levels of economic development. This is not only attributable to the HIV/AIDS and Tuberculosis epidemics confronting our country, but also due to the massive inequalities in the distribution of income and health and other social services which also contribute to poor health.

Maldistribution and Shortages of the Health Workforce

25. There is a serious mal-distribution of health workers in the country, with 60% of the nurses and 40% of the doctors serving 85% of the population using the public health sector. Most of the health workers work in urban areas while there is a serious shortage in the rural areas. This disproportionate distribution obtains by province, with the Western Cape and Gauteng having high numbers of doctor-to-population ratios when compared with the rest of the provinces.

26. Nurses form the backbone of the health care system, and yet they are in short supply. This is largely due to a number of factors including cuts in the provincial budgets and the closure of nursing colleges, which has resulted in fewer nurses being trained. But even those who were trained do not all go on to practice in this country. For example, it is estimated that about 67% of nurses who trained in the period 1997 to 2005 do not appear on the South African Nursing Council (SANC) register (Breier, et al, 2008). Some leave the country to seek greener pastures in countries that pay them higher salaries such as Saudi Arabia, Oman, United Kingdom, United States of America, Canada and Australia.

27. Another indicator of staff shortage is the vacancy rate. PERSAL data suggest that the vacancy rate was between 31.5% in 2006 to 36 % in 2007 (HST, 2007), which translates to 25 701 nurses that would be needed for different positions (Breier et al., 2008). This understates the magnitude of the staff shortages as it only relates to vacancies for existing posts and only relates to nurses. As indicated earlier, if staffing levels had kept pace with population growth and to address the growing burden of disease, more posts should have been created and that staff shortfall was closer to eighty thousand (80 000) in 2007/08. A good measure of shortage is failure to fill vacant posts following advertisements. Researchers at the Human Sciences Research Council (HSRC) found that the vacancy fill rate for registered nurses and midwives was 56%, suggesting that there is a shortage of nurses in general.

Some of the reasons given by employers for the failure to fill the vacant posts were that nursing is not a well-paying job, that it has low recognition, low promotion potential and long unsociable hours of work, that nurses run the risk of contracting HIV and that many migrate to other countries (cited in Breier et al., 2008). A major concern is that 16% of health workers were living with HIV (Shisana, at al, 2004) and 18.9% of the HIV positive workers were classified as eligible for ARV therapy (Connelly, et al., 2007).

28. Linked to the issue of nurses is the shortage of medical practitioners and other allied professionals. Access to quality health care for the majority of South Africans using the public health sector is negatively affected by inadequate supply of medical practitioners and allied professionals. Many migrate to developed countries in the North. In 2001, the OECD estimated that 8,921 South African doctors were in these countries. Reasons advanced for migration of these doctors include crime, deteriorating public education, better pay abroad, deteriorating conditions in the public sector and active foreign recruitment. These are challenges that the State must address if South Africa is to retain the doctors that it trains at a high cost of R780 000 per doctor (Breier & Wildschut, 2006).

29. The shortage of key health professionals is being experienced at a time when the size of the population dependent on public health services has been increasing, and the burden of ill-health among the population, primarily due to the HIV/AIDS and associated TB epidemics is increasing. This has placed incredible strain on public sector health services, and on the staff who work in public sector facilities.

30. Professional assistants or mid-level workers are a relatively new cadre of semi-skilled health care workers in the health sector in South Africa. This cadre of workers improves access to health care to all sectors of the population based on the Primary Health Care approach, irrespective of geographical location, by making up for the scarcity or absence of professionals such as doctors, dentists, pharmacists, physiotherapists or nurses, etc. Professional assistants play a particularly important role in staffing rural health centres, primary health facilities and district hospitals, to bridge the gap between the urban and rural divide, and well resourced and under-serviced areas.

Drug Shortages

31. Another challenge facing the public health sector is the shortage of drugs at public health facilities especially AIDS drugs and the ability to access medicines at lower prices. The private sector on the other hand has an oversupply of pharmacists resulting in pharmacies being located in close proximity to one another in urban areas. The rural populations on the other hand have little or no access to pharmacies. This mal-distribution is the result of the disproportionate healthcare financing system. Despite government efforts to reduce the prices of medicines in the private sector, they remain unaffordable to the majority of South Africans. Private insurance members often exhaust their medicines benefit before the end of each year and have to access their drugs through out-of-pocket payments or waiting in the long queues in the public sector.

Private Sector Challenges requiring Intervention

32.   In contrast to the public sector, expenditure in the private sector has continued to increase, at annual rates far exceeding the inflation rate since the 1980s. Membership to medical schemes has become increasingly unaffordable for South Africans; as expenditure increases, so do the contribution rates or premiums that are charged by medical schemes. In the late 1980s and early 1990s, contribution rates were increasing at between 25% to 30% per year in real terms (McIntyre et al. 1995). The rate of annual contribution increases has reduced dramatically in recent years, but the average annual real increase in contributions of 7% between 2000 and 2005 is still of concern. Although medical scheme membership increased from about 6.5 million in the early 1990s to 6.9 million by 1997, the absolute total number of beneficiaries decreased in some years thereafter and had only remained at 6.9 million by 2005. Medical scheme membership has declined considerably as a percentage of the population, from 17% of the population in 1992 (McIntyre et al. 1995) to less than 15% in 2005 (Council for Medical Schemes, 2006). It has increased in the last few years, largely due to the introduction of GEMS, but still only covers 16% of the population.

33   The main cost drivers of medical schemes expenditure have been private hospitals, specialists and medicines, administration and brokers. While in the 1980s and the first part of the 1990s, expenditure on medicines was increasing more rapidly than other categories of medical schemes expenditure, expenditure on private hospitals rapidly increased in the latter part of the 1990s and the 2000s (McIntyre and Doherty 2004). Real per beneficiary expenditure on specialists increased by 53% between 1997 and 2005, while that on hospitals increased by 74% over this period. Very little of the hospitals expenditure was directed to public sector hospitals; spending on private hospitals accounted for 98.5% of all medical scheme expenditure on hospitals in 2005 (Council for Medical schemes 2006). Medical scheme expenditure on hospitals per beneficiary increased three times more than inflation between 1997 and 2005 (McIntyre et al. 2007).

34. The current expenditure subsidy for medical schemes contributors was estimated to be around R10-billion of foregone revenue in 2005, or 20% of the public health sector budget. This tax policy has major flaws. Firstly it is inconsistent with the principles of universal access, efficiency and equity. The current tax expenditure subsidy on medical schemes' deduction has not contributed to increased access by low income earners in medical scheme membership nor improved the rising costs of the industry. Those in the high income tax brackets continue to benefit more from the subsidy than the middle and low income groups. Furthermore, the workers, including the informal workers, not covered by medical schemes, do not benefit from the tax subsidy at all. Secondly, even if low income earners were to get a tax subsidy, they would not be able to afford adequate coverage, leaving them with modest benefits and high cost sharing that will often make health care unaffordable.

35. There are a range of reasons for the large increases in medical scheme expenditure, including the fee-for-service reimbursement mechanism which encourages providers to supply more services than may be strictly necessary from a clinical perspective. There has also been a growing imbalance in the relationship between purchasers (medical schemes) and providers. This is particularly the case with private hospitals, where three large hospital groups own about 84% of all private hospitals (van den Heever 2007).

Hospital Capacity

36. Whilst hospital beds in the public sector have declined, the number of private hospitals and clinics continues to grow. The private sector has added almost 7 000 beds between 1998 and 2006. The 2007-2008 Council for Medical Schemes (CMS) Annual Report indicates that there are presently 28,000 private beds in South Africa, with an additional 4,000 added between 2004 and 2008. The bed occupancy rate in the private sector is currently at 65% and bed over-supply is roughly 10,000. Bed occupancy in the private sector increased slightly from 62.1% to 64.5% between 2006 and 2007. The mining industry also provides its own hospitals, and has 60 hospitals and clinics around the country with surplus capacity.

37. The 2007-2008 CMS Annual Report reflects increases on the total amount spent on healthcare in the private sector by schemes. Schemes paid R20.2 billion (36.0% of total spent) to hospitals. This translates to a 12.5% unadjusted increase or a 5.3% real increase in expenditure on private hospitals when adjusted for inflation.

38. The CMS Annual Report also indicates that specialists are the key drivers of increased hospital utilization and costs, as they are the professionals who predominantly admit patients in private hospitals. Specialists generate around 70% to 80% of hospital costs incurred, aside from their own professional fees and costs. Private hospital cost increases could also be a result of the excessive issuing of licensing for acute beds and expensive technology by provincial health administrations.

Misalignment between the public and private health sectors

39. Another significant challenge facing the South African health system is the need to address the inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each. Table 1 summarises the disparities that exist between these two sectors in relation to hospital beds and human resources. As mentioned earlier, there is more than twice as many hospital beds per beneficiary of private sector hospital services as there are for those dependent on the public sector. The disparities are even greater in relation to health professionals; each pharmacist in the public sector serves 12 to 30 times and each generalist doctor in the public sector serves 7 to 17 times, more people than those in the private sector. There is a six-fold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor, working in the public and private sectors in South Africa.

Table 1: Distribution of health care resources between public and private sectors (2005)

Item	Private sector	Public sector
Population per general doctor	(243) 588*	4,193
Population per specialist	470	10,811
Population per nurse	102	616
Population per pharmacist	(765) 1,852*	22,879
Population per hospital bed	194	399

* Data in brackets represents only medical scheme members (14.8% of the population), main estimate assumes that private GPs and pharmacists may be used by up to 35.8% of South Africans. **Source:** Data on personnel and bed numbers from Health Systems Trust's South African Health Review, 2005/06.

40. What is of concern is that public-private mix disparities have deteriorated remarkably over the past decade (see **Figure 3** below). While real expenditure per medical scheme member (health care benefits and administration and other management costs) were about *three* times greater than government health care expenditure per person who is not a medical scheme beneficiary in 1996, the difference in expenditure was about *six* times greater on medical scheme beneficiaries by 2006. This is due to the fact that real per capita expenditure in the public sector was relatively stagnant over this period, while medical scheme contributions and expenditure have been growing at rates far exceeding overall inflation throughout the period. This pattern of diverging public and private sector expenditure patterns was seen throughout the 1990s as well.

Figure 3: Trends in real per capita health care expenditure in public sector and medical schemes (2000 base year); 1996-2006
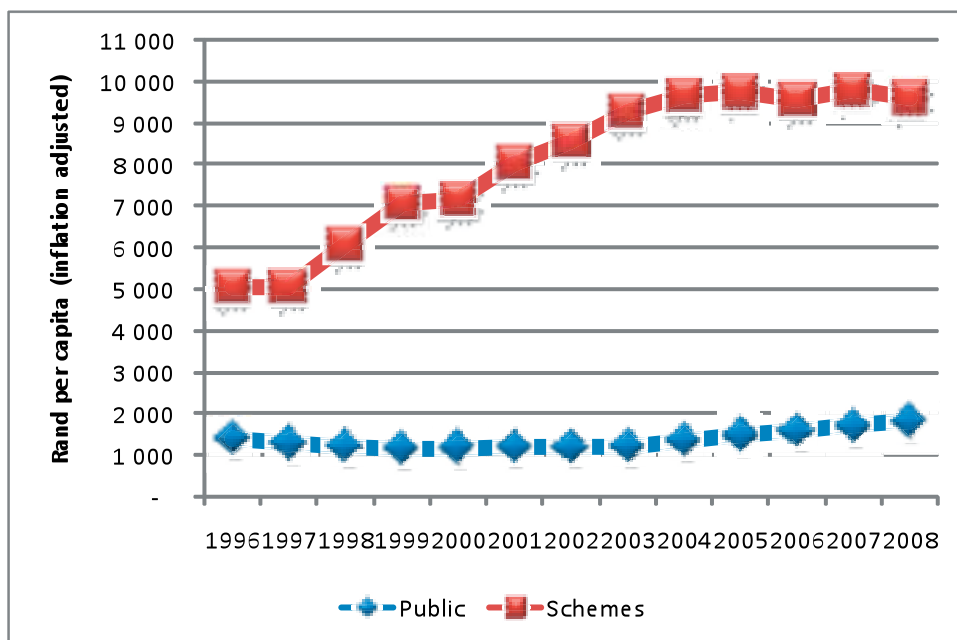
Source: Health Economics Unit (2009

The incidence of health care financing and service benefits in South Africa

41. The disparities in health care financing and service benefits alluded to above can best be illustrated through comprehensive financing incidence and benefit incidence analyses. A financing incidence analysis determines which socio-economic groups bear what burden of funding health services. A benefit incidence analysis determines what benefit (expressed in monetary terms) different socio-economic groups derive from utilising health services. These analyses enable one to assess how equitable a health system is; financing is regarded as equitable if contributions to funding health care are according to ability to pay, and health service use is regarded as equitable if benefits are distributed according to need for health care.

42. Figure 4 shows the distribution of the burden of health care financing across socio-economic groups. It shows that the poorest 20% of the population (quintile 1) contribute almost 6% of their household income towards funding health care. This is mainly through making out-of-pocket payments (e.g. fees at public hospitals or payments to a private GP or pharmacy) and through tax contributions (in the lowest income households, this mainly takes the form of indirect taxes such as VAT, excise duties, fuel levies etc.). This is similar for the next two quintiles. The richest 20% of the population contribute about 18% of their household income towards health care, with most of this in the form of contributions to medical schemes; their contributions to health care funding in the form of out-of-pocket payments and general tax payments is less than 8% of their income. The second richest 20% of the population contributes just over 10% of their average household income to health care payments, with nearly 6% being in the form of out-of-pocket payments and general tax payments.

Figure 4: Incidence of health care financing in South Africa, 2006
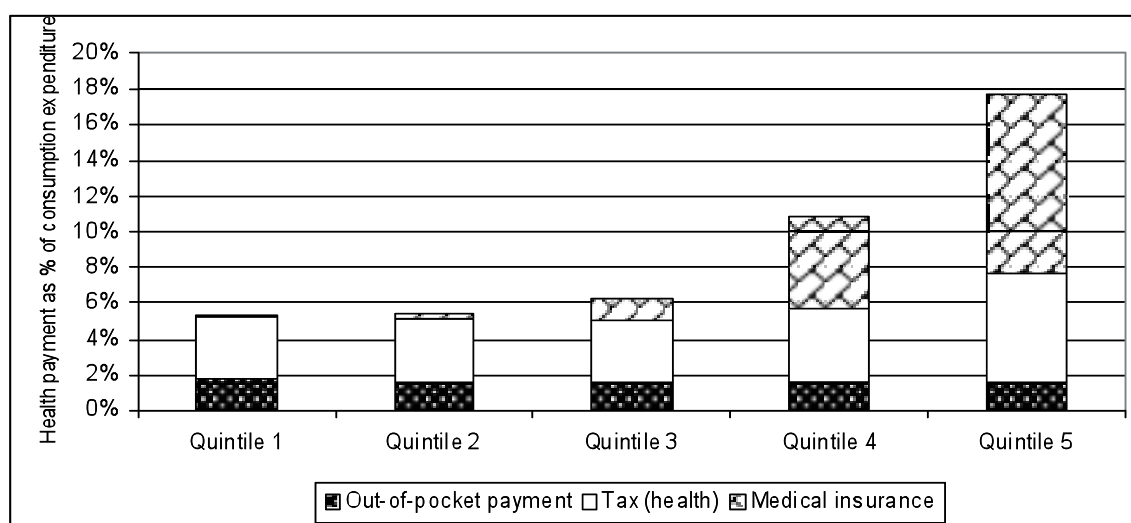
Source: Ataguba & McIntyre (2009)

43. The information depicted in Figure 4 clearly indicates that payments towards the cost of health care are progressive in South Africa (i.e. payments to health care as a percentage of household income increases as the level of income increases). However, it should be noted that almost all of the 'progressivity' of health care funding is attributable to medical scheme contributions as it is only the richest groups which contribute to medical schemes. However, it is also only those who contribute to medical scheme who benefit from funds in medical schemes. The distribution of health care funding in the form of out-of-pocket payments and general tax payments is relatively evenly distributed across socio-economic groups – although general tax payments are progressive, they are only slightly so, with the poorest 80% of the population (quintiles 1 to 4) bearing a very similar burden of funding these payments.

44. The fact that a large share of health care funding is attributable to medical schemes contributions and that only a small share (14% then and now16%) of the South African population benefit from the services funded by these schemes heavily influences the distribution of benefits from health care utilisation across socio-economic groups. Figure 5 shows that benefits are heavily concentrated on the richest 40% of the population, who receive about 60% of the health care benefits. This is particularly due to the use of private providers by this group, but also due to this group deriving the greatest share of benefits from the most highly specialized public hospitals.

Figure 5: Comparing total benefit incidence with levels of health care need
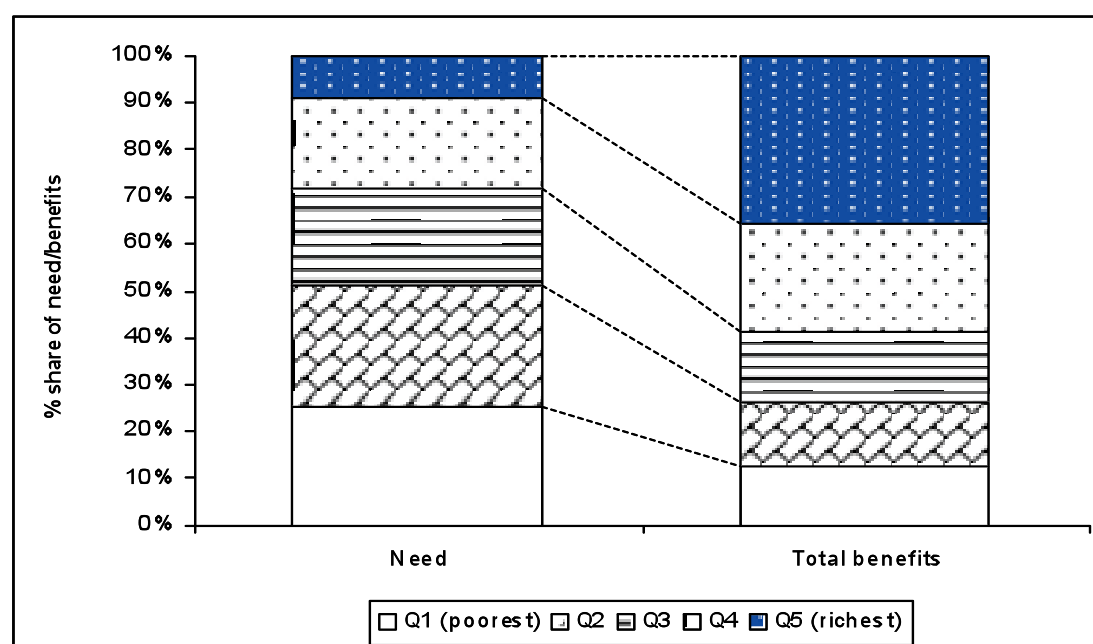
Source: Ataguba & McIntyre (2009)

45. What is even more striking is that health care benefits are not distributed in line with need for health care services. The benefit incidence of health care in South Africa is very 'pro-rich', with the richest 20% of the population receiving 36% of total benefits (despite having a 'health need share' of less than 10%) while the poorest 20% receive only 12.5% of the benefits (despite having a 'health need share' of more than 25%).

46. In summary: "there is a lack of cross-subsidies in the overall health system in South Africa. Although health care financing is 'progressive', this is largely due to the richest groups bearing the burden of medical scheme funding; however, the richest groups are the exclusive beneficiaries of these funds. It is indisputable that benefit incidence in South Africa is inequitable; benefits from health care are not distributed according to the need for health care," (Ataguba & McIntyre 2009).

II   AN APPROACH TO A TRANSFORMED AND BETTER FINANCED HEALTH SYSTEM

47. To address these imbalances in access and utilisation of health services as well as health outcomes, the health care system requires a fundamental transformation through the introduction of the National Health Insurance system (NHI) that enables an integrated, pre-payment-based mechanism and ensures the realisation of the right to health care for all.

48. The introduction of a national health insurance system has been on the agenda of government since 1994. The key objective of such a system is to address the problems of the dual health system by promoting social solidarity in order to achieve universal coverage. Despite considerable debate over the past two or more decades, no progress has been made in transforming the health system along these lines.

The case for change in health care financing in South Africa through the introduction of

> mandatory NHI health is both strong and urgent. The case for change should also be considered in the light of the lack of achievement of the Millennium Development Goals (MDGs) for health, and the stagnation and even deterioration in mortality rates and life expectancy.

49. This policy outlines the essential elements required for a comprehensive transformation of the health system through the introduction of a National Health Insurance (NHI). Support for the implementation of NHI will also require parallel efforts to improve the public health services system, with the major focus on improved infrastructure, human resources for health and management. The NHI is therefore being developed within the context of intensified health system reform; i.e. NHI is implemented as the system is improved; once a facility meets standards of quality of care, it is designated an NHI facility.

The need for a National Health Insurance in South Africa

50. The status quo in the South African health system as described above cannot continue. The rationale for introducing a National Health Insurance is that it would provide a mechanism for improving cross-subsidization in the overall health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. This would be achieved through having a single funding pool.

Political and Citizen buy-in for the National Health Insurance

51. There is public and political support for the establishment of the national health insurance as a means to increase access to good quality health care for all and to promote social solidarity.

52. A recent national household survey, conducted in 2008, shows that there is good support for NHI amongst the general public. There is a good understanding of the need for pre-payment to ensure financial protection from the costs of health care with 76% of all respondents agreeing with the statement: "I would agree to pay a small amount each month so that if I get sick, health care will be free, even if I am not sick now". More than two-thirds of respondents (67%) agreed with the statement: "I would join a publicly supported health insurance scheme if my monthly contribution was less than for current medical schemes". Importantly, an even greater number of medical scheme members (82%) agreed with this statement, strongly suggesting that there is widespread dissatisfaction with the high costs of medical scheme membership. Another important finding of this survey is that despite reported widespread concern about the quality of care in public sector facilities,

73% of South Africans agreed with the statement: "I would join a publicly supported health insurance scheme if I could use public health services for free" (McIntyre et al. 2008).

Business Case for the National Health Insurance

53. The implementation of a National Health Insurance (NHI) will provide an opportunity for significant economic and social benefits to South Africa. International evidence demonstrates that a properly implemented NHI as demonstrated in countries such as Japan, Taiwan, Chile, Thailand and South Korea, has resulted in economic and social benefits to a country. These benefits include having a healthier population, which in turn translates into a productive and effective workforce that grows local business, attracts foreign investors and grows the economy.

54. South Africa has a chance to make history by following the best evidence on health from around the world, implementing a highly effective, fair and cost-effective national health insurance system. The timing is right as a NHI will help protect the poor, prevent marked cost escalation in the private insurance market (which makes future reform even more difficult), and help secure a wealthier future for South Africans

55. Most high-income countries spread the risk of ill health across society as a whole by financing healthcare through a system of prepaid care, mostly with public funding: 73% of healthcare expenditure in the European Monetary Union is from public funds. Private insurance in most high-income countries is usually to supplement only a handful of discretionary medical services or "extras". The notable exception is the United States, which spends more than any other country on health (16% of US GDP and rising). US President Barack Obama is now attempting to address the problems caused by the US reliance on private finance.

56. Rich countries choose, in general, to finance most of their health care publicly. Three major arguments in favour of government involvement and public financing go well beyond traditional economic notions that governments should only fund "public goods", like infectious disease control or vaccination.

a) A free market for health care is often inequitable and inefficient. Individual needs for healthcare vary so much. Insurers are often unwilling to insure the very people who will need the most care, for example those who are already ill or who have a condition such as diabetes mellitus that is likely to predispose them to other health problems.

b) Those who buy care – insurers and patients – are unlikely to have all the information that they need to make proper choices on the most effective treatments (including avoiding harmful treatments). This is a significant market failure that can be combated by the involvement of governments.

c) Public spending acts as a break on overall spending: public spending "crowds out" private spending (which, unlike many sectors of the economy, is a favourable direction) and prevents the rapid cost escalation that has occurred, for example, in the United States of America (USA). Moreover, multiple insurance companies are inefficient, not competitive. Patients in the USA have reported their surgeons walking out in the middle of an operation to get approval from health insurance companies. A **full 1% of USA GDP** is spent simply on administration of the complex, and unwieldy system.

57. It should be stressed that public financing of healthcare need not imply that all healthcare is provided by the public sector. An increasing number of countries use public money to contract private doctors or organisations, an arrangement that can increase efficiency.

International experience relevant to the introduction of NHI in South Africa:

58. **Economic returns from health investments are substantial, including:**

a. **Healthier is wealthier.** Each extra year of life expectancy raises a country's GDP per person by around 4% in the long run. Poor health reductions in adult mortality explain 10 to 15 percent of the economic growth that occurred from 1960 to 1990 in 52 countries.

b. Health investments are important **safety nets** against poverty traps in times of economic upheaval. Lack of health insurance in India means that over 37 million Indians fall below the poverty line each year due to catastrophic health spending; families will often sell assets like livestock to pay medical bills.

c. Public finance of health **frees the poor to use more money to increase their own welfare and create jobs** for others. For example, in South Africa, 57% of health spending flowed via private intermediaries in the way of private health insurance contributions (44%) and out of pocket spending (13%). If the poor did not have to spend this 13% on out of pocket expenditure, they would either save it or spend it on other goods and services. Studies have shown that they would use it on other services including investing in other household assets, and other activities that create jobs in the economy.

d. **Businesses will have a healthier workforce at a lower cost**, which increases employment and attracts foreign direct investment. Canada's provinces introduced national health insurance in a staggered basis from 1961-1975. Across 8 industries in 10 provinces, employment rose after the introduction of NHI; wages increased as well, but average hours were unchanged. In addition, provinces with high initial levels of private insurance coverage had lower rates of employment and slower wage growth. More recently, Canada beat the US in attracting new automotive industries as the cost of building a car in the US includes some $5000 per car simply for health insurance of automotive employees.

59. **Many middle-income countries have implemented universal national health insurance (NHI) quickly and innovatively and to wide popular appeal.**

a. **NHI has been adopted by a number of middle-income countries** including Taiwan (China), the Republic of Korea, Mexico, Thailand and more recently Vietnam and Colombia. Taiwan started a single payer NHI in 1995 which enabled the country to manage health spending inflation. The resulting savings mostly offset the extra cost of covering the previously uninsured. Under the NHI, the Taiwanese have more equal access to health care, greater financial risk protection, and equity in health care financing and is rated positively by 70% of the public (vs. <10% in the US).

b. The United Kingdom (UK), Canada, and many high-income countries took sometimes decades to adopt NHI, but most **middle income countries did it much faster**: only 1-2 years in South Korea's case. Notably, Mexico's NHI was first rolled out to its poorest Mexican provinces, and the NHI "national package" (or list of what was covered) also **was very pro-poor**. Julio Frenk, the Mexican Health Minister responsible for the NHI, was judged then as one of Mexico's most popular politicians.

c. **China provides a notable example of what goes wrong when health insurance is withdrawn**. In the late 1980s, experimentation with market reforms (supported by the World Bank and IMF) led China to withdraw, almost overnight, health insurance for about 100 million rural Chinese citizens. Private costs skyrocketed, declines in infant mortality stagnated, the public surveillance system was weakened (and this led, indirectly some years later to SARS spreading out of China uncontrolled, and leading to worldwide economic loss of some $60 billion). Rapid income growth in China meant that some people were able to afford the more costly care, but now the Chinese government is committed to restoring public finance and has pledged to spend $30-40 billion more on public health than earlier.

d. The heart of a good NHI is **an explicit and inclusive discussion of what should be included in a national "package"**. This uses the principle that "everyone is covered" but not "everything is covered". Expensive therapies that have little impact on better health are discouraged, and the most cost-effective strategies are encouraged. This list of insured services can grow over time as incomes rise, or as government revenue grows. Importantly, this package is communicated to the population as a core "Entitlement Package". Figure 1 contains a recommended framework and accompanying principles for creating an Entitlement package which was applied in India and can easily be adapted to the South African context for determining a comprehensive package of health services under NHI.

Choosing Health: The Evidence

Disease Burden

Cost-Effectiveness

Feasibility of Scale-up

Entitlement Package
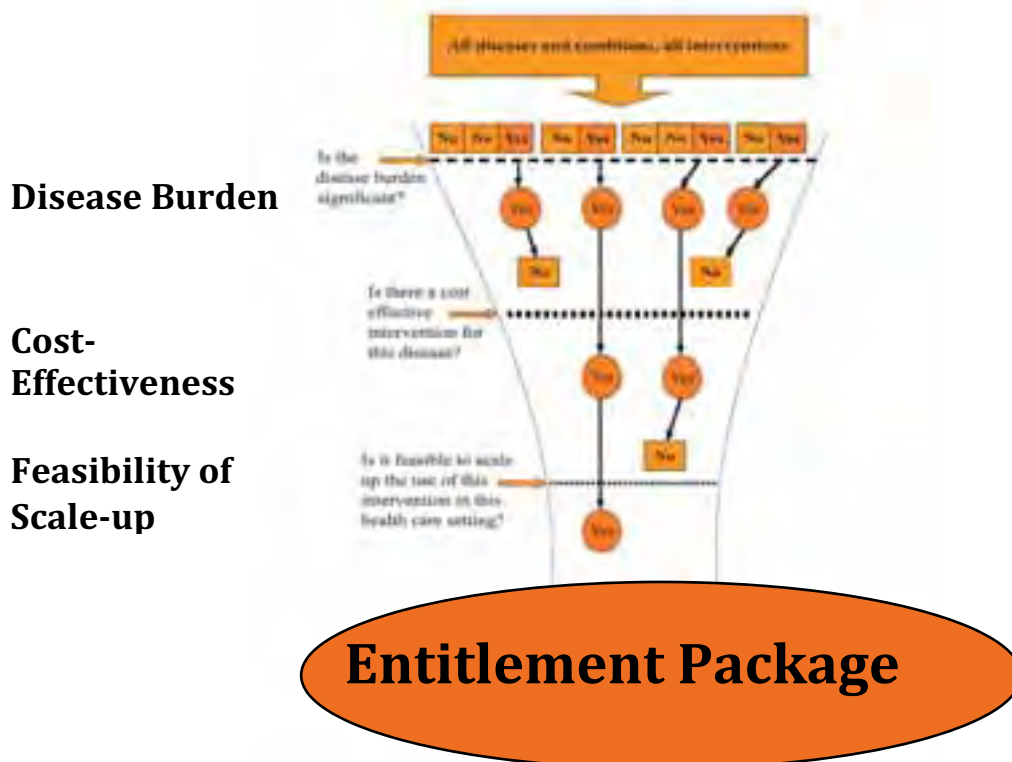
Source: Jha and Laxminarayan, Choosing Health: An Entitlement for all Indians, CGHR, 2009.

www.cghr.org/choosing

60. At present funding for health services in South Africa is fragmented on a number of different legislative and policy planes which leads to inefficient utilisation of resources, wasteful duplication of health cover and unnecessary overlapping of functions between various agencies. People continue to 'fall between the cracks' in the current health system with the result that their constitutional rights to human dignity and access to health services are being adversely compromised. Therefore, it is necessary to create a single focus for the funding of health care services that respects the rights of the wealthy, the poverty- stricken and all those in between alike.

61   The constitutional mandate of government to ensure the progressive realization of the right of access to health services requires the most efficient and effective utilization of resources in order to ensure such access for South Africans and permanent residents. There are urgent health care needs, for example those of the elderly, the indigent and very young that are not being adequately met due in part to the continued fragmentation of the current health system combined with historical inequities within this system.

62. The rationale for introducing a NHI system is that it would provide a mechanism for improving cross-subsidisation in the overall health system, whereby funding contributions would be linked to an individual's ability to pay while benefits would be in line with an individual's need for care. Health services would be accessible to all on an equitable basis, on the principle of non-discrimination. It should be noted that increases in contribution rates in a National Health Insurance are subject to changes in the implementing regulations of the core legislation.

63. The introduction of a National Health Insurance is aimed at strengthening the under-funded and overworked public sector and pooling resources in both sectors in order to progressively realise the right of all to access quality health care services. The introduction of a National Health Insurance will go a long way towards establishing a health care system in compliance with our constitutional rights.

Constitutional right to health care

64. The South African constitution is a transformative and progressive one in that it seeks to alter the inequitable economic and social conditions inherited from the apartheid era to a more equitable one – where human dignity, equality and advancement of human rights and freedoms, non-racialism and non-sexism form the founding values of the constitution. It is also one of the few constitutions in the world that includes socio-economic rights in the Bill of Rights. These include the right to access health care services as well as the underlying determinants of health such as the right to clean drinking water, the right to adequate housing, the right to a clean and a safe environment, the right to sufficient food & nutrition and social security. For a person to enjoy good health, it is therefore essential that the underlying social determinants of health are also enjoyed. In other words, these rights are indivisible and interdependent and that the government is obliged to take steps to ensure that everyone has access to quality health care.

III   PRINCIPLES AND GOALS THAT INFORM THE DEVELOPMENT OF NHI

The core principles on which the proposed NHI will be established include:

65. *The right to health:* The State must take reasonable legislative and other measures, within its resources, to achieve the progressive realisation of the right to access health care services. A key aspect of ensuring access to health care is that services must be free of any charges at the point of use.

66. *Social solidarity and universal coverage:* There is a commitment to social solidarity in the South African health system, which means that:

• Mandatory contribution by South Africans to funding health care according to their ability to pay. Given the massive income inequalities, progressive funding mechanisms will be used.

• There should be universal access to health services that meet established quality standards so that everyone is able to use health services according to their *need* for health care and *not* on the basis of their ability to pay.

67. **Public administration:** A mandatory national health insurance system that is structured as a single purchaser public entity supports the strategies to achieve economies of scale, promote redistribution of health care resources and cost-containment.

68. The **goals** of the national health insurance include:

- Providing universal coverage for all South Africans, irrespective of whether they are employed or not;

- Equity and solidarity among the population through the pooling of risks and funds;

- Accelerated national health system reform, especially in the public health sector;

- Increased strength of the health purchaser in negotiations with providers for both supply of services, and rational provider payment levels with quality assurance;

- Creation of one public fund with adequate reserves and funds for high cost care, health promotion and prevention, and appropriate research and documentation on the development of national health insurance;

- Promoting efficient and effective service delivery in both public and private sectors; and

- Assurance of continuity and portability of national health insurance within the country.

IV KEY PROPOSALS FOR A NATIONAL HEALTH INSURANCE

The key proposals for a National Health Insurance Policy are as follows:

The Establishment of an NHI Fund

69. At the core of the proposed health sector reforms is the reconfiguration of institutions and organisations involved in the funding, pooling, purchasing and provision of health care services in the South African health system. An NHI Fund will be established within the provisions of the appropriate laws and regulations, including regulations and guidelines on the short-term investment of reserves. The main responsibility of the NHI Fund will be to receive funds, pool these resources and purchase services on behalf of the entire population. The Fund will be publicly administered as a single purchaser with sub-national offices at the provincial levels to negotiate and contract with the health care providers and will be established within five years.

70. A single payer system is effective in collecting revenue, distributing risks through one large risk pool; and offers government a high degree of control over total expenditure on health. Evidence from other countries has shown that a single payer is administratively more efficient (with costs around 3 percent) than a multi-payer system. A single payer system is better able to negotiate prices, purchase commodities in bulk and more importantly control utilization using various methods.

71. At national level, the NHI Fund will be managed by a Chief Executive Officer (CEO) who will report directly to the Minister of Health, similar to the way SARS Head reports to the Minister of Finance. The CEO will be supported by an Executive Management Team and specific technical committees including the technical advisory committee, audit committee, pricing committee, remuneration committee, benefits advisory committee (BAC) and others.

72. The NHI Fund will be advised by a committee made up of experts in health care financing, medical and nursing services, public health, HIV/AIDS, research, pharmaceutical services, labour, administration of public insurance schemes, actuarial sciences, information technology and communication. The experts will come from the domestic public and private sectors as well as those emanating from countries that have implemented NHI and also from the World Health Organization.

73. The Minister of Health will remain responsible for oversight of NHI Fund, the development of national health insurance policy and any amendments that impact on the NHI Fund to meet changes in the country's health care needs as determined through changes in population demography, epidemiological profile and health technology development.

Of necessity and as evidenced by international practice and experience, the Fund must be a separate body for it to effectively perform its core functions: revenue collection and pooling, and most importantly purchasing of services. It will operate like SARS somewhat flexible to ensure efficiency (almost like a separate "Department" within the Ministry of Health). The National Department of Health will continue to play its overall stewardship role of the health care system, and also remain a major provider of services through its national, provincial and district level structures and facilities. In addition, the NDoH will continue to provide non-personal services including overall responsibility for infrastructure development for which it receives a budget. It remains critical that the responsibility of coordinating the development of overall health plans including personal services resides with the NDoH. The function that the NDoH will capitulate is the purchasing function for personal services, including personal health promotion and disease prevention services, since the NHI Fund will contract and directly reimburse both public and private providers. However, the fund will only purchase personal services in accordance with the approved plans by the NDoH. The second function the Department will relinquish is quality assurance, which will be done by the Office of Standards and Compliance, which should be outside of the Department of Health, but reports to the Minister of Health.

Universal Coverage

74. The NHI Fund will cover all South African citizens and legal residents. The cover will entitle individuals and households to a defined, comprehensive package of healthcare services provided through appropriately accredited and contracted public and private health services providers.

Benefit s under NHI

75. The NHI Fund will provide an evidenced-based comprehensive package of health services which includes all levels of care namely: primary, secondary, and tertiary. Quaternary health care services will remain the responsibility of the NDoH. The services to be provided to the public cannot be less than what they are currently receiving.

76. The comprehensive package of services covered by the NHI Fund will include:

- Primary care and preventive services
- Inpatient care
- Outpatient care
- Emergency care
- Prescription drugs
- Appropriate technologies for diagnosis and treatment
- Rehabilitation

- Mental health services

- The full scope of dental services (other than cosmetic dentistry)

- Substance abuse treatment services

- Basic vision care and vision correction (other than laser vision correction for cosmetic purposes)

- Hearing services, including the provision of hearing aids

77. A list of pharmaceutical, medical supplies and devices will be linked to the Essential Drug List (EDL) and updated on a regular basis by the BAC (currently being updated). Emphasis will be placed on primary health care, with referral to specialists and in-patient care. Through a defined allocation of the NHI Fund revenues, the national health insurance benefits will include personal preventive services, in accordance with developments in the disease burden in the covered population.

78. Though the NHI benefits will be comprehensive because it will cut across all levels of the health system, it will exclude medically unnecessary services and expensive therapies that have little impact on health care. The exclusion list will be regularly reviewed at agreed intervals by the Benefit Advisory Committee as articulated above (54h) taking into account a number of factors including the population's epidemiological and demographic profiles and the emerging evidence of health treatments, interventions or technology development locally and internationally.
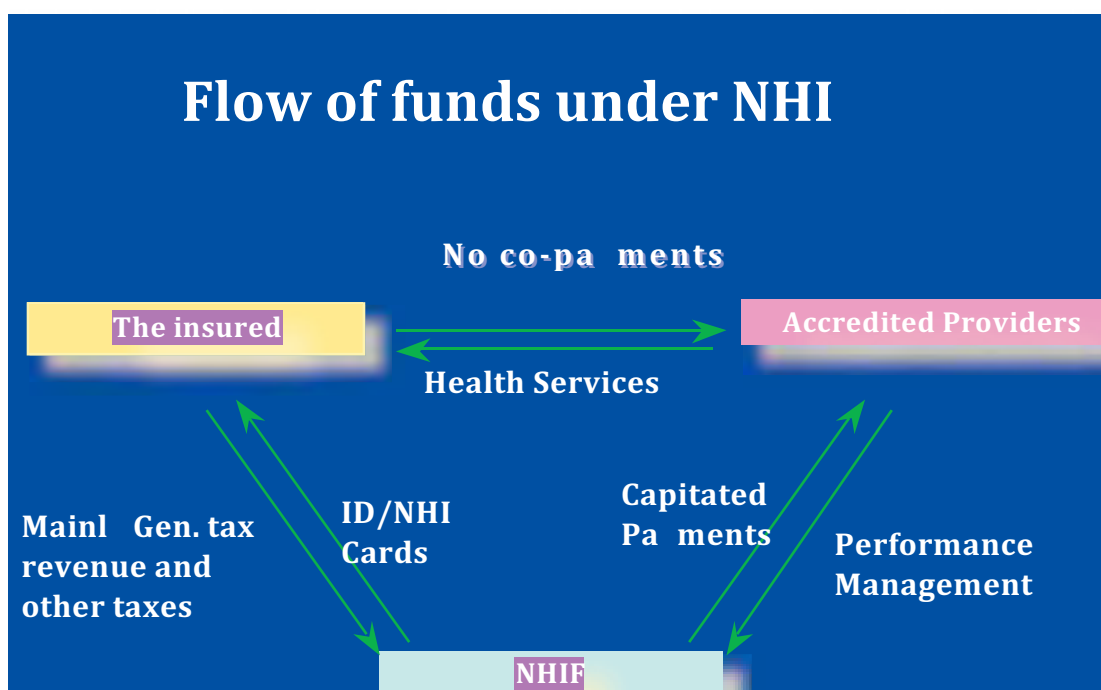
Services to be provided under NHI

77. Public and private health care providers will be accredited according to criteria to be developed as described below. The criteria will specify the minimum range of services provided by primary, second, tertiary and quaternary health care facilities. Providers will then be classified according to these levels. As indicated earlier, the NHI Fund will contract accredited providers (both public and private) to provide a defined comprehensive package of services at each appropriate level of the referral hierarchy namely: primary, secondary, tertiary, and quaternary health services. In addition, a referral process will be defined for services within and outside the district and province to assure continuity of care and effective cost containment.

78. At the primary care level, existing private general practitioners (GPs) can be accredited if they work in multi-disciplinary practices which include primary health care nurses and a range of allied health professionals. However, in areas where there are human resource constraints, there will be negotiations leading to adequate plans to deliver comprehensive health services. All South Africans can then choose which primary health care provider in the district they would like to register with and utilise health services.

80. The successful implementation of the NHI system will rest on the accelerated, visible and sustained improvements in the provision of quality services to all. Both public and private facilities will be accredited by a separate National Office of Standards Compliance using agreed national norms and standards. The separate status of the National Office of Standards Compliance will be established through the appropriate amendment of the National Health Act of 2004 and will play the role of ensuring that all health care facilities are appropriately licensed and accredited. The OSC office which will be part of the Ministry, just like SARS which reports to the Minister of Finance, will report directly to the Minister of Health based on clearly defined terms of reference. It needs to operate with flexibility in order to rapidly help in identifying areas where facilities do not meet the standards that are to be addressed by the Department of Health and speed up the accreditation. The aim is to accredit at least 25% of all facilities annually until all facilities are fully accredited during a five year phased period.

81. The accreditation process will be supported by quality improvement and quality assurance programmes to make sure that all facilities reach accreditation status (see section on quality improvement below). In addition, providers will be reimbursed on the basis of their willingness to accept negotiated payment levels as agreed to with the NHI, and the need for such providers within a particular area.

Funding Sources and Risk Pooling

82. The funding of NHI requires a thorough analysis of different contribution and/or tax options, as well as various combinations thereof. The Ministerial Advisory Committee is working with key officials from National Treasury to explore the following options: A surcharge on taxable income, payroll taxes (for employees and/or employers) and an increase in Value Added Tax which is earmarked to the NHI. These alternative funding mechanisms will be evaluated in terms of their revenue generation potential, and their potential impact on economic growth, employment, savings and income distribution. However, the main sources of revenue for the NHI Fund will be general taxation (See figure below). All of these funds will be combined in the NHI Fund, from which all services covered by the NHI system will be purchased.

Flow of funds under NHI

No co-payments

The insured   Accredited Providers

Health Services

Mainly Gen. tax revenue and other taxes

ID/NHI Cards

Capitated Payments

Performance Management

NHIF

83. Funding of the health sector from general tax revenue should be significantly increased. At present, the total government budget devoted to the health sector is insufficient to adequately meet the health needs of the country. Since all citizens will be entitled to benefit from NHI services, coverage is not dependent on employment status or whether or not one contributes via the mandatory contribution. Conceptually, universal coverage is achieved because government makes contributions via the allocations from general tax revenue to the NHI on behalf of those who are unemployed, poor and earning below the taxable income threshold.

84. Allocations from general tax revenue will be supplemented by a mandatory, payroll-related contribution. This mandatory contribution will be progressively structured and it will be collected by the South African Revenue Services (SARS). Everyone earning above the income tax threshold (adjusted annually) would be required to make this contribution (i.e. no one may 'opt-out' of the NHI), which will be shared between employers and employees. Those who are self-employed and are eligible to pay tax will contribute their share to the NHI.

85. This mandatory contribution will not cover the full costs of the NHI, but it is to supplement allocations from general tax revenue. The main rationale for introducing such a mandatory contribution is to establish a link between contributions that individuals make to public funds and the health service benefits to which they will be entitled under the NHI. Importantly, it provides a mechanism for cementing social solidarity in the health system through income-related contributions to a single pool of funds that will benefit all.

86. Additional funding for the NHI system will include the elimination of the current tax-deductions for medical scheme contributions and channelling these funds to the NHI Fund to provide additional funds into the NHI system. Over time these funds will dry up as more people are covered under NHI.

87. As there will be no charges at the point of service use for the insured under the NHI for the defined benefits to be covered by NHI, out-of-pocket payments are not seen as a source of funding health care for services covered by NHI.

> The exact level of mandatory contribution to be introduced and the magnitude of general tax funding required for the proposed NHI are still being refined and discussed. However, at this stage it is necessary to indicate that a policy commitment to a considerable increase in public funding of health services (through an appropriate mix of general tax allocations and progressive mandatory contributions) is required, to reach a funding level consistent with the needs of a publicly funded health system. It is also important to emphasise that the progressive mandatory contributions from individuals should not exceed their current contributions levels to medical schemes for similar benefits.

Reimbursement Models

88. Changing provider payment mechanisms is critical to ensuring effective cost-containment and the future sustainability of the NHI. The provider payment arrangements that the NHI Fund will use to reimburse all accredited providers will be risk-adjusted per capita payments (i.e. capitation) and global budgeting. The annual capitation amount will be linked to target utilization and cost levels. Facilities that do not meet the requisite standards will continue to get the global budgets until such time they meet requisite standards through support for a given period.

89. This applies to public and private providers in each category of service provision. The provider payment mechanisms must assure incentives for the health workers in the public sector, through supplements for specific tasks or sessional payment. It is also important to consider the implementation of performance-based payment mechanisms.

90. At district level, the capitation payment could be shared between health centres and district hospital, with a defined allocation for referrals to tertiary care providers. This would be determined by the supply and level of providers in each district and province.

91. While capitation should be maintained as one of the basic forms of provider payment, adjustment should be made in its application, with the following recommendations:

> *To ensure that all eligible citizens and permanent residents have access to the defined cmprehensive package of health care services, people will be registered with the NHI Fund. The NHI card will include health information history which allows for ease of access to patient information and for the portability of health services. If more than one accredited provider is available close to the area of residence of the members, they will be enabled to select the provider of choice. Members will be entitled to request changes in their provider selections only once a year.*

- The capitation amount should be a uniform amount for the defined levels of providers, regardless of public or private ownership.

- The capitation amount should be linked to an appropriate index such as CPI.

- The public and private health providers, contracted by the NHI Fund, will be assisted in controlling the expenditure through recommended formula, and corresponding to protocols for the treatment of common diseases. This will be necessary to assure the appropriate level of service provision and avoid under-servicing in a capitation payment system.

- High costs care for services excluded from the list of benefits under capitation will be reimbursed from a separate allocation of the NHI

92. There will be no co-payments or out-of-pocket payments to accredited providers at the point of health service use. Out-of-pocket payments and other direct fee-for-service charges to providers will apply only to the non-insured (such as tourists) or for health services excluded from the list of NHI benefits.

 During the transitional phase, budget allocations to the health care providers, through the provincial allocations will continue to be used for both primary care and hospital level providers in the public sector until such time that the minimum range of facilities (primary and secondary health services) in the specific district have been accredited and contracted with the NHI Fund. In the transition phase, the budgets will nonetheless be calculated on the basis of a risk-adjusted capitation formula taking into account key factors such as population age and gender distributions and disease profile.

Distribution of Funds within an NHI

93. The allocation of health insurance revenues should facilitate the provision of the covered health care benefits with improved quality, recognized incentives to recruit and retain qualified health workers, attention to special health and health system issues, and a reasonable level of reserves.

94. It is important that administrative costs are kept to a minimum as existing registration and existing contribution collection mechanisms will be used for a significant proportion of the population covered. In the initial years and until analysis of the actual utilisation and cost information, it is proposed that a needs-based formula for the allocation of resources be developed, implemented and regularly monitored and evaluated. The information systems, training activities and NHI Fund promotion will need to be adequately budgeted for in the initial stage to help ensure effective implementation.

Enrolment of People into the NHI

95. The registration of the national population will be based on a health facility approach. Using the green, bar-coded identity document or equivalent legal document people will be registered for the NHI system and eventually be issued with an NHI card that will be used to keep their health information history which allows for ease of access to patient information and for the portability of health services.

96. NHI cards for all population sectors, regardless of their contributory status, will be the same, to avoid the stigma of subsidised households.

Information systems and quality assurance

97. The NHI Fund will contribute to an integrated and enhanced National Health Information System (NHIS) that is based on an electronic patient record platform. This will enable any person who visits a health facility in any province or health district to be allocated a unique identifier and have their medical history recorded and stored electronically on an electronic health record that is linked to the NHI card. This system will be crucial for the implementation of the NHI system and the portability of services for the population.

The information systems of the NHI Fund will be developed to support:

- Monitoring of the extension of coverage in all population sectors

- Tracking of health status of the population and production of disease profile data for use in computing capitation

- All the financial and management functions

- Utilization of health care benefits by the NHI members

- Quality assurance programmes for the health care providers

- Production of reports for health facilities and health system management, and

- Research and documentation to support changes as the health care needs of the population change

98. To the extent possible, the NHI Fund's information system will be computerized, with linkage between the NHI Fund membership data base (with updated contribution status) and the accredited health care providers.

Awareness raising for the NHI

99. Through a transparent communications programme, a proactive social marketing approach will be taken to increase knowledge and understanding of the NHI Fund's functions and activities, including the health care benefits to which members of the national population are entitled. The sensitisation and promotion activities at national, provincial and district must include:

- Awareness raising among politicians and community leaders at all levels to enlist their active support for the NHI

- Development and updating of brochures and posters detailing the contributions, benefits, enrolment procedures and entitlement to benefits

- Development of audio-visual material for regular display at relevant sites

- Development of materials on rational health seeking behaviour

- Prominent placing of the NHI Fund logo in contracted health centres and hospitals, indicating accreditation and affiliation

- TV broadcasts by senior level politicians and officials

- Regular radio and TV spots and newspaper articles on progress with respect to NHI implementation and proposed changes

Medical scheme's role

100.   While the NHI calls for mandatory membership for all South Africans through mandatory contributions and social solidarity, it is up to the general public to continue with voluntary medical schemes cover only after they have contributed to the NHI Fund.

101.   Worth noting are findings from a recent study by McIntyre et al (2009) which showed that South Africans have concerns about the affordability of medical schemes: 67% of all respondents said that they 'would join a publicly supported health insurance scheme if my monthly contribution was less than for current medical schemes'. Even more striking is that 71% of those who are currently members of medical schemes agreed with this statement. This finding strongly suggests that South Africans are willing to consider alternatives to the existing medical schemes.

Estimates of NHI prior to Public Consultation

102.   The costing estimates presented in this section focus on providing an indication of the estimated resource requirements for achieving universal coverage, based on cost effective delivery of health services.

103.   It is not possible to model with 100% accuracy the precise resource requirements of the future NHI, but the figures presented provide a good indication of the likely magnitude of resource requirements and more importantly allow for the implications of key NHI design elements (e.g. of different benefit packages) to be assessed. The figures presented here are preliminary estimates of the resource requirements for the NHI as developed by the Costing Sub-Committee of the MAC. This sub-committee intends doing further work to refine these estimates to take account of detailed proposals being developed by other sub-committees, particularly in relation to strategies for gate-keeping at primary care level and provider payment mechanisms to avoid over-utilisation and over-provision of services.

104.   The model used in this preliminary costing adopts the approach recommended by the International Labour Office[1]: Total expenditure = user population **X** service utilisation rates **X** unit costs. It takes account of the population size and how population will grow over time as well as the age and sex composition of the current and future population (as young children, the elderly and women of childbearing age have greater health service needs). It also takes into account how frequently different groups use different health services and how this may change over time, particularly when financial barriers to access are removed under a NHI. Finally, it considers how much it costs (now and in future) to provide each type of health service drawing on the current cost of provision of public sector services and the need to dramatically improve resourcing of public sector health services.

105.   The model presents the estimated resource requirements using a 'public sector framework'. This implies that a ***comprehensive*** package of services is provided for ***all*** South Africans, but this package is not specified as in current medical schemes in terms of specific services that will be covered (e.g. whether or not chronic medicines for depression are covered). Instead, the comprehensive package is defined in terms of individuals having access to primary care facilities and to specialist and hospital care on referral. For each of these broad categories of services, there are 'norms' in relation to the type of staff that should be employed, equipment that should be available and the range of services that should be provided. In addition, it is based on public sector unit costs, ***but*** at substantially improved resourcing levels than at present. The improvement in resourcing is phased in over a 5 year period (i.e. it is regarded as an urgent intervention).

106.   The model makes allowance for large increases in utilisation when financial barriers to service use are removed under an NHI (of over 70% in outpatient care and about 80% in inpatient care for those who are currently 'uninsured' relative to their current utilisation levels). This is comparable to the extent of utilisation increases experienced with the introduction of free care for children under six and pregnant women in South Africa in the mid-1990s and to increases in Thailand when a universal coverage system was introduced. It will take considerable time for the supply capacity (facilities and health professionals) to grow to accommodate such utilisation increases. For this reason, these increases are phased in over a 14 year period.

107.   This model indicates that resource requirements under this model increases from R128 billion in 2012 to R267 billion in 2020 and R376 billion in 2025 if phased in over 14 years. These figures are expressed in real terms (i.e. these are the values in 2010 financial terms).

108.   These figures should be placed within the context of current spending levels. The 2010/11 health MTEF budget is R101 billion and increases to R117 billion in 2012/13 [1]. This does not include spending by other departments (such as health spending by Defence and Correctional Services). In addition, a similar amount is being spent on medical scheme contributions (totalling R74 billion in 2008 – the most recent year for which audited figures are available[2] – and estimated to total about R97 billion in 2010 based on the rate of increase between 2006 and 2008). This represents a total of over R200 billion being spent on health services in South Africa in 2010, which is equivalent to 9.7% of GDP.

109.   It should be noted that increased spending on the NHI (see table below) will be partially offset by the likely decline in spending on medical schemes (as all South Africans will be entitled to benefit from NHI services). In addition, National Treasury is projecting real GDP growth of 2.3% in 2010, 3.2% in 2011 and 3.6% in 2012. The figure below shows that the NHI will require an increase in spending on health care from *public* resources (general tax revenue and a mandatory NHI contribution) that is faster than projected GDP increases. However, the ultimate level of spending on a universal health system relative to GDP (of 7.8%) is *less* than current spending by government and via medical schemes (of 9.7%).

Year	Non-AIDS-related services	AIDS-related services	Additional services	Total Direct Healthcare costs	NHI Operational costs	Total costs in delivering services
2011	0	0	0	0	0	0
2012	62,046,136,519	17,166,207,505	44,849,610,373	124,061,954,397	3,721,858,632	127,783,813,029
2013	73,025,380,580	19,715,909,555	47,972,448,892	140,713,739,027	4,221,412,171	144,935,151,198
2014	87,589,233,705	21,986,952,564	51,274,311,806	160,850,498,075	4,825,514,942	165,676,013,017
2015	100,333,926,287	26,244,506,794	54,781,914,327	181,360,347,409	5,440,810,422	186,801,157,831
2016	114,898,755,097	28,728,750,718	58,499,982,602	202,127,488,417	6,063,824,653	208,191,313,069
2017	123,189,099,264	31,030,939,052	60,040,879,634	214,260,917,950	6,427,827,539	220,688,745,489
2018	133,591,674,074	33,149,581,757	61,597,254,837	228,338,510,667	6,850,155,320	235,188,665,988
2019	144,903,912,419	35,111,160,178	63,170,046,508	243,185,119,105	7,295,553,573	250,480,672,679
2020	157,508,970,776	36,941,489,310	64,759,982,811	259,210,442,897	7,776,313,287	266,986,756,183
2021	171,300,907,435	38,660,495,022	66,367,461,533	276,328,863,990	8,289,865,920	284,618,729,910
2022	187,415,239,881	40,285,667,400	67,992,907,505	295,693,814,787	8,870,814,444	304,564,629,230
2023	205,248,449,873	41,834,116,750	69,636,768,171	316,719,334,794	9,501,580,044	326,220,914,837
2024	225,012,871,360	43,303,832,918	71,299,372,411	339,616,076,689	10,188,482,301	349,804,558,990
2025	246,938,067,931	44,715,842,637	72,980,932,232	364,634,842,800	10,939,045,284	375,573,888,084

Year	Non-AIDS-related services	AIDS-related services	Additional services	Total Direct Healthcare costs	NHI Operational costs	NHI Implementation costs
% of total in 2012	42.484%	11.754%	30.710%	84.948%	2.548%	12.504%
% of total in 2025	64.121%	11.611%	18.951%	94.683%	2.840%	2.476%

NHI % GDP
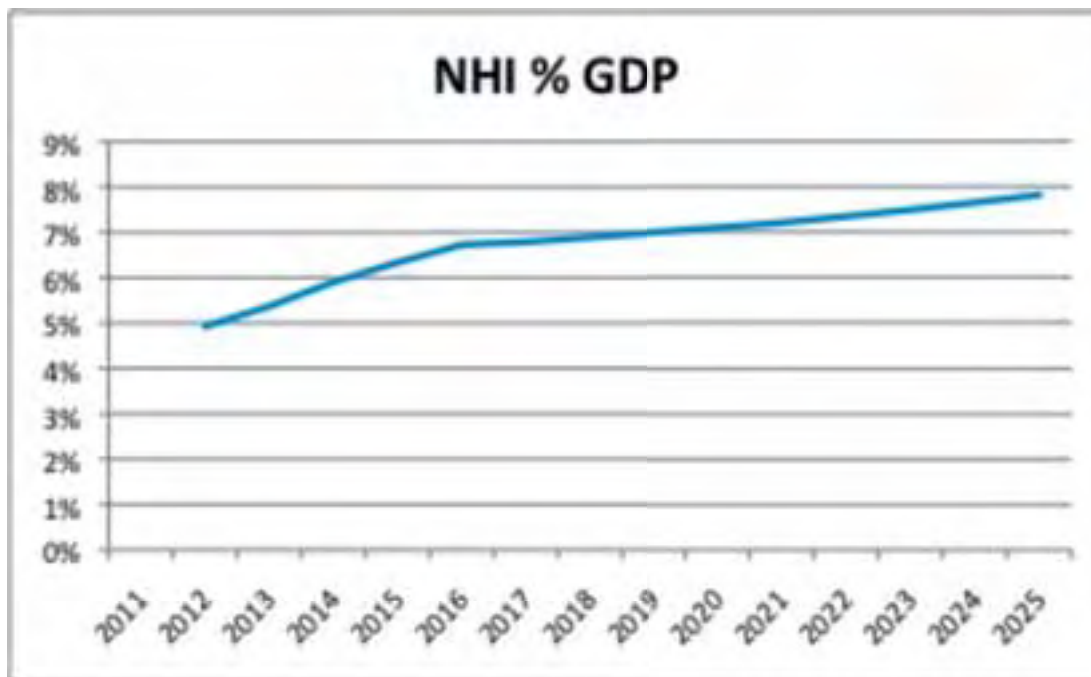
110.   The Costing Sub-Committee is still developing a full range of revenue estimates. Its preliminary findings suggest that the health sector's share of the overall government budget will need to increase to about 14% to 14.5%. This increased expenditure on health services will, to some extent, be offset by the proposed removal of tax subsidies for medical scheme contributions by individuals / employees.

111.   This will need to be supplemented by a mandatory NHI contribution that is progressively structured from less than 1% (0.5% for employees and 0.5% for employers) for the lowest income earners to a maximum of about 7-8% (3.5-4% for employees and 3.5-4% for employers) for the highest income earners.

112.   This NHI contribution should be compared to the current level of medical scheme contributions. Based on data from the 2005/06 Income and Expenditure Survey, the overall average level of contributions for all medical scheme members is over 9% of income. The lowest income medical scheme members currently contribute over 14% of their income to medical schemes (for the lowest 40% of scheme members), the middle 20% of scheme members spend nearly 12% of income on medical scheme contributions, the second wealthiest 20% of medical scheme members devote over 9% of their income to contributions while the richest 20% of scheme members devote about 5.5% of their income to medical scheme contributions. The intention is that the NHI benefits, to which all South Africans will be entitled, will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply draw on their NHI entitlements.

113.   From these estimates, it appears that NHI is affordable, particularly given that many of those who will required to make mandatory contributions to the NHI are currently paying more for medical schemes than will be required for the NHI contributions.

V   SYNCHRONISED AND CONCOMMITANT IMPROVEMENT OF THE HEALTH SYSTEM

114.   **The National Health Insurance system will be implemented in parallel with health system strengthening over the next five years**. The improvement, expansion and revitalisation of public healthcare infrastructure and services is critical to realising the principle of universal coverage and reducing inequalities of access. Therefore, a parallel health systems strengthening plan has been developed to assure infrastructure maintenance, improvement and expansion (capital costs), and service provision (recurrent costs).

115.   The health system strengthening plan has several key components, as outlined below:

Improvement in Infrastructure for the provision of Health Services

116.   In the plan it is proposed that a detailed inventory of both public and private facilities, including infrastructure, human resources and technology, in all parts of the country must be done in order to establish the stock and distribution of these facilities. The inventory will serve a dual purpose: Firstly, as an assessment of the current capacity of the national health system to provide services at different levels and where this capacity is located, and secondly, to identify gaps for expansion and facilities that require refurbishment. A subsequent facilities refurbishment and expansion plan will be developed, in line with the existing health care facilities revitalisation programme.

Improved Functioning of District Health Councils

117.   Capacity to deliver quality **primary health services** under a NHI system is premised on a revitalised and adequately financed district health system to meet the needs of the catchment population. District Health Councils (DHCs) throughout the country will be strengthened by improving political governance, managerial oversight and accountability structures. The focus on strengthening the DHCs will primarily be on improving service integration, the quality of services offered within facilities and outreach programmes, efficiency and effectiveness, as well as community participation, developmental and multi-sectoral approaches. Significant and sustained improvements in managerial capacity will be fundamental to achieving all this.

118.   The district level offices will assist to manage the flow of funds from the NHI Fund to providers based on agreed plans and using a combination of agreed payment mechanisms.

Primary Health Care Approach under NHI

119.   At the core of revitalizing and strengthening of the South African health system is a primary health care approach that seeks to improve access to quality health services as the first point of entry to the health system. The principles of the primary health care component of the NHI are contained in Chapter 5 of the National Health Act which deals with the District Health System, as well as the concept of universal coverage, which is defined as access to an essential package of health services based on need.

120.   The composition of the primary care package of services will extend beyond services traditionally provided in health facilities such as clinics, community health centres and district hospitals to include extensive community and home based services in which community health workers forms and essential part.

121.   Countries with a team of PHC personnel, typically with a doctor or clinical associate, nurse and 3-4 community health workers who are responsible for a designated catchment population appear to have the biggest impact on health outcomes. In a re-engineered primary health care system, it is envisaged that community and home-based services will be provided by such teams with each team being responsible for a population of about 10 000 people... This implies that we will need to develop 5 000 teams to cover the population (5 000 doctors/clinical associates and nurses and between 15 and 20 000 community health workers. Given the current estimates of around 60 000 community health workers, the number of CHWs per team can be doubled. The inclusion of doctors/clinical associates and nurses can be phased in as (a) additional cadres are trained and recruited and those currently in the private sector are brought into the national health insurance system.

122.   These teams will focus on population health and when visiting homes also taking care of minor ailments and advising on rehabilitation. They will also facilitate community involvement in their health as well as intersectoral collaboration. They are therefore the primary proponents of the primary health care approach as envisaged in the Alma Ata Declaration and will ensure that upstream factors (social determinants of health) are responded to.

123.   These teams will be supported by health professionals operating in fixed health facilities (clinics, CHCs and district hospitals) as well as a network of group practices contracted into the NHI system over time to provide essential primary care services on a capitation basis. The primary health care system will provide 80% of care needed by communities with access to secondary and tertiary care being on a referral basis only (with the exception of emergency care).

124.	A re-engineered primary health care system must also ensure that access to medicines is made easier for patients, especially those with chronic diseases. Private pharmacies may be contracted (like other private health providers) to dispense medicine and be reimbursed by the NHI system. Equally, both private pharmacies and the public health sector should courier medicines to stable chronic patients with the primary health care teams (described above) ensuring that medicines get to these patients and that they comply. These teams will also be responsible for managing patients using point of care technology as relevant (again making it unnecessary for patients to travel to fixed health facilities for the purposes of collecting medicines and diagnostic work-ups).

125.	Employing a PHC approach entails that the supportive referral hierarchy that includes the secondary, tertiary and quaternary services and emergency medical services need to be equally strengthened to ensure continuity of care and management of complex conditions and diseases. For this approach to work, it is equally important to have the right numbers of mix of health workers at each level so that referrals become a function of clinical need and not health system constraints (e.g. shortage of doctors or an x-ray machine).

126.	Finally, it is clear that for effective implementation of the PHC approach significant community involvement at all levels of the system is necessary. This means that clinic committees and hospital boards as well as the District Health Councils need to be strengthened. It is critical that appropriate strategies be designed on how communities will be involved in planning of health services at district level including their role in providing inputs into district health plans.

Giving Public Health Care Managers Authority and Responsibility to manage

127.	As part of the parallel health systems strengthening plan, actions will be taken to create concrete mechanisms for increasing the efficiency of public health facilities, particularly of hospitals by increasing managerial autonomy in public health care facilities in order to improve decision making and accountability. At the same time, the current efficiency in the use of provincial allocations will be reviewed to assure reduction in duplication and optimal use of the allocations. Procurement and supply functions will also be revised where necessary and improved.

Improved Staffing of the Health System

128.	Changing the financial arrangements of the health sector without dealing with the Human Resources for Health (HRH) challenges will not yield the desired results. It is for this specific reason that the NHI plan proposes a set of comprehensive strategies for increasing the supply, quality, distribution and retention of various categories of health workers in the country.

129.	Data on the employment of health professionals indicates that there has been growth in professional registrations across most health professions (see Table 2 below) and fairly substantial increases in public sector full-time permanent appointments. However, these increases conceal the fact that in many categories of staff, South Africa is heavily undersupplied with key health professionals and is facing a huge challenge in the medium to long-term:

Table 2 Growth in professional registrations, 2002 to 2008

Professional Category	2002	2003	2004	2005	2006	2007	2008	%change	Annual av. growth
Medical practitioners	29,903	30,578	31,214	32,198	33,220	34,324	34,687	16.0%	2.5%
Professional nurses	94,948	96,715	98,490	99,534	101,295	103,792		9.3%	1.8%
Enrolled nurses (staff nurses)	32,495	33,575	35,266	37,085	39,305	40,582		24.9%	4.5%
Enrolled nursing assistant	45,426	47,431	50,703	54,650	56,314	59,574		31.1%	5.6%
Dental practitioners	4,505	4,500	4,514	4,620	4,815	4,937	5,110	13.4%	2.1%
Dental therapists	364	381	390	417	443	450	455	25.0%	3.8%
Student dental therapists	92	102	143	123	131		166	80.4%	10.3%
Pharmacists		10,629	10,891	10,824		11,547	11,905	12.0%	2.3%
Dental assistants	not yet	not yet	not yet	16	131	375	2,147	13318.8%	412.0%
Oral hygienists	851	885	933	929	952	953	946	11.2%	1.8%
EMS practitioners	18,242	23,899	28,937	31,346	36,496	41,831	46,888	157.0%	17.0%
Environmental Health Officer	2,215	2,307	2,513	2,540	2,607	2,602	2,567	15.9%	2.5%
Medical technicians	1,001	1,095	1,193	1,214	1,276	1,271	1,378	37.7%	5.5%
Medical physicist	88	82	84	83	88	86	93	5.7%	0.9%
Medical orthotist prosthetist	292	294	323	344	345	342	351	20.2%	3.1%
Orthopaedic footwear technicians	39	37	39	34	50	52	52	33.3%	4.9%
Nutritionists/ Dieticians	1,322	1,433	1,592	1,575	1,687	1,795	1,844	39.5%	5.7%
Occupational Therapists	2,465	2,511	2,819	2,808	2,922	3,159	3,189	29.4%	4.4%
Optometrists	2,146	2,218	2,401	2,516	2,633	2,733	2,882	34.3%	5.0%
Physiotherapists	4,196	4,400	4,785	4,760	4,915	5,240	5,372	28.0%	4.2%
Physiotherapy Assistants	283	269	275	272	257	249	263	-7.1%	-1.2%
Occupational therapy assistants	495	501	511	506	527	519	475	-4.0%	-0.7%
Psychologists	5,302	5,401	5,774	5,878	6,130	6,391	6,598	24.4%	3.7%
Radiographers	4,669	4,789	5,221	5,237	5,433	5,624	5,757	23.3%	3.6%
Speech therapists and audiologists	1,282	1,345	1,397	1,391	1,396	1,441	1,294	0.9%	0.2%
Speech therapy assistants	7	7	6	6	5	5	4	-42.9%	-8.9%

Sources: Health Professions Council of South Africa (HPCSA), South African Nursing Council (SANC), South African Pharmacy Council (SAPC).

130. Human resources are critical to the accelerated and effective delivery of quality services for all. As part of strengthening the district health system which forms the basic unit of a unified health care system, primary care providers must be adequately staffed to deal with the bulk of services needed at that level.

131. Accordingly the following key strategic issues need to be taken into consideration, to address staff shortages and to ensure sustained capacity for the provision of quality health services. These issues will require proactive engagement of all stakeholders in the human resource supply and demand chain. This will help to ensure that the health system has a sustainable and reliable source of human resources for health to effectively deliver the package of services as defined for the NHI Fund.

132. The first step is to undertake a comprehensive audit of the health professional workforce across the country, province by province, to determine the numbers and categories of personnel needed in the light of national and provincial health plans. This audit should include age among other demographic characteristics. Vacancy figures need to be validated and appropriate and context-specific norms and ratios developed.

Nurses

133. There is an urgent need for a reassessment of the restructuring of the public nurse education system that led to the merging and closure of colleges which has led to reduction of production of professional nurses who would be suited for the public health system. Colleges must be re-opened if necessary and staff who left the system for the private sector need to be encouraged to return.

134.   The associated emphasis on the degree as the four year qualification of choice must be reconsidered. South Africa still produces a very small pool of school leavers with the correct grades and combinations of subjects to access university education, due to continued inequalities in schooling and socio-economic circumstances. The emphasis on the degree could serve to exclude students who might otherwise make good professional nurses through a four year college diploma.

135. The public sector must also resume its role in the production of enrolled nurses and enrolled nurse auxiliaries. The training of such nurses must be reprioritised in provincial and hospital budgets. If the production of enrolled nurses is to reach the levels required for provision of services under NHI plan then production must be doubled at the very least. If the attrition rates are to be taken into account then we should be turning out at least six times more per year than at present.

136. The emotional as well as physical effects of the HIV, AIDS and TB epidemics need to be taken into account when considering the numbers of health workers we need to train in this country. It appears that we certainly need to train more nurses than might otherwise be the case. But more importantly, we need to devise programmes to encourage health workers, in particular nurses, to be tested and we need to provide access to confidential treatment while at the same time trying to break down the stigma associated with HIV positive status among health workers.

137. There needs to be re-examination of projected production totals of nurses in the light of the HIV, AIDS and TB epidemics which have not been considered sufficiently.

Doctors

138. There needs to be rapid identification, assessment, advertising and filling of vacant posts regarded as appropriate and creation of new medical practitioner posts where required.

139.   Workload of doctors working in the public sector, particularly rural areas needs attention. The introduction of medical assistants could alleviate some of this load in the future. In the meantime, more private doctors must be recruited into offering their services on a sessional basis.

140.   Attract doctors through incentives– the opportunities for research and personal development which such work might offer and the personal satisfaction of working for the benefit of the poor.

141.   In rural areas, the importance of salaries, improved hospital infrastructure and improved quality of accommodation, study and career progression opportunities are critical to recruit and retain doctors.

142.   To mitigate against emigration of health professionals government must pay attention to the reasons why professionals leave, provide incentives to stay and make use of professionals from other countries that choose to work and live here. There is also considerable scope for homecoming recruitment.

143.   **Task shifting** should be introduced where tasks are delegated to workers with lower qualifications or from trained professionals to lay health workers; however training of these professionals should be appropriate to the level of work they are required to do and fits appropriately between other professional levels rather than alongside and duplicating them.

144.   Health workers' unions and professional associations need to be involved in the development of scopes of practice and all policy discussions concerning mid-level and community health workers.

145.   Learnership programmes for the training of community health workers, HIV/AIDS counsellors and home based carers should be developed and sponsored in terms of the National Skills Development Fund.

Importing of Health Workers into South Africa

146.   The importation of health professionals should be used as a temporary measure to address the shortages in South Africa. Doctors and nurses from other African countries who are already in the country should be allowed to work here in their fields of expertise for specified periods which can depend on the length of time they have been here, their status of residence and the particular need for their field of expertise. They should be deployed to areas where there are large numbers of refugees from other African countries, particularly their own, and thereafter to other areas of the public and rural service where shortages prevail.

147.   NGOs and professional associations which are seeking to recruit professionals from developed countries to work in South Africa should be provided with financial and moral support.

148.   Foreign doctors who meet the requirements to work in South Africa should not be restricted to the public sector only but should be allowed to work in NGOs that are serving the poor and uninsured.

Training of Health Facility Managers

149.   The management of health facilities from primary care to tertiary hospital level requires particular forms of knowledge and skills that need to be recognised and developed in health management training. Universities offer a number of out- and in-service programmes of varying duration. The possibility of supplementing these initiatives with a new health institute with dedicated health management programmes should be investigated.

150.   In the short term, managers from the private sector and non-health sectors can also be utilised to help improve efficiency and manage change. Apprentice or job-shadow arrangements should also be considered to build capacity in the public sector.

151.   Finally, there is a need to devolve greater authority to managers to allow them to take decisions and be accountable for meeting goals using resources allocated on the basis of their plans. This will reduce frustrating time lags, and cushion managers from bureaucratic inefficiencies.

152.   Research shows that the HIV/AIDS and TB epidemics are major factors contributing to disillusionment with the public sector (see Breier et al, in press) and also that many health workers are themselves infected with HIV. Therefore, the planning for human resources for health outputs will have to account for the impact of the HIV/AIDS and TB epidemics in terms of training numbers to fill the existing vacancies and to meet the needs of the future generation with regards to healthcare services.

Some of the key strategic steps to be taken are enumerated below.

KEY STRATEGIC STEPS	TIME FRAME
• Address decline in production of doctors	Medium-term
• Re-assessment of public sector nurse training - continue opening nursing colleges	Short-term to Medium-term
• Reprioritisation in provincial and hospital budgets so that public sector resumes its role in the production of enrolled nurses and enrolled nurse assistants.	Short-term to Medium-term
• Re-assess projected health professional production totals in the light of the HIV, AIDS and TB epidemics	Short-term
• Address career progression of community and mid-level cadres particularly the need for HIV/AIDS lay counsellors.	Short-term
• Address training of emergency care practitioners with attention to the implications of stopping modular training.	Short-term
• Allocation of more resources to public institutions of higher education including strengthening responsive institutions such as Medunsa.	Medium-term
• Establishment of additional tertiary institutions and/or satellites in each province and/or at community level such as in Cuba.	Short-term to Medium-term
• Strengthen teaching, training and research capability of the tertiary institutions awarding scholarships for training of specialists and super-specialists	Medium-term
• Extend internship and community service programme to all health professionals	Short-term
• Address Continuing Professional Development for mid-level workers	Medium-term
• Extend training and development programme in Cuba to other health professionals and support workers	Short-term to Medium-term
• Review the efficacy and efficiency of current management development programmes	Short-term
• Undertake audit of management qualifications of all National and Provincial Health Care managers	Short-term
• Integrated generic management training with specific material related to health care management	Short-term
• Introduce specialised courses on the PFMA	Short-term
• New and creative training approaches that combines formal instruction with informal practices to be on team-building interventions to create synergy amongst managers in a particular district/institution	Short-term
• Base formal instruction on an experiential approach and include case studies drawn specifically from the experience of the participants	Short-term
• Include mentoring and coaching, networking with colleagues and in-house programmes in management training programmes	Short to Medium-term
• Monitor and evaluate performance of managers on courses	Short -term to Medium-term
• Formal training courses to be provided by accredited providers – public bodies (universities) or private organisations	Short -term to medium

VI SERVICE EXCELLENCE PLAN

153.   The degree to which the South African public healthcare services meet the needs of the employed, unemployed, and indigent South Africans in the face of an HIV and AIDS epidemic, rampant tuberculosis, malaria, childhood diarrhoea and malnutrition varies from excellent to extremely poor. Similarly, the capacity to meet community needs varies from institution to institution and by district and province. Poverty, substance abuse, violence and related trauma also seriously impacts on the capacity of the public health services.

154.   Although poor infrastructure and a lack of resources is often blamed for the provision of poor healthcare, the attitude of staff towards their work and to their patients, associated with poor skills and corruption is equally, if not more, important.

155.   In general, the capacity of South African healthcare services to meet the needs of the citizens is impaired by:

*   a lack of management skills;

*   a lack of induction and in-service training;

*   failure to act on identified deficiencies;

*   delayed response to quality improvement requirements;

*   unsatisfactory maintenance and repair services;

*   poor technology management;

*   ineffective supply chain management systems;

*   inability of individuals to take responsibility for their actions;

*   poor disciplinary procedures and corruption; and

*   the significant problems in clinical areas related to training and the poor attitudes of some of the staff.

156.   To address the significant patient-care problems within the South African public health system, a carefully planned, organised, articulated, and documented quality improvement and quality assurance plan is required. It should be systematic and incorporate the setting of priorities for improvement through a performance assessment process that uses reliable methodology.

157.   This should be followed by the implementation of quality improvement activities that are based on regular assessments. A key activity in sustained improvement of the health services is a formal, structured process to maintain improvements that have been achieved and to improve upon them over time.

158.   It is essential that the quality improvement approach be organisation-wide involving both clinical and non-clinical managers and their functions. The improvement processes should be collaborative, using an interdisciplinary, cross-functional approach organised around the flow of patient care and involving all departments/services, settings and disciplines.

159.   This multidisciplinary approach should be guided by multidisciplinary standards that provide a blueprint for quality service provision. The management and staff should be actively involved with the multidisciplinary team. Of paramount importance is capacity building and skills transfer at all levels of the organisation to entrench both quality improvement and quality assurance in the national health system and to ensure their sustainability.

Plan to improve the Quality of Services for Public Health Facilities

160.   The types of facilities included in this quality improvement plan are hospitals, clinics, ambulance services and ART sites in both the public and private sectors.

161.   The proposed quality improvement approach utilises a continuous, collaborative, participatory, systems approach, integrating quality improvement into routine management functions. This approach regards quality improvement as a progressive and gradual process that relies on the guiding principles of teamwork, systems and processes, patient–centeredness and measurement.

162.   The plan outlines how quality improvement support and development may be carried out most effectively in South African public healthcare facilities and focuses on:

• Developing local capacity within the National Department of Health to support and monitor the quality improvement work in the provinces;

• Developing capacity within provinces and health institutions to develop and maintain continuous quality improvement programmes;

• Providing training to healthcare facilities in quality improvement methodology and monitoring and evaluation using an appropriate information system.

• The importance of peer review and benchmarking as the mechanisms to share best practice, which is essential if variations across facilities, district, provinces and the country are to be reduced.

• The systems required to provide coordinated hospital care. These include managerial, clinical, clinical support and "hotel" systems. Similar systems, modified as necessary, are set for primary healthcare and ambulance services. Standards are set for the component departments and services within each system.

• Institutions are required to develop human resources performance improvement plans that focus on workplace skills which indicate priorities for training. Plans will be collated into district and provincial plans to contribute to sector skills plans developed by the Health and Welfare Sector Training Authority (HWSETA). Development plans will be based on identified competency gaps of individuals.

National Office of Standards Compliance

163.   The National Office of Standards Compliance will:

• Meet internationally accredited standards set for accreditation agencies by an approved evaluative agency

• Facilitate the development of multidisciplinary organisational standards for healthcare facilities using principles set by the International Society for Quality in Healthcare (ISQua) for standard development

• Evaluate the compliance of standards in health care facilities

• Use a customised computerised information system to collate and integrate data, calculate performance indicators and generate deficiency reports that can form the basis of quality improvement programmes

• Have the ability to report on the progress of quality improvement programmes aimed at achieving standard compliance

• Accredits facilities that meet agreed quality standards

• Provide certification to participating facilities that have not met accreditation requirements to recognise degrees of progress made since entering the accreditation programme.

164.   The National Office of Standards Compliance will have to employ sufficient and appropriately qualified staff in the following categories:

- doctors with experience in community medicine and other disciplines;

- professional nurses with experience in both primary and secondary care;

- paramedical staff with experience in a range of healthcare sectors and disciplines;

- project managers;

- administrative support staff; and

- training staff with experience in information systems

165.   Efforts will be made to identify existing accreditation and quality improvement organisations with proven track records that meet the above requirements. These organisations will be evaluated to determine whether they have the competence and capacity to assist the National Office of Standards Compliance with the implementation of the accreditation process in South Africa and where necessary will be contracted to augment its activities and functions.

Measuring the Quality of Services

166.   The development of standards requires a formal approach and consists of a normative phase where experts give input as to what should ideally be in place. This is followed by an empirical phase when normative standards are tested in practice and thereafter there is a consensus phase in which standards that are reliable, understandable, believable, measurable and achievable are developed.

167.   During this process, the principles developed by the International Society for Quality in Health Care (ISQua), in collaboration with over 40 countries, will be used to guide the content and structure of the standards.

168.   The underlying philosophy of the standards is based on the principles of quality management and continuous quality improvement and aims to accommodate legal and ethical aspects.

169.   Standards are grouped to provide specific indicators of performance, which can be used as points of reference in evaluating actual performance compared to targeted objectives.

170.   In order to expedite the implementation of the quality improvement and accreditation programmes required to improve the performance of healthcare organisations, standards currently in use, or in development that meet the above principles and requirements will be identified and utilised, with modifications if necessary.

Evaluating conformity with the measure of quality

171.   At the facility level, healthcare organisations (hospitals, primary health clinics and ambulance services) will be surveyed against the appropriate standards to obtain a baseline assessment of the facility.

172.   Deviations from the standards will be prioritised according to the impact they have on quality and patient and staff safety. Based on the detailed analysis of prioritised deficiencies, an integrated quality improvement programme for the facility will be developed with inputs from the multidisciplinary team.

173.	All quality improvement interventions will be formally monitored. Time-frames and responsible people will be clearly identified for ease of monitoring and evaluation. A database will be established and will be regularly referred to for the identification of when time-frames are met and not met. When not met, remedial actions will be speedily taken to re-establish the quality improvement programme's objective of achieving facility-wide standard compliance.

Training Trainers to implement the quality improvement plan

174.	All training will be provided using a "Train-the-Trainer" methodology to enhance rapid skills and knowledge transfer. At a provincial level, quality assurance units will be trained by quality experts to understand multi-disciplinary quality standards, quality data collection and analytical systems.

175.	At a facility level a cascading "Train-the-Trainer" approach will be used whereby dedicated trainers will be identified to receive training and they, in turn, will train staff members in basic quality improvement techniques. These trained staff will be empowered to pass on their acquired skills as part of the induction process when new colleagues enter services in the facility.

176.	Four 'Expert Centres' will be identified in each province to be 'Centres of Learning' for the province. These will incorporate a hospital and three primary care facilities.

177.	The 'Expert Centres' will be the focal point for training to address identified skills deficiencies such as management and leadership; quality improvement techniques; evaluation and monitoring skills as well as additional skills-based training for supply chain, hotel, technology, and maintenance staff. This approach can be used for hospital services; primary health care services and ambulance service.

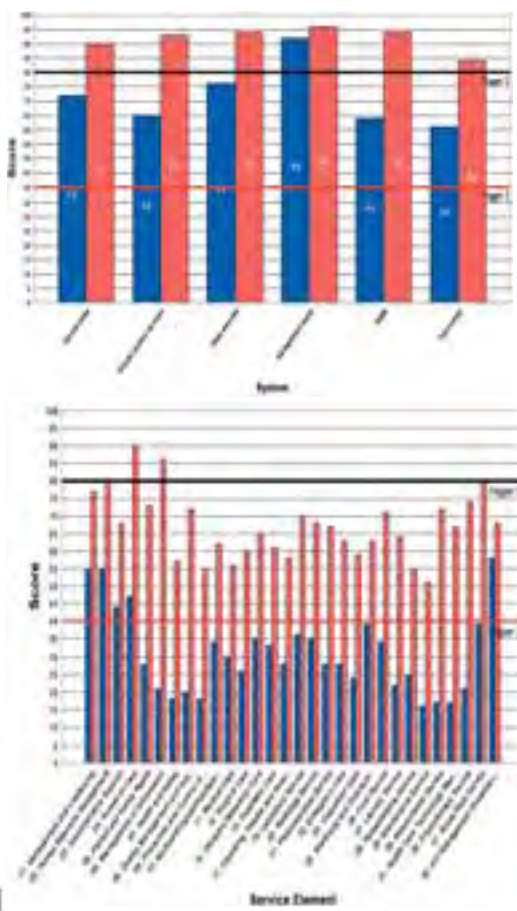**How quality health services will be monitored**

178.	A secure, web-based information system that provides access via the Internet to current standard compliance scores and other related information is an important monitoring component of the plan.

179.	The monitoring of ongoing quality improvement initiatives in facility departments and services will enable management to make informed decisions and prioritise their interventions.

180.	To facilitate this process, staff will be trained to evaluate their facility against the set standards, input their standard compliance data into the information system, extract the resulting information from the database via the web and then use it to manage their facilities better.

181.	Monitoring of the standard compliance scores of facilities can be carried out on individual or grouped facilities. Using this process, national and regional staff will be in a position to use the information to monitor the performance of any facility that falls under their jurisdiction and to encourage staff to improve their clinical performance on a continual basis.

182.	At the end of the standard implementation phase, facility-wide surveys are carried out against the standards. Facilities are awarded certificates according to the level of standard compliance achieved. Facilities that achieve substantial compliance with the standards are awarded an accreditation certificate.

183.	Facilities that do not achieve accreditation will be encouraged to continue their efforts towards achieving overall standard compliance through a graded certification programme, based on the recognition of improvements achieved.

184.　　　An example of the system to be used is shown in figure 6.

Figure 6: The Quality Assurance Monitoring System

Quality Information System that:

- provides continuous access to current standard compliance data.
- allows facilities to input their own data and monitor their own performance.
- supports ongoing quality improvement programmes.
- enables management at all levels to make informed decisions.
- assists facilities to reach and maintain accreditation standards.
- is a tool for the ongoing monitoring of performance indicators.

Monitoring Patient Safety

185.　　　Patient safety in the hospital environment has become a global and regional issue of immense importance in both industrialised and resource constrained settings. About 50% of healthcare errors are considered preventable, with an estimated average of 10% of all in-patient visits resulting in some form of unintended harm. The overall costs of adverse events can be considerable. As well as causing avoidable human suffering, the financial and opportunity costs to health services are estimated at between 5% and 10% of health expenditure.

186.　　　In May 2002, the World Health Assembly passed resolution WHA55.18, which urged countries to pay the greatest possible attention to patient safety.

187.	A number of provinces in South Africa have introduced pilot adverse event monitoring and management programmes over the past three to four years. One of the most far reaching of these is the research project set up to investigate the feasibility of establishing an adverse event management system in the Free State. The project is beginning to produce useful results that may lead the way to developing a national reporting and learning programme. Patient safety is challenged by the complexity of care processes and a culture of denial and blame. This has resulted in inconsistent reporting and learning that has prevented the collection and dissemination of information in any meaningful way. The Free State has introduced a 'Just Culture' approach that has shown to significantly improve the level of incident reporting.

Service Improvement Goals

Objective 1: Quality Improvement within facilities

188.	To provide the technical expertise to enable the National Department of Health and provincial health services to bring about an internationally accredited quality improvement and accreditation programme for hospitals, primary healthcare and ambulance services.

Objective 2: Increasing Access to HIV Treatment to meet the 2011 NSP goals.

189.	To focus on meeting the treatment gap, improving quality of care, and addressing bottlenecks in the accreditation process that occur at the provincial, district and facility level to ensure that quality is maintained in a sustainable manner.

Objective 3: Patient Safety

190.	To provide a system for the collection, classification and analysis of incidents that occur during the delivery of healthcare facilities and services, (including adverse events, near-misses and hazards) that will lead to the reduction and prevention of adverse incidents and improved patient safety.

Objective 4: Disease Management:

191.	To provide the technical expertise to enable the National Department of Health and provincial health services to deliver effective services for conditions such as HIV / AIDS, TB and other long-term conditions at all levels of health service delivery.

192.	The key stakeholders in the project will be the National Department of Health, provincial departments of health, healthcare facility staff across South Africa and the National Office of Standards Compliance.

193.	Public sector staff with the required expertise and skills to effectively roll out of this project will be identified. Such staff will include:

•	medical doctors, some with management experience who have worked in a variety of health care facilities;

•	professional nurses, ideally with management experience that have worked in a hospital and/or primary health care facilities;

•	experienced paramedical staff;

- project managers;

- administrative and clerical staff; and

- trainers.

Partners Roles and Responsibilities in improving quality of health services

194.   The following is a high level outline of the impact and engagement of stakeholders:

195.   Government

- Set the long term policy agenda

- Allocate funds for NHI

- Identification of the impact of the burden of disease and shortfalls in health service delivery resulting in, for example, long waiting lists – e.g. 150 000 people awaiting cataract surgery

- Support the initiative and monitoring progress nationally

- Set the policy framework and associated regulations

- Delegate responsibility for programme and accreditation process to OSC

- Implementation of timetable

- National leadership Task Force

196.   Provincial Authorities

- Identify priorities in the province

- Set up Quality Assurance units

- Agree on local implementation plans

- Resource allocation

- Monitor performance, acknowledge success, motivate stragglers, identify local champions and task teams

197.   District Teams

- Identify implementation teams

- Resource distribution

- Implement programme according to identified priorities

- Monitor progress and provide local support

- Introduce district-wide interventions as appropriate

- Support local champions

198.   Facility Managers

- Lead local implementation and monitoring
- Resource utilisation
- Introduce performance-based initiatives for departments
- Identify facility champions
- Facility level training
- Inter-facility cooperation

199.   Facility staff

- Implement programmes
- Train the trainers
- Local knowledge sharing and skills transfer

200.   Quality Improvement providers

- Work with the OSC to identify priority quality improvement interventions
- Provide technical knowledge and assistance
- Provide training on quality improvement using "Train-the-Trainer" methodology
- Assist facilities to implement priority quality improvement requirements

Office of Standards and Compliance

- Coordinate and monitor the progress of quality improvement interventions
- Ensure provision of technical knowledge and assistance
- Ensure training on all aspects of the standard implementation and self-evaluation programme using "Train-the-Trainer" methodology
- Monitoring and evaluation of progress made towards accreditation
- Provide regular reports on progress made by facilities, singly and grouped as the work towards achieving substantial standard compliance and accreditation status
- Ensure accreditation surveys are conducted and determine accreditation status of facilities
- Report on the accreditation status of facilities

201.   Trade Unions

- Fundamental rights for labour relations
- Trade unions participation in the workplace to ensure improvement of service delivery
- Shop stewards monitor employers' compliance with laws regulating terms of condition of employment whilst ensuring that the process of service delivery is uninterrupted and high levels of productivity are maintained

- Unions make inputs towards improving quality at provincial and national levels as regulated by the labour Relations Act No 50 of 1995.

- Unions monitor compliance with the relevant legislation to ensure a therapeutic environment for both the healthcare users and providers

- Unions play a role in ensuring that equipment, appliances and technology are of the required standards.

- Unions monitor the setting of quality management structures such as Committees for Infection Control, Occupational health and safety and Quality Assurance and their performance.

- Unions should monitor training in the development of personnel

- Unions share experiences with unions from developed countries in particular and learn important lessons for benchmarking and improving the quality of health.

VII ROLLOUT OF NHI

202.   The introduction of an NHI requires a substantial transformation of the aspects of funding and providing health services in South Africa. For this reason, its implementation will be phased in 14 years. The priorities for the first phase will include, but not limited to: wide consultation to get inputs from the public and private, stakeholders (labour, employers, community groups, NGOs, civil society); comprehensively review relevant legislation and drafting of new legislation to facilitate NHI implementation; increase funding of public sector health services from general tax revenue; revitalisation of public health infrastructure;; introduce quality improvement and quality assurance programmes; and development of human resources programme.

Moving from the current system to an NHI

203.   The transitional process from the current to the proposed NHI environment within the South African health system will require a well-articulated implementation plan. A number of interrelated elements must be carefully addressed to ensure an effective transition process. These elements include:

204.   Review of existing legislative and regulatory laws to inform the preparation of the Bill/Act that will create an enabling environment for the implementation of a NHI system in South Africa

205.   The assessment of existing infrastructure in the country and a plan to improve its capacity and effectiveness to support health services delivery and provision within the NHI system

206.   Determination of the appropriate revenue mobilisation and provider payment mechanisms and implementation of interim mechanisms to move from the current system and to support the single-funder NHI system.

207.   Determination of the pooling systems that will be implemented to ensure the NHI Fund yields the full economies of scale from the publicly administered monopsony structure as proposed in the draft NHI policy document.

208.   Determination of a transition plan for addressing the current Human Resources (HR) shortages in the health system and mobilisation of additional HR resources to support enhanced health systems delivery within the NHI system.

209.   Development of a comprehensive plan for quality improvement, assurance and compliance for all providers supported by an independent standards body. The standards body will also be responsible for the determination of the standards and norms to be used in the accreditation process.

210.   Development of an integrated plan to support processes around population registration. This plan must be informed by building on existing capacities in the country and through involving various stakeholders

211.   Development of a strategy that allows for the establishment and strengthening of provincial and district health structures to support service delivery within the NHI

212.   Development of a plan that informs the processes around implementing innovative contracting and procurement processes to allow the NHI Fund to yield the best economies of scale

213.   Costing of the financial resource envelope that will be required to adequately fund the NHI Fund and service delivery platforms at the primary and tertiary levels, including the concurrent health systems strengthening activities that are informed by the Department of Health's Ten point plan

214.   Development of a detailed transition process from the current fragmented health information system to an integrated health information system that supports efficiency, effectiveness, information portability, confidentiality and enhanced proactive decision making and system planning

215.   All these activities will have to be undertaken by a number of stakeholders, both internal and external to government. The transitional processes that are adopted must be guided by the principles of equity, effectiveness, appropriateness and efficiency. This will help in ensuring a smooth and consistent implementation plan that is informed by a needs-based approach.

216.   Together, let us work towards achieving health care for all. Particularly at this time of global economic crisis, we need to assure social safety nets for health for all, through concerted effort to create a National Health Insurance Fund.

SOCIAL TRANSFORMATION
"WORKING TOGETHER WE CAN DO MORE, EVEN BETTER"

This Social Transformation Committee's discussion document for the National General Council outlines social challenges that require concerted effort for redress in reconstructing apartheid legacy. This is not a progress report in meeting delivery objectives – which has been submitted separately. However, it is a discussion document intended to lead to critical discussion, reflection on current programmes and political direction on pressing social issues that confront our transformation agenda and how they can be realistically addressed. The document does not necessarily provide answers to questions raised, but offers some guidance on policy reviews necessary to realize political objectives. The document is primarily derived from various inputs submitted and also relies on various secondary sources.

1. BACKGROUND:

South Africa has had four successful democratic general elections in the last sixteen years. These general elections continue to strengthen democratic participation and consolidate the necessary democratic political culture. During the same period, the ANC in government has made remarkable progress in the programme to address the legacy of apartheid which reproduces patterns of development and underdevelopment in our society.

Our social transformation goals are informed by the democratic principles of a people-centered and people-driven state and a belief system based on human solidarity. However, there is a need to recognize the challenges of achieving not only a democratic South Africa – one which is often measured by the number of democratic participatory processes such as elections – but also one that is truly united and in which the value of all citizens is measured by their humanity, without regard to race, gender and social status.

Central to the task of social transformation is the role of the ANC in government in addressing the challenges of poverty and underdevelopment. Apart from the negative effects of the global economic crisis of the last two years, there is a positive mood and confidence in the economy. Further, delivery achievements in meeting basic needs, including housing, education, health, social development and the success and aftermath of the 2010 Fifa Soccer World Cup in South Africa, there is a need to focus our attention on a path of accelerated delivery, acceleration in economic growth and social cohesion.

There is a need to recognize systemic developmental challenges, which continue to undermine achievement of the desired level of social development. In large parts of South Africa, development is hampered by factors which will take time to resolve. Amongst others, these include:

Rapid and ongoing urbanization: the intensifying movement of people from rural to urban areas which has fundamentally transformed the organization of society, and created the syndrome of urbanization of poverty, leaving large sections of society marginalized in slums;

Re-configuration of the economy: the relative decline in the primary economic sectors, coupled with reduced labour intensity, has resulted in an employment bias unfavourable to a generally unskilled workforce. The emerging sectors require a more educated and better-skilled workforce which will take time to develop;

Pre-existing levels of abject poverty: the levels of deprivation have severe inter-generational impacts on affected individuals and families, with long-term social and economic consequences;

Effects of the aftermath of the global economic slump: which have adversely affected the most vulnerable in our society. While our social security system net has provided the necessary cushion, it has not been sufficient to insulate the poor. The regularity of service delivery protests attests to existing disparities in our society.

In large part, this poverty and associated inequalities stem from systemic factors limiting the natural expansion of formal employment. Both the causes and the consequences of poverty are challenges which we have committed ourselves to address as a movement. The provision of public goods and services, and related interventions, are the cornerstone of responses to South Africa's unbalanced development, poverty and inequality – with education, health, social security, basic services, social cohesion, youth and women development as key interventions. It is important to understand the specific role required of each of these policy interventions and how they are integrated to complement each other in building a developmental state.

The purpose of this document is therefore to (a) reflect on the current challenges of social transformation such as social development, land reform, rural development, human settlements, education, water provision, vulnerable groups and others, (b) to provide points for the General Council's discussions on some of these challenges and how best to address them in the shortest period possible. Our attack on poverty must necessarily seek to empower people to take themselves out of poverty and participate in their deliverance from the social deficits of apartheid. From this General Council, the Social Transformation Committee envisages outcomes or resolutions on various issues for discussion raised in this document. Such outcomes or resolutions would consolidate our commitment and leadership of the democratic forces that unite our people.

2. SOCIAL TRANSFORMATION OBJECTIVES:

The work of the Social Transformation Committee is central to our vision of an equal society. It is the ANC's social programmes that connect the movement directly to the people who make up the largest political constituency. Any election campaign takes place within the context of social issues that confront South African society and the objective to address deprivations of the past. As such, the Social Transformation Committee's primary responsibility is to ensure that the ANC's programme of action is given effect within government and achieves the desired impact on society.

However, delivery on the programme of action has been hampered by the global economic downturn, which continues to pose significant constraints on resources required to build a developmental state. A developmental state is one that develops the capacity to drive and manage economic development strategies that fundamental transform and modernize un(der)developed economies. It is a state that is also built on active participation of its people in development progammes, which are central to its priorities.

Government's resilience in efforts to develop social safety nets, improve healthcare, access to education, etc. continue to protect the most vulnerable South Africans from the negative effects of the economic downturn since late 2008 and throughout 2009.

Establishment of new ministries or departments, such as the Ministry for Women, Children and Persons with Disabilities, has increased the Social Transformation Committee' scope of work. Further, the effective implementation of Polokwane Resolutions also required appropriate allocation of responsibilities to relevant departments or ministries – some of which have only come into existence in the current administration.

Building on the Reconstruction and Development Programme, and informed by the Strategies and Tactics document, and the Social Transformation agenda in the context of eight years of democracy, the 2002 ANC Conference in Stellenbosch affirmed that "the creation of a non-racial, non-sexist, and democratic society, is about the liberation of the Africans in particular, and black people in general from political and economic bondage, and uplifting the quality of life of all South Africans, the majority of whom are African and female. The Strategy and Tactics document of (1997) states that "the central aim of transformation is to improve the conditions of the people, especially the poor."

As a movement, we still recognize poverty as the single greatest burden of South Africa's people. Therefore, attacking poverty and related deprivations is the first priority of the democratic government. This objective should be realised through a process of empowerment, which gives the poor control over their lives and increases their ability to mobilise the necessary resources to sustain their livelihoods.

The Strategy and Tactics document further states that the ANC's "programme for social transformation must ensure that it builds a better life by providing land and houses, comprehensive health and social security, basic services which include water and sanitation, human resource and capacity building, a clean and safe environment, food security, and an improvement in their health profile, including dealing with communicable and non-communicable diseases, causes of mortality, and sports and recreation." In addition, Social Transformation must also ensure the development of a South African identity, which draws from the multiplicity of talent and heritage, to reflect an African nation on the southern tip of the African Continent.

Critical to nation-building is the de-racialization of South African society. In respect of the gender imbalance in South Africa, the Social Transformation agenda must also lead to the elimination of patriarchal relations, which require that we address the socially constructed "gender roles" that conspire to degrade women. Such a nation must therefore not only affirm gender equality, but must also ensure that it is lived in practice by all South Africans, and finds expression in all policies and programmes of the nation.

In addition to these, there are broad challenges facing us as a movement in the process of transforming South Africa. There are particular groups within our society that must continue to receive targeted attention in our reconstruction project. These are groups of vulnerable people such as women, youth, children, persons with disabilities and the elderly. There is widespread recognition that charting this course would make the movement remain true to its character as a revolutionary democratic organization that works for fundamental change. Further, our movement would remain non-racial and non-sexist – one that is s determined to bring an end to the legacy of apartheid social relations in all facets of life. As the champion of transforming our society, our movement would remain a leader of the democratic forces that unite our people.

The 51st Conference held in Stellenbosch reaffirmed the perspective that the central challenge remains the eradication of poverty and inequality through economic growth and development, job creation and social equity. It is important to note that both the Stellenbosch and the Mafikeng conferences were not informed by sufficient implementation experience from which lessons could be drawn. However, the task of the Stellenbosch Conference was to assess progress in advancing the social transformation agenda on the basis of eight years of experience of the interface between policy and implementation.

On the other hand, the Polokwane Conference took place just as South Africa had entered its second decade of freedom. There was sufficient scope for the conference to assess South Africa's achievements in the strengthening of democracy and acceleration of the programme to improve the quality of life of all the people. The 10-Year Macro-Social Report released shortly before the conference inspired a positive mood and confidence in the economy.

The Polokwane Conference acknowledged that we were only at the beginning of a long journey to a truly united, democratic and prosperous South Africa in which the value of all citizens is measured by their humanity, without regard to race, gender and social status. In this regard, the Social Transformation Committee has monitored government's fulfillment of the 52nd Conference's Resolutions in Polokwane.

3. STRATEGY, TACTICS AND SOCIAL TRANSFORMATION:

The Strategy and Tactics document adopted at the 50th Conference in 1997, "All Power to the People - Building on the Foundation for a Better Life", defines the environment within which we are conducting the struggle, the character and the objectives of that struggle, the forces to carry it out as well as opportunities and obstacles. Strategy and Tactics of the ANC should inform discussion of all issues. Essentially strategy represents the broad definition of the ultimate objectives of the struggle. Elements of our strategy include: what kind of society do we seek to create? What are the forces that drive the struggle and the forces against them? On the other hand, tactics are the different methods we use to achieve objectives of strategy.

Strategies and tactics evolve over a period of time and change accordingly to suit prevailing circumstances. Currently, the Social Transformation Agenda is informed by the Strategy and Tactics as adopted by the ANC in Polokwane in 2007. The Strategy and Tactics document asserts that the tasks of the National Democratic Revolution have to be undertaken in a global environment of contradictory tendencies. The document acknowledges that the dominance of a capitalist system with minimal regulation presents enormous challenges for amongst others social development. At the same time, programmes of progressive social change are finding pride of place on the agenda of many developing nations and some global institutions.

The Strategy and Tactics document raises critical questions regarding the kind of society we seek to create and the character of the National Democratic Revolution. Strategy and Tactics document summarized the main current challenges in the form of five pillars:

• To build an strengthen the ANC as a movement that organizes and leads the people in the task of social transformation;

• To deepen our democracy and culture of human rights and mobilize the people to take active part in changing their lives for the better;

• To strengthen the hold of the democratic movement on state power, and transform the state machinery to serve the cause of social change;

• To purse economic growth; development and redistribution in such a way as to improve the people's quality of life; and

• To work with progressive forces throughout the world to promote and defend our transformation, advance Africa's renaissance and build a new world order.

The National Democratic Revolution seeks to build a society based on the best in human civilization in terms of political and human freedoms, socio-economic rights, value systems and identity. Such human civilization should be reflected, firstly, in the constant improvement of the means to take advantage of our natural environment, turn it to collective human advantage and ensure its regeneration for future use.

Secondly, it should find expression in the management of human relations based on political equality and social inclusivity. If there were to be any single measure of the civilizing mission of the National Democratic Revolution, it would be how it treats the most vulnerable in our society. It is to these tasks and their elaboration in the Resolutions of Conference that the Social Transformation Committee has, since Polokwane, focused its attention.

4. MEETING DELIVERY OBJECTIVES:

A prelude to South Africa's delivery objectives necessarily requires a critical reflection of South Africa's Human Development Index compared to other countries of comparable levels of economic development. While this comparison may appear biased because countries have had different trajectories of development, which are shaped by historical experiences of inequalities – the comparison is nonetheless relevant as it helps us measure ourselves against others.

The United Nations Development Programme has been publishing international Human Development Indexes since 1990. The Index is a composite statistic used to rank countries by their level of human development and separate developed, developing and underdeveloped countries. The statistic is composed of data on life expectancy, education and per-capita income as an indicator of the standard of living. It is important to shift the focus of our achievements from the fetish for quarterly economic growth figures, but instead focus development economics to take account of people-centered policies.

Despite our level of economic growth, our Human Development Index is still classified under the third category, of Medium Human Development, after Very High Human Development and High Human Development. In this category, South Africa is classified together with such countries as Congo, Sudan, Tanzania, Ghana, Uganda and others. In 2009, South Africa's Gross Domestic Product was US$495.689 billion. However, in the same year, 16 years after democracy, countries in a category higher than South Africa included Latvia with a Gross Domestic Product of US$34.435 billion, Bulgaria (US$ 92.551 billion), Romania US$261.570 and Venezuela with (US$353.998 billion).

Without getting into complex analyses of these figures and their true meaning, the success of South Africa's reconstruction agenda will only be measured objectively by the extent to which there is marked improvement in overall human development indicators such as life expectancy, education, and health and per-capita income. For instance, in the latest Human Development Index published by the United Nations, South Africa has dropped 35 places to 120th which reflects increasing levels of disparities between the rich and the poor. Legitimate questions for deliberations on all these matters should revolve around the following:

• What lessons have we learned in meeting people's expectations in the past 16 years?

• What has worked and requires concerted government investment to maximize impact?

• What must be prioritized in the medium to long-term – over a defined period of time as our resolution and political commitment to address?

- Should South Africa still have mud schools by 2015[?], how about the bucket system [?], informal settlements [?], sanitation [?], access to water [?] – The list goes on across a spectrum of societal concerns;

- Is our infrastructure sufficient to meet our delivery objectives over a period of time? This would include the capacity of our current sewage system nationally, electricity generation capacity and others?

- Have the policies we adopted as government helped narrow the divide between the rich and the poor over the past 16 years – or we have essentially shifted the basis of inequality from race to class?

Politically, these are difficult questions – but they nonetheless have to be confronted to understand policy gaps in the implementation of our programmes. To achieve the political goals set over a period of time, hard choices have to be made from a calculus of competing interests. In the past few years since the last General Council, government has been publishing Development Indicators as a framework for presenting aggregate data on progress in human development since 1994.

Such progress is a useful yardstick against which advances in transforming South African society can be measured accurately. There is consensus that South Africa has made remarkable progress in meeting social transformation objectives. A mid-term assessment of progress made in meeting Polokwane Resolutions on all areas of social transformation is encouraging. Trend analysis of those indicators that relate to social transformation such as employment, poverty and inequality, health, education, social cohesion and safety and security have registered marked improvement in the last three years – but more work still needs to be done. The section below dealing the social transformation through delivery of basic services outlines some of the proposals of the Social Transformation sub-committee to strengthen the effectiveness of our programmes.

There are delivery challenges that have begun to undermine social cohesion and political realignment – all to the detriment of the ANC. Apart from the ANC's internal organizational matters of leadership, discipline and culture, the real challenges to delivery are impacting directly on progress in social transformation, thus reducing the ANC's political hegemony in "traditionally sympathetic" political constituencies. For instance in July 2010 municipal by-elections, the ANC lost support in eight wards, mainly in the Eastern Cape, Mpumalanga and the Western Cape. However, overall, the ANC won 19 out of 26 wards contested countrywide. A careful analysis of the underlying causes of the ANC's political misfortunes at local level ballot box reveals:

- Unscrupulous elements within the party operating at the local level who want leadership positions because of vested narrow self-interest;

- Incompetent local councillors;

- Corruption by public representatives and government officials with regards to tenders and procurement;

- Public servants hired on patronage practices of political connections and not on merit.

Studies aimed at establishing the reasons for social discontent have indentified grievances of citizens who came to believe that service delivery protests were the only way in which they could make themselves heard. Local conditions and even the performance of specific individuals were among the triggers that set off confrontations. Essentially, uneven delivery is prompting *legitimate* questions regarding the dividend of democracy and ultimately what people struggled for against apartheid.

5. SERVICE DELIVERY PROTESTS:

Service delivery or the lack thereof, remains a contentious issue for many South Africans. Since late 2004, frustrations and impatience of our people over the rate of service delivery and the quality of governance in certain municipalities fuelled a wave of protests – some even violent – which spread to municipalities in most parts of South Africa. Without getting into a discussion on whether these are legitimate demands for democratic dividend, some of the underlying causes of these protests can be attributed to:

• Inadequate service delivery,

• Corruption,

• Intra-party contestation,

• Activities of social movements and advocacy groups, and

• The re-demarcation of provincial and municipal boundaries at local government level.

• Perceived indifference of local government officials and councillors to communities' plight.

The service delivery protests are rooted in high levels of frustration at inadequate service delivery and corruption in local government, particularly in accessing government contracts and tenders. Most supporters and organisers of the protests are members of the ANC, with party structures being [ab]used to rapidly mobilize communities. Municipalities at the epicenter of the protests are also the worst performers in terms of service delivery.

In some municipalities, service delivery protests have significantly reduced our people's confidence in local government as a vehicle to address delivery challenges. Such protests have also rendered a municipal manager's position to be one of the most dangerous jobs in South Africa. For instance, when a community perceives a lack of service delivery, elements of vandalism and plain criminality prevail: a municipal manager's house can be torched. Worse still, a municipal manager can even be murdered. Such is the gravity of communities' discontent over "poor" or "inadequate" service delivery. There are numerous other disturbing incidents, which include destruction of valuable infrastructure.

Service delivery protests have an adverse effect on local tourism, on the stimulation of the local economy through investment, on the erosion of social capital, creation of new jobs and the reduction of poverty. These protests can be attributed to communities' growing impatience with municipalities, especially in relation to the delivery of housing and basic municipal services. Residents in areas experiencing protest action continue to complain about poor human security-related delivery of the following core services:

• Adequate water supply

• Sewerage collection and disposal

• Refuse removal

• Access to electricity supply

• Environmental health services

• Municipal roads and storm water drains

• Municipal parks and recreation facilities

• Access to adequate housing

• Governance issues

• Financial management problems

Violent service delivery protests present a challenge to the evolution of South Africa's democracy and the consolidation of institutions necessary for it to function optimally. To address service delivery protests, the following recommendations are worth considering:

- The ANC and government should implement efficient client interface and complaints management systems. Effective communication will ensure that communities are kept informed about council's budget allocations to various stakeholders and decisions regarding services. Where service delivery problems are experienced, ward committees, organisations and members of the public can access officials, service centers, helpdesks or other services that deal with such problems;

- There is a need to monitor implementation of structural budget identification planning;

- There is a need for a developmental response to service delivery protests in order to avoid service delivery protests degenerating into violent stand-offs between communities and the police. Recommendations that rely solely on the reaction of law enforcement agencies do not address the underlying causes of service delivery protests, and largely serve to antagonize communities further. Therefore, policing should not be the only or immediate response to service delivery protests;

- Local authorities should provide residents with opportunities to participate in and address their needs in the most appropriate way. Such an approach will contribute towards building an informed and responsible people with a sense of ownership of government developments and projects. This will further allow municipalities to develop partnerships with stakeholders;

- To manage the activities of social movements and advocacy groups, the ANC should engage with concerned citizens' groups to bring them into the mainstream of government's attempts to address service delivery challenges;

- To address the dissatisfaction around demarcation issues, the ANC should increase interaction with affected communities at grassroots level to explain and communicate decisions taken.

There is an urgent need for the ANC to revisit delivery on issues of social justice. Managing expectations and what can be realistically delivered also requires political deliberations to avoid South Africa splitting into social classes. This is essential, as poverty remains the single greatest burden of South Africans and is the direct result of the apartheid system.

6. TRANSFORMING SOCIETY THROUGH PROVISION OF BASIC SERVICES:

The transformation of South Africa's society from the dehumanizing legacies of apartheid will remain central to government's programme for some generations to come. It is interesting to note that such a government programme is prescribed in South Africa's Constitution for posterity. South Africa's inequalities remain defined by race, class and gender. However, in the national discourse on transforming South Africa's society, there is consensus on the future shape of South Africa. Such a future rests on the ANC government meeting delivery demands of various deprivations across a wide spectrum of societal challenges. It is through progressive delivery and subsequent redress that South Africa's society would be transformed from the prevailing legacies of social stratification. Amongst others, such delivery challenges include:

6.1 Human Settlements and Housing Delivery:

The reality of current human settlement challenges is that South Africa has a housing deficit of 2.1 million units – with 12 million South Africans living in housing conditions that do not meet acceptable minimum requirements for residential quality. While over three million houses have been constructed since 1994, there are still over 2, 700 informal settlements. This is largely due to rural urban migration trends as our people move to perceived "income-earning areas" in search of jobs. This reality has created the syndrome of urbanization of poverty, leaving large sections of society marginalized in slums. These migratory trends continue to make it difficult to determine accurate housing demand and therefore affect the necessary planning processes. Further, lack of such planning process also affects the allocation of resources to meet increasing demands.

Housing delivery for the period 2010 to 2014 is projected at roughly 230, 000 units per annum – which represent only 10 per cent of the current housing deficit which increases by the same percentage annually. Simplified, South Africa would not meet the need for acceptable standards for residential quality for some time to come. This reality should inspire us to think differently about our existing programmes for meeting the needs for acceptable habitat. In this regard, critical questions include:

- Have we improved the overall outlook of apartheid spatial human settlement patterns or we have simply consolidated continuities of apartheid settlement patterns along class lines?

- Is our housing delivery approach sustainable over a period of time when the structural integrity of such houses is questionable?

- What about the amount of resources committed to rectify structural integrity of such houses?

It is important to note that the current housing budget and projections for the Medium Term Expenditure Framework can only deliver 10 percent of the housing deficit – which is itself a moving target. When informal settlements are built faster than the provision of formal housing, the ANC has a moral responsibility to consider appropriate policy options to avoid the obvious inevitable political consequences of such reality. These realities are further compounded by the unintended consequences of the current housing policy – which include the selling of homes by beneficiaries. The following proposals are worth considering:

- There is an urgent need to revise the current funding model, technical and programmatic options that are neither sustainable nor produce desired impact on beneficiaries;

- There must be sustained increases in the MTEF budgeting cycle for additional resources. Such increases must be equivalent to the annual delivery output projections of provinces;

- There is also a need to re-confirm the centrality of the state in human settlements – with particular reference to land and the requirements of proximity to income-earning areas, financing, and access to socio-economic opportunities;

- The Human Settlements mandate also requires alignment in terms of powers, policy development, funding and related responsibilities. This would necessarily include the alignment of such instruments as the Municipal Infrastructure Grant and other related grants.

The realities of living in informal settlements or slums also means that residents of these areas are often not eligible to access basic public services such as proper sanitation facilities, refuse removal, electricity and other essential infrastructure. As such, the provision of adequate housing is central to government's transformation agenda through improvement in residential quality. For the provision and access to adequate housing remains a catalyst for development and is also the primary requirement towards sustainable livelihoods.

6.2 Water and Sanitation:

In 1994, about 15 million people were without safe water supply and over 20 million without adequate sanitation services. Prior to 1994, there was no single national government department responsible for water supply and sanitation in South Africa. Because of these realities, South Africa made a remarkable decision to recognise the right to access to water at the constitutional level, where it underpins the law and water policy framework.

The outcome of this policy framework was the implementation of the Free Basic Water policy. Since then, South Africa has made satisfactory progress with regard to improving access to water supply, reaching universal access to improved water source in urban areas, and in rural areas the share of those with access to water increased from 62% to 82% from 1990 to 2006.

In 2009, government announced a framework to ensure that South Africa's water resources are managed sustainably to meet future demands. Within the context of this strategy, the department embarked on programmes to:

• Diversify water-mix, ensuring that other sources of supply, for example, desalination of sea water in coastal areas and strengthening effluent reuse are explored;

• Intensify public awareness about the value of water to instill a culture of responsibility and change of attitude and behaviour to water use and scarcity.

However, South Africa's current water infrastructure is insufficient to meet growing needs for both domestic and industrial consumption and therefore requires urgent attention. Steep increases in water tariffs could serve to intensify social problems. A solution would have to be found to address water infrastructure funding requirements.

There are concerns regarding water pricing, water management and water infrastructure funding. The pricing strategy is implemented in terms of Section 56 of the National Water Act. The current strategy does not adequately address the real cost of water to all user groups. For example, there is a "historic" water price capping applied to the agricultural sector for irrigation water use (an indirect subsidy to irrigators). A political decision is required on water infrastructure and funding model. The following recommendations are worth considering:

• There is a need to intensify water conservation and intervene in the management of sources from which our communities get water;

• Access to water by the poorest of the poor is critical as water forms the very basics of human existence;

• There is also an urgent need for political intervention to address water concerns, particularly the matter of water privatization;

• There is a need for legislative review to address barriers to broadening access to water

- There is also a need to ensure improved linkages to the land reform programme;

- There is also a need to review the issuing of water licenses for mining activities abstraction and the discharge of such water in relation to mining activities;

- The efficiencies of current water boards also require some review;

- There is also a concern that water tariffs are too high – particularly in the rural areas and there is therefore a need to establish a Water Regulator to set the guidelines for water provision. The existence of such a regulator would address problems of natural monopolies.

The deteriorating water infrastructure requires the Department of Water Affairs to recover costs to maintain existing infrastructure. The provision of water to communities is one of the ANC's primary commitments. As such, government should be part of any strategy that seeks to address infrastructure costs pressures.

There is also a need to review current water boards. This is important because left to themselves water providers over-charge consumers. In public-owned water utilities, there may be a case where utilities charge too little – leading to poor supply and delivery. The existence of a Water Regulator would provide even tariffs across national water providers. The National General Council should note the misalignments of services that are obstructing delivery. An example of the difficulties and costs involved in providing few households on a mountain top with basic services ranging from water, electricity and refuse removal often comes to mind.

Sanitation remains a critical area and more than 35% of South Africans do not have access to proper human waste disposal. The cholera epidemic of 2000 reawakened government to address the slow rate of progress in sanitation provision. The 2008 cholera outbreak which also spread to South Africa resulting in acute cases of diarrhoea was a reflection of the state of South Africa's sanitation infrastructure. Other affected provinces in South Africa included Gauteng, KwaZulu-Natal, Mpumalanga and the Western Cape. Other previous cases of water borne infections such as Typhoid in Delmas revealed the extent of the deterioration of human waste disposal infrastructure. As early as March 2009, more that 9, 000 households were still using the bucket system across South Africa. The following recommendations are worth considering:

- There is an urgent need to provide adequate sanitation to the remaining 9, 000 households that are still using the bucket system;

- There is an urgent need to attend to the sanitary disposal of human waste without contaminating water sources;

- While the recent "toilet violence" in the Western Cape province in the course of May-July 2010 may have different underlying causes, it serves to reflect the importance of access to proper sanitation and waste disposal. The NGC should deliberate on appropriate political decisions to address inadequate sanitation, which is one of the remnants of apartheid's denigration of human dignity.

6.3 Comprehensive Social Security:

South Africa has made remarkable progress in providing a social security net and distributing income to vulnerable groups in the past 16 years. The Polokwane Conference acknowledged the value of a comprehensive social security net in providing a targeted approach to eradicating poverty and unemployment. There has been progress in meeting Polokwane Resolutions on social security. For instance, child support grants have been extended to 18 years, while pensionable age has been equalized at 60 years of age for both men and women.

However, gaps in the coverage of social security remain. The prospects for expanding social security coverage are encouraged by the successes of the Unemployment Insurance Fund. An amount of R30 billion in reserves has so far managed to pay for new beneficiaries of Unemployment Insurance Fund on interests alone. However, it does raise the question regarding social benefits to be gained if huge reserves are building up in the context of high levels of poverty and unemployment. The following policy proposals to improve social security provision are worth considering:

- There is a need to improve means-test for prospective beneficiaries of social grants;

- There is a need to extend the term of unemployment benefits to those who are employed to protect them from the prospects of being unemployed within the same framework of relying on existing reserves to fund such expansion;

- There is also a need to consider contributory pension fund dispensation to cover those in formal employment who are excluded, and sport personalities, musicians and related categories so that they are never left neglected once their time-bound careers have ended;

- There is also a need for an assessment of the extent to which beneficiaries of social security benefits have graduated from the cover through gainful employment;

- There is a need to improve the administration of payments, through formal financial institutions. This would lead to significant estimated cost-savings of about R1 billion over time;

- There is also a need for more effective administration and better targeting of social relief of distress to address needs of the most vulnerable. It would also be ideal if this responsibility is devolved to provinces.

While these commitments will help achieve expansion of the social safety net, it is necessary for the Economic Transformation Committee to expedite its plans to create employment opportunities to reduce pressure on the social grants system and consideration for income support to economically people. Not addressing this challenge poses a real risk of the creation of an underclass. For, over time, it is important that government does not create dependency on social grants. The growing percentage of national budget spent on social grants far exceeds most other expenditure and this should be cause for concern. Envisages social insurance reforms are as follows:

The Unemployment Insurance Fund should be enhanced either by paying it for a longer period or to increase the benefit value. Consideration is being given for a continuation benefit beyond a 12 month period for those who remain unemployed beyond expiry of unemployment benefits. Consideration is also being given for inclusion of public servants, fixed-term contract migrant workers, learners and those who are self-employed.

Adjustments may be needed to risk-benefits covered through other state programmes (UIF section 14 exclusions). Relevant departments should develop frameworks for linking unemployment benefits with measures aimed at re-integration into the labour market.

The Road Accident Fund's current outlook may require some considerations. A policy framework to reform the Road Accident Fund to a Benefit Scheme consistent with social security principles was presented to the Social Transformation Committee and Cabinet with a view to start public consultations. The framework aims to abolish the fault-based system and proposes a more equitable, affordable and sustainable system. The following recommendations are worth considering:

• Access to medical care for all road accident victims without payments required or membership of a medical scheme;

• Income support benefits for lost income and earnings capacity, instead of a lump sum payment;

• Family support benefits for spouse or life partner and dependent children of the deceased in the event of death of a breadwinner.

Considerations in the proposed policy framework cover amongst others:

• Access to medical care for all road accident victims without payments required or membership of a medical scheme;

• Income support benefits (for lost income and earning capacity) instead of a lump sum payment;

• Family support benefits (spouse or life partner and dependent children of the deceased) in the event of death of a breadwinner.

There are overlaps between the National Health Insurance, the Compensation for Occupation Injuries Disease Act – COIDA, the Road Accident Fund and the Unemployment Insurance Fund. The Social Transformation Committee has recommended harmonization of all social security funds once the National Health Insurance is in place.

An alignment of these benefits will obviate the need for risks benefits, that is, for disability and survivor benefits to be provided at the same time as mandatory retirement fund with risk benefits. The implication is that the Compensation and the Road Accident funds be consolidated and focus on providing health insurance for emergencies incidents.

The Private Industry has served South Africa well in providing savings arrangements. This has contributed to the development of financial markets and savings products. Notwithstanding the successes, there is a need to review the current regulatory framework for private and organized labour funds. One such consideration is to have all public and private sector funds under single pension regulatory framework.

Governance and Institutional Arrangements for Social Security is fragmented. Inevitably, as a result, policy proposals often lack coherence with the entirety of the system. Accountability and governance arrangements are key elements in the long-term success of the proposed social security reforms. Currently, Executive Authority responsibilities cut across several Ministries:

- Social assistance: Social Development

- Social insurance: Labour, Health, Transport, Social Development and Finance

- Retirement reform: Social Development, Labour and Finance

Accountability and governance arrangements are key elements in the long-term success of social security reforms. Currently, executive authority responsibilities cut across several ministries. There is therefore an urgent need to harmonize institutional arrangements for government's provision of social security.

6.4 Land Redistribution:

There is poor delivery on land redistribution. However, progress in land redistribution remains the yardstick with which to measure the extent to which we have empowered our people materially. As we move towards the centenary of the 1913 Land Act, the liberation movement is tasked with a strategic imperative to decisively reverse the macro-social and economic adversity of that racist legislation, which ushered systematic and unjust pilfering of land of our people.

Thus, land reform and redistribution remains one of the anchors of our economic transformation agenda. However, the execution of this policy fundamental has proven complex and slow-moving. Simply put, after 16 years of our constitutional democracy, the progress in land redistribution is not satisfactory.

In 2007, the 52nd Polokwane Conference of the ANC resolved to redistribute 30% of land before 2014. The conference noted that:

- Current approaches to land reform are not achieving the outcomes required for the realization of a better life, particularly for rural South Africans;

- Government has only succeeded to redistribute 4% of the agricultural land since 1994, while more than 80% of agricultural land remains in the hands of 50, 000 white farmers and agribusiness;

- Limited opportunities of sustainable livelihoods in rural areas, insecurity of tenure and widespread evictions – which contribute directly to the growth of informal settlements in cities and towns.

The Conference also noted a lack of development in infrastructure and inability to unlock land value. South Africa's legacy of racially biased land ownership was formalised in 1913 by the Natives Land Act. The consequences of the 1913 Land Act for Black land and property ownership in general were that over 80% of South Africa's land went to White people, who made up less than 20% of the population at the time.

The Act stipulated that Black people could live outside the reserves only if they could prove that they were in White employment. Although the law was applicable to the whole of South Africa, in practice it applied only to the Transvaal and Natal. In the Free State, such legislation was already in force since 1876, while a law forbidding Blacks to own property in the Cape would have been in conflict with the constitution of the Union of South Africa, as Cape property-ownership was one of the qualifications for Black franchise.

This Act did not go unchallenged. While it was being discussed in Parliament, the ANC, which was formed a year earlier in 1912, rallied against the proposed law. Since 1914, the ANC submitted various petitions and sent various deputations to both the South African Parliament and to the Imperial Parliament in London asking for intervention to stop the Act, but failed.

The advent of democracy has bestowed on us the levers to redress the legacy of asset dispossession without appealing to colonial masters. However, progress in this regard is rather slow. To meet the target of redistributing a total of 30% of agricultural land by the year 2014 requires a minimum of 6.5% land redistribution per annum between 2010 and 2014.

To achieve the targets set for land redistribution, the following policy considerations should be considered:

- An urgent need to review and reconsider the "willing-buyer-willing-seller" principle, on which the current land redistribution is based, in order to expedite land redistribution;

- Review the current Expropriation Act (1975), as it is inconsistent with the Constitution. This includes the departure from the current narrow and obstructionist "public purpose" principle to a broader "public interest" principle, the overhaul of the compensation regime to be in line with section 25(3) on standard of compensation). The latter denotes departure from the current linear outlook of market value to other fundamental variables as provided for in the constitution;

- Much of the land already distributed to our people is largely characterised by neglect – we therefore need to participate in the land restitution programme beyond redistribution to ensure that redistributed land retains its value through proper utilisation;

- The urgency of this matter is such that a realistic target date is set for both the departments of Public Works and Land Reform and Rural Development to finalise all processes required for legislative amendments.

Once all the processes are completed, revised legislation would be a tool to implement an integrated programme land reform and economic transformation, which should register real redistribution in pursuit of the 2014 targets.

6.5 The Expanded Public Works Programme:

The Expanded Public Works Programme (EPWP) seeks to alleviate unemployment by absorbing the unemployed into productive work. The programme remains central to government's response to labour market integration and poverty alleviation through systematic creation of short and long term work opportunities.

The second phase of the expanded public works programme EPWP (II) is intended to generate 4.5 million work opportunities between 2010 and 2015. By March 2010, the programme has created 604, 000 work opportunities. The target for the financial year 2010-2011 is set at 642 000.

The recent High-Level Review of EPWP (II) raised two fundamental imperatives to further deepen the application and impact of the programme:

- deepening of the programme's labour intensity; and

- the need to increase provincial and municipal registration to qualify for incentive grants, especially for rural municipalities.

The Department of Public Work's EPWP Unit has communicated the minimum labour intensity criteria to all provinces and municipalities, and will continue to monitor its effective implementation and strategic outcomes. Increasing the capacity to absorb labour intensity of programmes would boost the numbers of jobs created per province and municipality that register and qualify for incentive grants (in the 2009/10 year the grants were under-spent due to low registration).

The EPWP Unit within the Department of Public Works (DPW) has in partnership with private service providers and the Development Bank of SA (DBSA) initiated a capacity-building pilot project in four municipalities. The success of this pilot project would allow it to be broadened to other especially rural municipalities to ensure that we increase the qualification registration and accessing of much-needed funds from the incentive grant thus increasing the spending rate of the incentive grant in coming financial years.

Together with provincial departments and the South African Local Government Association, the Department of Public Works is strengthening the implementation of criteria for labour intensity and skills development in expanded public works projects across departments, provinces and municipalities. This will not only increase job opportunities created, but also the developmental effect of the programme on the lives and future of the people.

6.6 Nationalism, National Identity, Patriotism and Social Cohesion:

Social Cohesion refers to those factors that have an impact on the ability of a society to be united for the attainment of common goals. Broadly, social cohesion is a process through which national identity and nation-building is consolidated. Social cohesion is the glue that binds communities, society and the nation together. After 16 years of democracy, the legitimate question to ask is how far has South Africa progressed in building national identity, patriotism and social cohesion?

The "xenophobic violence" of 2008 reminded South Africans of the need to build a caring and prosperous nation, one that is tolerant of not only South Africans, but also of foreigners. Progressive nationalism, national identity, patriotism and social cohesion should be measured by the extent to which we have been able to inculcate the mandate of togetherness. Further, to what extent has the moral regeneration campaign helped us achieve our objective of transforming society? In addition to these, other questions include how people connect to the state and the responsibilities of both the state and society towards each other. However, grievances registered during "xenophobic violence" reinforce the extent of growing disparities between South Africans along material possessions, standards and living conditions. Such disparities discourage social cohesion and a sense of common belonging, which are increasingly defined by one's access to material resources.

The 2010 Fifa Soccer World Cup in South Africa has demonstrated better relations between South Africa's race groups. Such better relations were showcased to tourists and soccer visitors and tourists during the tournament. A unique South African culture was also displayed and sport proved itself to unite people across different race groups, and age diversities. It has also reawakened a spirit of patriotism, a sense of national pride and confidence never before witnessed in South Africa since 1994. However, there is a need to sustain the momentum of national consciousness that has been ignited by soccer.

While the 2010 Fifa Soccer World Cup encouraged patriotism and pride towards our national anthem, national symbols, the flag and a sense of belonging, the end of the tournament was inundated by rumors of threatened violence against foreigners. There were fears of the repeat of 2008 "xenophobia violence." All these examples indicate the delicate state of South Africa's national identity, patriotism and social cohesion. The following policy recommendations are worth considering:

• Need for concerted government and civil society campaign to strengthen national identity;

• Need for government to expand and intensify the visibility of South Africa's flag and other symbols of national identity beyond schools and the current display on taxis;

• Consciously explore ways to maintain the enthusiastic embrace of the South African flag as demonstrated during the 2010 Fifa Soccer World Cup;

• It is also important for school kids to understand the national anthem and its meaning. Fifteen years after democracy, South Africans' knowledge of the national anthem is not satisfactory.

The ANC was founded on principles of togetherness. It is important for the ANC to harness its experiences in this regard to improve social cohesion and to lead South Africa's social transformation process. It is therefore critical that we develop programmes that seek to strengthen social transformation. The consequences of lack of such programmes have been the problems witnessed in Sudan, Rwanda, the Democratic Republic of the Congo and others. We also need to harness heritage sites to enhance nation-building. Until such time that the issue of class is addressed in South Africa, the divide between the rich and the poor will continue to undermine efforts towards social cohesion.

Our nation-building project can only be sustained through ongoing programs that address some of the deficiencies outlined above. The overall outlook of South Africa reflects a united, democratic and prosperous nation, in which the value of all citizens is measured by their humanity, without regard to race, gender, sexual orientation and social status.

6.7 Education and the Youth:

Currently, (2010) South Africa has 28, 000 schools, with 386, 587 teachers, 12, 260, 099 learners, of whom 11, 809, 355 are in public schools while 450, 744 are in independent schools. In essence, 96.3% of learners are found in public schools, with 3.7% in independent schools. Projected spending on education will take up 18.2% of total government expenditure by 2011/2012. Participation levels of the 7 to 15 year age group in the South African population have reached universal enrolment levels approximately 90% or higher in all provinces.

However, there are serious concerns regarding school "dropouts" – that is those who leave school before completing a given grade or secondary education altogether. On average, between 11% and 15% of children leave school each year after grade nine – which is the last year of compulsory education. There is also a prevalence of substance abuse at schools and among high school dropouts. Some of the underlying causes of dropouts could be repetition and low achievement due to lack of remedial programmes. Further, poor quality of interaction between teachers and learners may also be a factor.

There are obvious social and economic consequences for society arising from school dropouts over a period of time. This is because education is an avenue through which we inculcate values required for us to achieve the change we desire in our society. Education is central in the socialisation process and the development of a generations' social awareness by infusing norms and sets of belief systems that society deems relevant for the youth to contribute to development as good citizens. Further, education also serves to develop one's faculties to fit within society by shaping behaviour from youth to mature individuals. Finally, education also helps one to develop principles of life that inform decisions and the pursuit of goals and objectives.

The virtues outlined above are critically important for South Africa to have confidence in future generations and their capacity to manage, recognise and appreciate the programme of transformation. Critical as these may be, it is disheartening to see school-age children – usually intoxicated – begging at streets intersections in the cities and in rural areas. This reality reflects a lost generation with no future prospects of contributing meaningfully to South Africa's development. Overtime, it would be a generation without the values and convictions necessary for the progressive realisation of our objectives as a nation. It is important to emphasise that the success of South Africa's reconstruction agenda is predicated on ensuring sustainability of the transformation agenda through improved education. Proposals to improve our education system should include:

- Increasing the number of Grade 12 learners who pass the national examinations and qualify to enter a Bachelor's programme at a university from 105, 000 to 175, 000;

- We should also strive to increase the number of Grade 12 learners who pass mathematics and physical science to be 225, 000 and 165, 000, respectively;

- Improve the percentage of learners in Grades 3, 6 and 9 in public schools who obtain the minimum acceptable mark in the national assessments for language and mathematics (or numeracy) to increase from between 27% and 38% to at least 60%;

- There should also be standardized national assessments of the quality of learning to take place in Grades 3, 6 and 9, on an annual basis. There should be universal access to Grade R for all age appropriate children by 2014;

- It should also be compulsory to complete Grade 12 to move beyond functional literacy over a period of time. This is necessary to put individual potential to maximum use, both for the benefit of the individual and the economy. The dividend of such compulsory investment in the youth is incalculable.

While the fundamental purpose of education is to nurture good human beings, there is a disturbing trend of drug abuse in South African schools. Left unattended, schools may become incubators for future social problems. There is no need for statistical evidence to prove that drugs are a problem in South Africa schools. Drugs that are readily available to school kids include alcohol, cigarettes, marijuana and inhalants. What needs to be done?

- There is a need for the school curriculum to include life orientation and the effects of drugs on individual's general well-being;

- There is a need for government to intensify public awareness campaigns both in print, audio and visual mediums on the dangers of drugs to society;

- It may not be drastic to introduce random compulsory drug testing in schools at different intervals and the provision of psycho-social assistance;

- Government should also send a clear message to anyone who provides drugs, and there should be national consensus on minimum penalties for offenders. For instance, there are people in both rural and urban areas that are known to provide substances such as marijuana in their locality – yet nothing is done to save the community.

- There is a need to pay special attention to child-headed households and provision of necessary assistance to avoid the devastating effect of drugs on such households.

Different government departments have introduced internship programmes that seek to alleviate problems of youth unemployment and to address the growing problem of youth militancy.

7. WOMEN, CHILDREN AND PERSONS WITH DISABILITIES:

The Reconstruction and Development Programme and the policy instruments that derive from it 9sectoral policies, manifestos etc) address the broad programmatic challenges facing us as we transform South Africa in the interest of the motive forces. In addition, it also identifies particular groups/sectors within the motive forces – who by virtue of the nature of oppression or discrimination that they have, because of particular vulnerabilities or specific sectoral issues or needs – must receive our targeted attention. These groups include:

- Women – by virtue of gender oppress, and thus the triple that they face;

- Youth – as a social strata that were particularly affected by apartheid, but also the opposition that they occupy in society as a transitional stage between childhood and adulthood;

- Children – who are the most vulnerable sector in any society;

- People with disabilities – who have special needs and face discrimination.

In response to challenges facing these vulnerable groups, following the general elections in 2009, government established a dedicated Department for Women, Children and Persons with Disabilities to re-affirm the resolution of the 51st Conference which sought to address the legacy of the past, which still imposes a heavy burden on South African society, especially on the poor, on women, youth, children, the elderly, and people with disabilities. The establishment of the department will accelerate the objective for equity and access to development opportunities.

The newly established department for Women, Children and Persons with Disabilities is however currently confronted by numerous institutional and mandate challenges that require political direction. Amongst others:

- Integrated action for the protection of women children and disabilities rights still needs continuous strengthening in Government, within civil society and between the two sectors;

- The gender equality component of the national equity and equality programme needs to be strengthened to advance human rights delivery in our country. Strategic separate and inclusive programmes for women and men need to be supported across Government and in civil society;

- There are inadequate systems to protect the rights of foreign nationals in the women, children and disabilities sectors;

- Development agencies still need to align their support for women children and disabilities programmes with the Government's agenda for transformation and development.

There are governance and institutional arrangements that require urgent political decision. These institutional arrangements must be addressed to clarify issues of accountability and executive authority. Currently, there are overlaps and parallels between the Ministry for Women and Persons with Disabilities and other statutory entities that were established before the ministry such as the Gender Commission.

There are some competencies that should remain with such institutions while others should naturally fall under the purview of the Ministry for Women, Children and Persons with Disabilities. There is no doubt that the establishment of the Ministry for Women, Children and Persons with Disabilities has raised matters of mandate for some institutions. The following recommendations are worth considering:

- The need to review some of the roles and mandates of all Chapter Nine Institutions. Such mandates should not be interpreted as a relationship of conflict, but complementary;

- The need to review the gender machinery in its entirety. This is necessary for the Ministry for Women, Children and Persons with Disabilities to succeed.

The Department of Women, Children and Persons with Disabilities would have to introduce various legislative amendments and proposals to Parliament to address deficiencies in our current statutory framework where they exist. Such legislative amendments would have to be undertaken for purposes of consistency.

8. THE SCOPE FOR OPTIMISM:

No country is insulated from the global financial crisis. The global economic downturn highlighted the significance of our social security system that protects incomes while promoting employment opportunities in a fiscally sustainable manner. Government's efforts in developing the welfare safety nets have protected the most vulnerable from the adverse effects of economic downturn since late 2008 and throughout 2009. However, delivery on the programme of action has been hampered by the global economic downturn, which continues to pose significant constraints on resources required to build a developmental state – one that transforms our society from legacies of the past.

While South Africa's economy will still have to contend with the realities of recession for the first time in 17 years, there is confidence in projections of economic growth in the course of 2010 and beyond. The impact of the global economic crisis was cushioned by social development and economic redistribution policies that South Africa adopted since 1994. The prospects for improved economic growth provide sufficient scope for the availability of resources necessary to finance social development programmes for the future continuation of our social transformation agenda.

GENDER

CONTENTS

A. INTRODUCTION

1. This discussion on gender and women's empowerment is taking place at a critical time when the ANC is moving towards its centenary celebration in 2012 and celebrations of women's struggles which intensified and became more organized around 1913.

2. This paper is meant to re-examine progress made by the ANC towards its commitment to a non-sexist society both within the organization and within the state, identify shortcomings and propose recommendations that would ensure that women's issues and gender equality are mainstreamed across and within the organization and also develop a concomitant trajectory into governance priorities – in particular the 10 Outcomes of Government adopted and endorsed by the nation during the 2009 elections.

3. The commitment to a non-sexist society has always been part of the ANC policy. According to the ANC Constitution and the country's Constitution (1996), women are recognized as equal citizens, with equal rights and responsibilities. Except for the earlier years after the formation of the ANC in 1912 whereby the main focus of the struggle was on issues such as land, pass laws, and the franchise, until after three decades of its formation, the commitment to gender equality has always been articulated as a vision for the ANC.

4. At different conferences the ANC adopted a number of resolutions concerning the emancipation of women.

5. The resolutions were structured in such a manner that there was a logical flow of ideas from the conceptual (the definition of gender), the strategic (the emancipation of women and capacity building programmes to achieve this, customary laws and discrimination against women), gender policy of the ANC, the gender machinery established by statute, the over-arching concept of the Women's Movement, the more narrow concept of strengthening the Women's National Coalition as one component of the women's movement, to the organizational-specific role of the ANC Women's League.

6. The ANC's commitment to the creation of a united, democratic and non-racial, NON-SEXIST, and prosperous South Africa is always articulated in the Strategy and Tactics document.

7. More important, it is the revolutionary, historic and heroic contributions that women made in the struggle for their franchise, emancipation and human rights that laid a concrete foundation for leading and sustaining this fight into the future.

8. Their struggles provided sound principles underpinning the battles waged especially in respect of providing political leadership on the gender agenda; ensuring that the struggles for women's emancipation remain mass-based, and also maintaining the moral high-ground. To date these principles continue to remain a foundation for the organization and the women's struggle in South Africa.

9. The ANCWL has always led on gender equality and women's struggles through consistent commitment to serving women. The work of the ANC Women's League has been the critical pillar within the Party to conscientize, raise awareness, sustain and carry forward women's empowerment and gender equality agenda.

10. The strategy is also premised on utilizing programmatic measures and interventions including special temporary measures such as gender quotas and affirmative action measures.

B. THE BASIS FOR ENGENDERING ANC POLICY

11. The women's struggles for emancipation and the ANC's commitment to non-sexism requires effective equality.

12. By Gender Equality we refer to the equal enjoyment of rights and the access to opportunities and outcomes, including resources, by women, men, girls and boys. It implies a fair distribution of resources between men and women, the redistribution of power and care responsibilities, and freedom from gender-based violence. It entails that the underlying causes of discrimination are systematically identified and removed in order to give women and men equal opportunities. It takes into account women's existing subordinate positions within social relations and aims at the restructuring of society so as to eradicate male domination. It is also understood to include both formal and substantive equality.

13. Gender inequality and other patriarchy-related social ills are an integral part of what should be the transformation agenda of the ANC. In effect what this NGC must look at are ways to actually address patriarchy within its realms and the realms of society as a whole, as well as look at the concept of "decolonization of the Human Mind."

14. It is important to acknowledge, as central, men's power over women and the resulting oppression. Social roles, duties and responsibilities have been allocated and ascribed to women and men in particular societies and at particular times. Such roles, duties and responsibilities and the differences between them, are conditioned by a variety of political, economic, ideological, cultural and social factors characterized in the main by unequal power relations. It is also important to distinguish "gender" from "sex" which is biologically determined.

15. In order to effectively implement policy decisions that impact on women's empowerment and gender equality, it is critical to have a full understanding of the theoretical underpinnings on which these are premised.

16. Patriarchy as an ideological is a whole system encompassing ideologies, beliefs, values and practices underpinning the organisation and structure of society – resulting in unequal power relations between women and men. The subjugation and subordination of women in all spheres of life beginning with the family is impacted upon by patriarchal attitudes. Patriarchy is a historical and widespread phenomenon, continuously reinforced by social practices, institutions, including education, work, religion, culture, the arts and the media and has come to be as "natural, God-given or part of the tradition and culture".

17. While patriarchy is a distinct system, it does not exist on its own. It thrives on the basic economic-political system under which it exists, becoming a way of life by all. Thus state or government alone, or one group or organisation for that matter, cannot eradicate patriarchal practices on its own. It requires all the forces of society, particularly because it coexists with and survives even under the most progressive political systems. This is because these practices are institutionalized and entrenched within religious, cultural, and family traditions and reinforced by legal and other forms of institutionalization of such practices.

18. The struggle against patriarchy is therefore a "struggle within the struggle" and must be addressed sharply, in line with the key attributes of a developmental state.

C. THE STRATEGY

19. Gender mainstreaming as a strategy for achieving gender equality was identified by governments at the Fourth World Conference on Women, held in Beijing in 1995. Mainstreaming a gender perspective is the process of assessing the implications for women and men, of any planned action, including legislation, policies and programmes, in any area and at all levels.

20. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of all policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of gender mainstreaming is to achieve gender equality.

21. The strategy is also premised on utilizing programmatic measures and interventions including special temporary measures such as gender quotas and affirmative action measures.

22. The tactics that ought to be employed are vested in improving the quality of life of women through concerted programmatic measures in the areas including health, education, social security, basic services, employment, economic empowerment and increasing opportunities in the public and political sphere.

23. In order to do all of these effectively and speedily, we have to address the underlying causes as to why they fail to occur – which is really the persistence of patriarchal thinking or the continuation of institutionalized sexism.

D. CURRENT STATUS OF WOMEN IN SOUTH AFRICA

24. The ANC's commitment to the consistent improvement of the role played by the legislative organs of the state as tribunes of the people and as platforms to monitor and advance the programmes of change has tremendous import for the lives of women, especially within the context of a developmental state.

25. At a broad level, we have translated the achievement of equality chiefly through the achievement of equity. Given our emphasis on the latter especially through our policy and legislatives measures and programmatic interventions, much of the gains that have been made in terms of advancing women and achieving gender equality have failed to make an impact on addressing and eradicating the persistent practice of patriarchy and institutionalized sexism.

26. The statutory and policy architecture for gender equality in the country is comprehensive and multi-dimensional, with individual laws and policy overlapping to provide seamless protection of the rights of women and girls. Progressive legislation includes the Promotion of *Equality and Prevention of Unfair Discrimination Act, the Employment Equity Act, the Domestic Violence Act, Sexual Offences Act* and *Civil Union Act*, among others.

27. The country has also ratified a number of international and regional instruments that promote gender equality, including the 1979 Convention on the Elimination of All Forms of Discrimination against Women (ratified 1995), the 1993 Declaration on the Elimination of Violence Against Women (signed 1996), the 1995 Beijing Declaration and Platform for Action and the Optional Protocol to CEDAW, ratified in 2005, and the AU Heads of States Solemn Declaration of Gender Equality in Africa (adopted in 2004). The ratification of the SADC Protocol on Gender and Development which was signed by the President in 2008 must be fast tracked. South Africa is bound by international, regional and sub-regional laws ratified and must take all necessary steps to protect women from discrimination and abuse in all spheres.

28. In terms of institutional mechanisms, the National Gender Machinery (NGM), as outlined in the 2000 South African National Policy Framework for Women's Empowerment and Gender Equality, is an "an integrated package" of structures located at various levels of state, civil society and within the statutory bodies, in particular the Commission for Gender Equality. The recently formed Ministry for Women, Children and Persons with Disabilities is a central co-ordinating point for the advancement and protection of the rights of women, children and persons with disabilities.

29. Furthermore, the Public Service adopted a Gender Management System – a network of structures, mechanisms and processes – that enables the mainstreaming of gender across government. The Eight Principle Plan for Heads of Departments provides a mandate to see that gender equality becomes a goal in all aspects of government departments.

30. The status of women in South Africa and the extent to which gender equality gaps are reduced in the country can be seen in national indicators that speak to capabilities (access to education, health), opportunities (access to economic resources) and to leadership positions) and security (levels of violence against women).

31. Government's major achievements, among others, include:

• In 2008 gender parity in schooling was achieved;

• Progress in addressing the primary health care needs of women and girls;

• Combating of violent crimes against women and children identified as a priority;

• Specialised courts to deal with sexual offences instituted with staff working at these courts empowered with specialised skills;

• Progressive amendments to the Sexual Offences Act;

• Addressing issue of increased feminized poverty through a comprehensive anti-poverty strategy;

• Significant progress in achieving gender parity at senior management level within the public service;

• Great strides in the representation of women at the political and decision-making levels, placing South Africa currently 6th on the Global Report Index;

• A number of civil society, non-governmental and research organisations working in the field of gender equality with significant successes in advocating for and shaping gender legislation;

• Influencing policies and providing evidence of successful methodologies.

32. However, as a country, we still need to realize *de facto* or true equality in practice. While several gains and many milestones have been achieved in this process, many challenges nevertheless remain in the creation of a women-friendly environment and an engendered society which is capable of eradicating the many practices that constrains women's advancement and empowerment.

33. Dealing with the legacy of discrimination and transformation of society, particularly the transformation of power relations between women, men, institutions and laws, is fundamental to building an inclusive, progressive and prosperous society. Collective efforts must be directed at addressing gender oppression, patriarchy, sexism, structural oppression and creating a conducive environment which enables women to take control of their lives.

34. It remains a fact that in South Africa within and between race groupings, women continue to bear the burden of inequality. South Africa's rankings on the Gender-Related Development Index (GDI) and the Gender Empowerment Measure (GEM) are quite divergent, with a low GDI score but a relatively high GEM. This reflects the dichotomous nature of South Africa's transformation process: significant progress has been made in empowering women in the political, public and educational spheres, but the marginalization of poor women severely compromises progress.

E. ENGENDERING ANC POLICIES

35. This NGC offers us an opportunity to report on progress, identify outstanding challenges and to chart the way forward. The paper is biased towards the engendering of Government's five priorities especially at a service delivery level. These are: creation of decent work and sustainable livelihoods; education; health; rural development, food security and land reform; and the fight against crime.

36. As mentioned earlier, the ANC and the country have made progress in pronouncing on non-sexism but the challenge of sexism and patriarchy continue to haunt us.

37. Whilst the ANC remains committed to gender mainstreaming, a careful analysis of the priorities clearly points to some implementation challenges.

F. ON EDUCATION

38. The ANC committed to providing equal access to quality education for all South Africans, with a view to eliminating gender disparities in education at all levels. *The National Education Policy Act* provides for redressing the inequalities of the past in educational provision, including the promotion of gender equality. This is meant to make it possible for both boy- and girl-children to access basic education, as well as participate in gateway subjects such as mathematics and science.

39. In addition, there are a variety of social protection policies and programmes dedicated at promoting and protecting access to education for vulnerable children, especially for children with disabilities.

40. As a country, indeed we have managed to improve access to basic education in the country. Furthermore, we have attained gender parity especially at the secondary level. In fact there are more girls enrolled for the senior certificate examinations than boys.

41. Challenges include learner pregnancy and sexual abuse in schools. Sexual abuse and educator to learner sexual relationships are outlawed in the schooling system, and punishable by dismissal of the particular educator if found guilty.

42. However, the pass rate for girls remains lower than that of boys. The SA draft MDG country report 2010 indicates that according to the General household survey, school attendance for those aged 7-13 has increased from an already high level of 96, 5 %(boys 96.4% and girls 97.0%) in 2002 to 98.6 %(boys 98.4% and girls 98.8%) in 2009.

43. Performance in National Senior Certificate examinations show that more females than males entered the exams. The pass rate for girls is 57% while it is 60% for boys. The lower pass rate for girls even though they are in larger numbers indicates that there may be areas of gender implications – such as early motherhood, gendered division of labour, household chores and child headed households.

44. At the tertiary level, there is indication that there are more females than males enrolled in tertiary institutions at 56.4%. However, women are in lower numbers in technical universities, and therefore in technological and scientific fields of study. Women still dominate in areas which are stereotypical "feminine" areas.

45. Statistics also indicate that more women are enrolled at the higher level of study such as in masters. However, other statistics in the employment fields show that more men are employed than females. There is therefore no correlation between women's success in numbers and studies at higher levels with that of employment in the economic sector.

46. While this may be case, more women are increasingly accessing tertiary education, as well as increasingly entering previously male domains with respect to career choices. However, the science, technology and engineering fields are still predominantly male in nature.

47. Cases of sexual harassment and sexual violence continue to be reported in South African public schools. Evidence shows that girls experience sexual harassment and violence more than boys.

48. Teenage pregnancy is among the major concerns facing young people in South Africa today. There are serious intervention measures to deal with the challenge as it is one that can effectively undermine efforts to keep the girl child in school for as long as it is required, thereby defeating efforts to contribute towards ensuring that all learners realize their full potential. The South African Constitution criminalizes discrimination on the basis of pregnancy; therefore pregnant learners cannot be denied their constitutional right to education because of pregnancy.

49. It is imperative to reflect on the challenges that persist, particularly in terms of women's adult basic education and literacy. There are innumerable case studies and examplars in countries that show a strong correlation between women's education and the improvement in the quality of life of the family, including education of their children. Literacy and education empowerment of rural women is essential if the quality of their lives is to improve, and they are able to access justice and economic empowerment opportunities.

Recommendations

50. 50% of all learnerships must be earmarked for young women to ensure that empowerment is provided especially for previously male dominated areas.

51. Schools have a particular responsibility to protect young people from social problems. Education must play a dual role in relation to discrimination and gendered or sex based harassment and violence. It must prevent such activities from occurring in education institutions and mobilize the medium of education to develop in students the knowledge, skills and life orientation to ensure that they repudiate discrimination and gendered violence and become advocates against it.

G. HEALTH

52. Since the dawn of democracy in 1994, a number of initiatives have been implemented to improve access to health services by women. One of the first initiatives was to remove user fees for children under six and pregnant and lactating women. Later, user fees for people with disabilities were also removed. Primary health care was also made free to all.

53. The health sector remains committed to the White Paper for the Transformation of the Health System's (1997) vision, which accentuated the need to: decentralise management of health services; establish the District Health System to facilitate implementation of Primary Health Care (PHC); increase access to services for citizens; ensure the availability of good quality essential drugs in health facilities; strengthen disease prevention and health promotion in areas such as HIV and AIDS, and maternal, child and women's health; implement the Integrated Nutrition Programme to focus more on sustainable food security for the needy; and rationalize health financing through budget reprioritization bears testimony to the Department's commitment to Transforming the health sector.

54. According to the SA draft MDG country report 2010, a total of 625 of maternal mortality cases were recorded during 2007 which is far above the MDG target of 38 by the year 2015. It is unlikely that this target can be achieved. Under five mortality, which is linked to maternal health, also recorded 104 the same year and unlikely to achieve the MDG target of 20 in 2012.

55. Human Sexuality, gender inequality and vulnerability are interlinked issues which must be addressed. The high prevalence of HIV among women suggests the extent to which women in South Africa are vulnerable to the epidemic. Besides evidence from the annual antenatal surveys, it is also the case that more young women than men are infected. Women are vulnerable because of their position in society, including the imbalance in the power relations between men and women (reflected in their ability to negotiate condom use), and multiple and concurrent sexual partners. Violence against women and children is also a major challenge and contributes to the HIV epidemic.

56. While guidelines and protocols are available, access to the appropriate services is still limited and social structures to address the prevention of these ills are still weak. Women with HIV are also particularly vulnerable to emotional, material and physical abuse and neglect.

Recommendations

57. Delivery on the four key areas must be accelerated viz., increasing life expectancy; combating HIV and AIDS; decreasing the burden of diseases from Tuberculosis (TB) and improving health systems effectiveness, with special emphasis on deliverables aimed at improving the health status of women and children. These focus areas are consistent with the health related Millennium Development Goals (MDGs).

58. Major challenges also remain with respect to health of women in marginalized communities such as those in rural areas, women on farms, foreigners in the country as well as commercial sex workers.

59. Women are the major health care providers; when women are infected, there is very little social infrastructure integrity to care for them. This includes when women are affected and afflicted by other conditions as well, such as cancer, chronic diseases and old age and therefore support services are needed for them.

60. Health education and promotion also need to be strengthened, especially among the adolescents and youth.

61. School health services need strengthening also, with emphasis on the promotion of personal and sexual health and the prevention of intentional and unintentional injuries, including violence, infections, pregnancy and substance abuse.

62. This includes high vaccination coverage through the Expanded Programme on Immunization.

H. WOMEN AND HUNGER

63. Many women live in abject poverty, i.e. living under a dollar a day. Consequently, women's financial dependency increases their vulnerability to marginalization and all forms of abuse.

64. Women have a crucial role to play in the fight against hunger. As mothers, farmers, and entrepreneurs, they hold the key to building a future free of malnutrition and hunger.

65. A key factor contributing to hunger and food insecurity in the country is gender inequality in families, communities and society as a whole. Due to gender power imbalances, women are often denied access to available food; food production activities (the labour market); and production spaces and tools such as land and implements. This disadvantaged position in any given society is based on the relations of, among others, gender-based access to social resources and opportunities, defining as well women's unequal access to these resources and opportunities.

66. It is commonly known that women generally own less land and the land they have is often of lower quality than the land owned by men. Most women in the country are situated in rural areas where poverty and underdevelopment are rife.

67. Rural women's lack of access to resources and basic services is compounded by their unequal rights in family structures, as well as unequal access to family resources, such as land and livestock. This explains further why African rural women are not only poorer in society as a whole but also in their own families. It also defines why their level and kind of poverty is experienced differently and more intensely than that of men.

68. Despite the critical role women play in food production and management of natural resources, they have ownership of a very minute percentage of agricultural land. Lack of access to and control over land has intensified their difficulties, their access to credit, technical assistance and participation, all of which are essential for development. Little access to credit limits their ability to purchase seeds, fertilizers and other inputs needed to adopt new farming techniques.

69. The conspicuous absence of particular reference to interventions targeting gender inequality or improving the status of women as a strategy for addressing food insecurity is one of the major gaps that exist. Without such a focus, the root causes of hunger and food insecurity may not be fully understood and interventions may miss the mark in terms of their orientation and goals.

70. Impacts of climate change are not gender neutral. Women bear a major responsibility for household production and supply, energy, and food security, which when combined with inhibitions rooted in their traditional roles, unequal access to resources and limited mobility, results in them being disproportionately affected.

71. Africa's land and natural wealth is immense and increasing in value. This increases its vulnerability to exploitation by foreign investors. Given the leadership role on the continent, **South Africa must ensure that women and children are safe guarded from further exploitation and are direct beneficiaries of the revenue from land and natural wealth.** Therefore this revenue must be utilized to promote sustainable and equitable development for all.

72. The ANC must oversee that, in compliance with the Copenhagen agreements on climate change, women and children are not further exploited, discriminated and disadvantaged. **Women must make up 50% of the green jobs and the green economy in South Africa.**

73. The Industrial Policy and Action Plan for 2010/11 – 2012/13, which builds on the National Industrial Policy Framework, represents a significant step forward in scaling up efforts to promote long-term industrialization and industrial diversification. The objective is to go beyond traditional commodities and non-tradable services. The Action Plan places emphasis on more labour absorbing production and services sectors, and increased participation of historically disadvantaged people in the economy.

Recommendations

74. Given the key role of women in the agricultural sector, improving their situation means progress for the sector and for the economy as a whole. Measures to improve their situation include:

- Increasing their access to farming land, fertilizers, seeds and ploughing implements;

- Increasing their access to credit;

- Ensuring that they receive education;

- Increasing their participation in decision-making; and

- Strengthening their role within the family.

75. Research must be undertaken on best practices and case studies on programmes for alleviating hunger e.g. Brazil's Zero Hunger Programme in the Context of Social Policy.

76. Foreign policies of South Africa especially to address issues of foreign countries using up land space in the country or in Africa for their biofuel use by planting trees and harvesting these at the expense of land for food production must be carefully scrutinised.

77. Climate change will increase the cost of MDGs attainment – in food production, health, water, energy, infrastructure and other areas – and will have disproportionate effects on women and the poor. It therefore cannot be treated as a standalone issue but **must be mainstreamed across government's five priority areas.**

I. WOMEN AND THE ECONOMY AND EMPLOYMENT

78. We acknowledge that the role of women in the economy has to change. The demand for gender equality has deepened democracy and transformed our society. Our constitution proclaims equality but social and legal practices still mutter otherwise. South African women make up 52% of the entire population, and 57 % of women are found in the informal sector.

79. Despite significant employment equity gains in South Africa as a result of labour legislation and other policies that have responded to historical race and gender inequalities, the patterns of inequality continue to be reflected in labour force data. Continuing disparities in employment highlights the broad trends that reflect a gendered nature of employment, skewed in the favour of men.

80. Given the lack of compliance mechanisms and legislated means by which to achieve this, the proposed gender equality legislation will be well placed to cover this issue especially in the private sector. The CEE and the Employment Equity Act have clearly not been sufficient to achieve this goal. While numbers are not the foremost determinant of gender equality, it is a special measure adopted to achieve equality. However, we must remember that the gender equality legislation will need to look at a "beyond numbers" approach to measures that would ensure the transformation at the workplace. The current environment means that even though women are increasingly entering the workplace, they are continuously negotiating these spaces within an organizational culture that has been determined previously and which is fundamentally maintains male domination hegemony.

81. Although there is a concerted effort towards striving for a 50-50 representation of women at the political level and within Government SMS levels, this is not reflected at the private sector and corporate levels, including at the trade union levels. Transformation at the workplace, remains rather slow.

82. A high percentage of women undertake low-skilled, low wage employment. Women primarily serve as domestic labour and home-based care-givers. Women remain consistently under-represented in high-skills, high-wage employment.

83. They remain significantly under-represented in senior management and leadership positions. As a result, many women continue to operate in the informal trade sector, including in informal cross border trade.

84. The international context adds to the challenge. The global economic meltdown in 2008-9 had tremendous negative impact on the lives of women. While financial and economic crises have gender-specific impacts and place a disproportionate burden on women, in particular poor women, they also present opportunities to change strategies and actions.

85. Women's increased participation in the labour market has not been accompanied by an increase in men's participation in unpaid work. Women have to spend too many hours on domestic work, preventing them from participating in societal or development activities. Macro-level policies continue to neglect the existing inequalities in the gender distribution of paid and unpaid work to the detriment of women.

86. While women form the majority of small business owners, they are significantly outnumbered by men in the formal sector of the economy. Women-owned businesses, although more numerous than male-owned businesses, remain weaker because they are usually smaller, less formal and operate in more vulnerable sectors, especially in trade, catering and accommodation.

87. The negative unintended consequences of the growth path in the country include large and unsustainable imbalances in the economy and continued high levels of unemployment. These have significant impact on women's lives. Together with the global recession, the impact has been tremendous especially on women located largely within the informal sector of the economy and for women within the household level. This Industrial Policy Action Plan, as one component of broader, integrated inter-related policies, will place the country on a new growth path. This has tremendous importance for the upliftment and economic empowerment of women.

88. It is estimated that the Industrial Policy Action Plan will result in the creation of 2 477 000 direct and indirect decent jobs over the next ten years. It will diversify and grow exports, improve trade balance, build long term industrial capability, grow the domestic technology and catalyse skills development.

89. Women-only co-operatives account for a significant proportion of the cooperative-landscape in South Africa. In a "Baseline Study of Cooperatives in South Africa", undertaken by the Department of Trade and Industry in 2009, indicates that there are more female co-operative members than male members. Co-operatives that consist of only women members account for 264 co-operatives, representing over 20% of the total co-operatives sample. Sectors which had women-only co-operatives were textiles (19%), services (16%) and food and agriculture (16%).

90. The findings of the survey reflect a sector where the majority of co-operatives are of a survivalist nature and most of them are not in a position to have their applications for loans and grants approved. The findings highlight a problem of co-operatives not being able to access the finance they need to grow their businesses.

91. The EPWP and other aspects of South Africa's poverty alleviation programme have also paid special attention to rural women's economic empowerment. This has created opportunities for women to become construction entrepreneurs and for others in public works jobs such as road works, which were previously given to men only. However, the reality is that males still benefit more from the EPWP, for example, men still predominate the construction industry, particularly as owners.

Recommendations

92. The transformation within and of the economy must therefore be in line with the creation of decent work and sustainable livelihoods as well as rural development. This must be within the context of a sustainable, equitable and inclusive economic growth path.

93. Responses to the financial and economic crises, including stimulus packages, need to take into account the needs and priorities of women and girls to ensure that the gains made in promotion of gender equality and empowerment of women are not reversed.

94. Primary areas of policy intervention have to focused on reducing the burden of unpaid work, including through the reconciliation of work and family responsibilities, the provision of services and investment in public infrastructure. The value and cost of unpaid work should be recognized and valued by all stakeholders, including Government and the private sector.

95. Women therefore require a multifaceted approach to address disparities though some of the following measures:

- Micro-financing arrangements where the major financial institutions are provided with incentives to provide loans to women entrepreneurs;

- Skills development and training directed at potential women entrepreneurs in both the urban and rural areas especially in drawing up business plans and proposals and in skills in managing a business particularly in accounting and budgeting;

- Providing mentorship and learnership opportunities for women seeking to become entrepreneurs; and

- Encouraging young women / young female learners to take business courses in high school and tertiary education.

96. **Women must make up 50% beneficiaries of this target for jobs and within all the sectors identified, including in the skills development provided.**

97. **There is a need for a fully fledged co-operative education and training institute of some sort to provide the necessary skills for women's cooperatives to be successful and sustainable**. Women require skills in business proposals, tender and contract processes, financial management, and marketing, amongst others. **It is recommended that a mentorship programme be established to support emerging co-operatives, particularly those that are still at a survivalist stage**.

98. The Co-operative Development Policy and related legislation provide for the development of an institutional environment, including the establishment of a Co-operative Advisory Board and secondary and tertiary co-operatives, which would provide some of the support services and create that enabling environment that the sector currently needs. **The establishment of the Advisory Body must be fast-tracked**.

99. State Owned Enterprises must ensure that in **awarding tenders and contracts, 50% is awarded to women**. In awarding contracts and tenders, especially to women-only cooperatives, SOEs must ensure that they **create markets, value-chains and value-add for sustainability** of these businesses.

100. All economic empowerment codes such as those set by BBBEEA, PPPFA, Mining Charter, Legal Sector Charter and others must be reviewed to be strengthened, engendered and directed at the creation of entrepreneurial-ship. The targets in **all Codes must be reviewed to include 50% women as direct beneficiaries** of procurement and enterprise development. The intention should be toward increased and extension of ownership for women.

J. EMPLOYMENT

101. Despite the successes made in representation of women at the political and decision-making levels, there are serious questions around the meaningful participation and inclusion of women in the political sphere and private sector.

102. There is progress in achieving gender parity at senior management level within the public service (currently at 36% women in SMS positions). This is made up as follows: 40 (27.77%) Directors-General out of a total of 144; 169 (34.7%) Deputy Directors-General out of a total of 486; 596 (34%) Chief Directors out of total of 1750 and 2085 (36.7%) Directors out of 5676 in total. Majority of women are located at the entry level of the SMS. **The 50/50 parity target must be actively pursued at all levels of Government and that compliance and accountability must be enforced**.

103. The private sector has, in spite of employment equity requirements, made less progress in achieving gender parity within the ranks of its senior management. According to the South African Women in Leadership Census 2010 conducted by the Business Women's Association, in 2004, 59.9% of the country's corporations had no female Board representation and, where women were included, they made up only 7.1% of the board members.

104. This differs significantly in 2010 where 21.5% of the country's company boards have no female representation and 16.4% of directors are women. However only 10.4% of CEOs and Board Chairs are female and women executive managers make up 19.3%. Trends over a three-year period 2008 to 2010 indicate that women CEOs and Managing directors increased from 3.9% in 2008 to 4.5% in 2010, while Chairpersons increased from 3.9% in 2008 to 6% in 2010. Directorships held by women increased from 14.3% in 2008 to 16.6% in 2010. There are 19.3% women executive managers in 2010, having decreased from 25.3% in 2008.

105. The private sector responses to gender inequality in South Africa are embedded in the socio-political context of the country through the Broad Based Black BEE legislation and codes, the Employment Equity legislation, industry Charters (such as in mining or finance), and national umbrella bodies amongst others. There is evidence of a narrowing of gender imbalances; an increasing response to gender equality obligations and a range of mechanisms are in place (bursaries, scholarships, internships) to facilitate entry of women into industries. However much more must be done to especially empower women economically and ensure that the majority of women do not remain confined to the informal sector of the economy.

Recommendations

106. **The envisaged Gender Equality Bill must be fast-tracked to speed up 50/50 parity in the private sector and the corporate world**.

K. TRANSFORMING THE CRIMINAL - JUSTICE SYSTEM

107. The South African Constitution has an extensive Bill of Rights which gives primacy to the right to equality and guarantees women equal rights with men. The Constitution also protects rights relating to custom, culture and religion subject to the Bill of Rights.

108. The historical disadvantages that undermine women's equal access to justice were not necessarily created by the current justice system; they are however reinforced by the identical treatment of women and men when accessing the justice system. This results in failure to respond to systemic social, economic and cultural disparities in society.

109. The position of women, especially black women, in terms of access to justice is aggravated by their oppression based on gender, race, class, culture, language and other factors. Women and children have borne the brunt of ineffectual, insensitive and inept services when accessing the criminal justice system where they have fallen prey to, for instance, sexual abuse, and in certain cases, the very role players they turn to for assistance and support have exacerbated trauma inducing further victimization.

110. Historically, the criminal justice system was created for the needs of men, as the market was male only. However, currently the market has changed to include women. Accused persons going through the criminal justice system have different needs determined by their diverse nature of being either female or male. Females are prosecuted and incarcerated on the same basis as males.

111. Customs, social and religious systems, including culture, have in the past promoted patriarchy and the oppression of women. Discrimination against women due to the above institutions took a variety of forms, from disenfranchisement to various forms of abuse. These institutions are still intact and still practice their cultures.

112. There is no doubt that tremendous progress on improving access to justice for women has been achieved. However, all that is achieved so far is mostly *de jure* or legal equality. Unfortunately, many of the problems that the law reform processes sought to address, still persists.

113. The role of the judiciary in translating human rights law into practice is not a subject which can be addressed in abstract terms. It is to a large extent determined by the laws, the legal culture and conditions of life existing in the country. Transformation of the judiciary should be understood within this context.

114. There are often unintended consequences of the law which impact negatively on women. For example, the Domestic Violence Act 1998 is one of the milestones of law reform aimed at protecting women against domestic violence. However, the Act has many implementation challenges. One of the major deficiencies of the act is the absence of built-in measures to address the underlying causes and influencing factors in domestic violence situations and recidivism. In many instances victims continue to endure abuse despite having secured protection orders. In some of these cases the abuse can progress to murder or "intimate femicide".

115. Due to lack of gender sensitivity, some members of the judiciary are not willing to fully implement provisions of the Act, for example, (i) refusal to issue an order for the removal of a firearm in terms of section 7 of the Act; (ii) refusal to issue orders evicting the perpetrator from the premises.

116. There are 96 shelters throughout the country accommodating and rendering psychosocial services to women and their dependent children who are victims of abuse. During 2010, 13 of the existing shelters were strengthened to accommodate victims of human trafficking.

117. In response to the problem of violence against women, government has identified factors such as law reform on bail, sentencing, victim empowerment, capacity building, extending access to courts to previously disadvantaged areas and integrated responses, as critical pillars of the fight to end violence against women which accordingly needed to be strengthened.

118. Violence against women is a manifestation of the historical unequal power relations between men and women, which have led to the domination over and discrimination against women, by men, and to the prevention of the woman's full advancement. Furthermore violence against women is one of the mechanisms by which women are subjugated and subordinated by men.

119.   SAPS Statistics released on 9th September indicates that a ratio decrease of - 4.4% in sexual offences, representing a decrease of 2182 cases from 70 514 to 68 332. Although there is a decrease in sexual offences, the numbers are still too high, calling for an increased capacity within the criminal justice system in handling this issue, and increase in the provision of victim support, especially in the rural areas.

Examples of cases against women

120.   Lack of transformation of the judiciary is clearly evident in the following cases: In the case of **S v Mahomotsa**, the female victims were both 15 years old, and both raped by the accused at different times. However, the ruling was that the complainants sustained no physical injuries and had suffered no psychological damage as a result of the rapes, and that they had not lost their virginity from the rapes as they had already been sexually active, one of them having had sexual intercourse two days before she was raped by the accused. In the case of **Nkomo v the State**[1], the victim was a minor and the medical records showed that the victim sustained bruises of the labia minora and a torn hymen, and that the victim lost her virginity as a result of the rape. However on appeal the SCA found that the sentence of life imprisonment imposed for multiple rape of complainant was wrong because the court a quo used a wrong test to determine whether substantial and compelling circumstances were present and the sentence was set aside and one of 16 years imprisonment was imposed.

121.   While there are currently 803 police stations in the 9 provinces with victim support rooms, as well as a total of 17 Thuthuzela Care Centres as of 2009, these are clearly inadequate in meeting the needs of victims of sexual violence. Thuthuzela Care Centres are 24-hour one-stop centres where rape victims have access to all services such as the police, counselling, doctors, court preparation and prosecution. During 2009, a total of 10 213 matters were reported at the Thuthuzela Care Centres.

122.   In order to respond to the international problem of trafficking in persons, government has developed a Bill, the "Prevention and Combating of Trafficking in Persons Bill", which aims: (i) to prevent trafficking in persons, (which disproportionately affect women and children); (ii) the prosecution of traffickers and other role players; and (iii) the protection of victims of trafficking. It inter alia provides for the criminalisation of trafficking in persons and related acts such as subjecting a victim of trafficking to debt bondage and destroying or confiscating the travel documents of victims of trafficking. The Bill is not yet promulgated as an Act. Even though there are other laws that are used to prosecute perpetrators, women still fall through the cracks.

123.   The current legal framework on prostitution and sex work is total criminalization against the seller. However, there are local governments, which based on their local understanding and mobilization by NGOs have abandoned the arrest of people who are prostituting themselves. The Constitutional Court decision in Jordaan v State, 2002 (6) SA 642 (CC); 2002 (11) BCLR 1117 (CC) did not advance the course of prostitution. However, the South African Law reform Commission (SALRC) is in the process of investigating this matter.

124.   Possible law reform approaches to prostitution as provided for in the SALRC Issue Paper 19 on Sexual Offences: Adult Prostitution is as follows: Criminalization model, Regulatory model and Total decriminalization. The ideal approach for the ANC will be for the support of a position that **will embrace the dignity of women (guided by the work done by cde Madlala-Routledge).**

125.   Much has been achieved to date on the area of transformation of the judiciary. Prior to 1993, there were only two white female judges, now there are about fifty women judges out of a total of 208 judges. At the Magisterial level, there are about 650 women magistrates out of a total of about 1900 magistrates. This falls short of the 50/50 principle.

126. At the magistrates level, the Jurisdiction of Regional Courts Amendment Act of 2008 which came into operation on 9 August 2010 expands the jurisdiction of the Regional Courts by conferring on regional courts, civil jurisdiction to adjudicate over civil disputes of between R100 000 and R300 000 and has divorce jurisdiction. Sixty-two (62) existing Magistrates' Courts have been designated as seats of the civil regional courts - the list of these courts and their areas of jurisdiction have been published in the Gazette and advertised widely.

127. The South African Law Reform Commission is investigating regulation of arbitration and alternate dispute resolution. The aim of Alternate Dispute Resolution is to relieve court congestion, as well as prevent undue costs and delay; enhance community involvement in the dispute resolution process; facilitate access to justice; and provide more effective dispute resolution.

128. Women and inheritance: Reform of Customary Law of Succession and Related Matters Amendment Bill, 2008 is intended to bring the Customary Law of Succession in line with the Constitution, thereby eliminating unfair discrimination in that area of the law. The Bill, among others, abolishes the customary law rule of male primogeniture. It will contribute to the promotion of gender equality, allowing more women and children to share directly in the proceeds of deceased estates. The Bill has been approved by the National Assembly and is receiving the attention of the Select Committee on Security and Constitutional Affairs.

129. Some women who are prosecuted and incarcerated are pregnant or have little children, and they are incarcerated with their children who are not guilty. The Minimum Standards Rules that are used in prisons were developed 100 years back and are outdated. The current incarceration programme does not address the issue of women and children integration into society, to ensure that they are not stigmatized and discriminated against.

Recommendations

130. Women are still under-represented in the judiciary. **There is a need for specific training programmes to fast track the employment of women into the judiciary at all levels.**

131. Despite the tremendous progress in improving access to justice, much still has to be done to translate the obligations and commitments made, into action so as to achieve real factual equality as promised in the Constitution. Legal literacy is critical to enable access to justice for women. Legal literacy is a process of acquiring critical awareness about the law and the rights contained in it. It is also about the ability to assert rights and the capacity to mobilise for change. It is a tool for women's empowerment so that they can be able to deal with gender inequalities in the legal and political systems as well as pervasive social oppression. Women have to understand and follow the processes of the development of laws, especially marriage laws, and make inputs during the initial stages of developing such laws.

132. There are a number of Bills that are in the process of being introduced to Parliament that will have a profound impact on the transformation of the judiciary, such as the Constitution Amendment Bill, the Superior Courts Bill and the Legal Practice Bill.

133. In order to eradicate systemic discrimination and inequalities between women and men in prisons, **the Minimum Standard Rules must be reviewed to take into account the new market** which includes women, and to ensure that the rights of children of those women incarcerated are promoted and protected as provided for in the Constitution.

L. MEDIA TRANSFORMATION, OWNERSHIP AND DIVERSITY

134.   Women's concerns about the media extend beyond ownership to issues of control, representation and portrayal of women and girls and the lack of gender analysis in the realm of media content, policy and participation.

135.   Communications play a major role in deepening our democracy, promoting a culture of human rights and non-sexism as key pillars of transformation of our society. The recommended media appeal tribunal will go a long way in ensuring that vulnerable individuals and groups have recourse in cases of unfairness and lack of objectivity in reporting.

136.   There has been progress in increasing participation of women as part of historically disadvantaged individuals (HDI) within the broadcast media. This has been as a result of regulation of this section of the media requiring ownership diversity as prerequisite for licensing. This has however not been the case with regard to print media which is currently unregulated by law. Avusa has highest HDI representation at 25% followed by Media24 at 15% while Caxton and Independent has 0% ownership share for HDIs. There is a need for further analysis of the current media ownership stake transferred to HDI to determine the extent of the role of historically disadvantaged women.

137.   The 'Glass Ceiling' survey conducted in line with SADC Protocol on Gender and Development indicates that there is still lack of career paths identified for women and inadequate gender policies. While there was high proportion of women in the media in general (50%), these figures are not reflected at decision making (top management - 25%). High number of women in the media is employed on part-time or non-permanent basis (61%). Many women are confined to support departments (human resources – 74%, marketing/advertising – 61%, administration – 59%).

138.   The Glass Ceiling report further highlighted that discriminatory practices, structural inequalities, cultural factors, prejudices, patriarchy and sexism continued to plague South African newsrooms to a greater or lesser extent.

139.   Global Media Monitoring Project and Gender and Media Baseline Study (GMBS), conducted in Southern Africa demonstrated that women constituted less than 10% of news sources in the economics, politics and sport categories. Men constituted 92% of all those assigned to the sports beat.

Recommendations

140.   There is need for greater effort to be made to improve the gender make-up of management, production of content and the composition of the workforce employed in these industries.

141.   The ANC should call for the development of a transformation charter for the media with gender targets on ownership, management and control, employment equity, skills development, preferential procurement, enterprise development and socio-economic development; as well as encourage the introduction of gender studies into the curriculum of communication/media/journalism courses.

M. WOMEN AND ICT

142.　　　While there is recognition of the potential of ICT as a tool for the promotion of gender equality and the empowerment of women, a "gender divide" has also been identified, reflected in the lower numbers of woman accessing and using ICT compared to men. However, the gender dimensions of ICT- in terms of access and use, capacity building opportunities, employment and potential for empowerment should be explicitly identified and addressed. ICT can be a powerful catalyst for political and social empowerment of women and the promotion of gender equality.

143.　　　In addition to physical access to the technology and the ability to utilize it, access refers to the ability to make use of the information and the resources provided. The factors identified as constraints to access and use i.e. poverty, illiteracy, including computer illiteracy and language barriers are particularly acute for women. Women's access to and use of ICT is constrained by factors that go beyond issues of technological infrastructure. Socially constructed gender roles and relationships play a key role in determining the capacity of women and men to participate on equal terms in the formation society.

Recommendations

144.　　　Important steps to be taken include, among others: the need for **public access centres for women in the rural areas in particular where training can be provided**; small business stimulation, create networks and support, increase income and access to employment for women as well as participation in the formal economy and workforce at higher levels and with higher pay.

N. WOMEN'S MOVEMENT

145.　　　Informed by the understanding that the women's struggle should be mass based, the ANC at its 1997 Mafikeng Conference, noting concerns about gender equality and the need for a broad women's movement operating within the broad front for transformation, resolved that:

"The ANC should in conjunction with its alliance partners; convene a National Conference on gender and women which shall discuss the formation of such a broad women's movement. Such a conference would amongst others make proposals on the form that such a women's movement should take; how it will be formed; what its role will be, and where the funding will come from. Such a conference should b convened soon".

146.　　　This conference was successfully launched in 2006 in Mangaung and the **Progressive Women's Movement** launched involving a broad range of women organizations from different parts of the country representing different women's organizations, non- governmental organizations and community based organizations.

147.　　　In this regard, the 2006 resolution of the Progressive Women's Movement of South Africa are very crucial. Among other things, the Progressive Women's Movement proposed that:

• Women should work in partnership with women in all sectors for social transformation;

• The development of young women must be prioritized, with young women included in progressive structures;

• The promotion of gender equality and strengthening of the gender machinery within government, the legislature and within civil society must be emphasized; and

• That the conference noted the challenge is to reach out to rural women and other women's formations at a local level.

Recommendations

148.	Again as mentioned earlier, the women's struggle is a national struggle hence the importance of commitment to national obligations and organisations. In this regard South Africa is currently hosting the Pan African Women's Organisations and it is very important that leadership is provided to strengthen PAWO to foster a broad women's movement at a continental level.

149.	At a national level, strategic leadership must be continued to be provided to social formations established by the ANC such as SAWID, Malibongwe, PWMSA and other women's organisations, in order to coordinate, monitor and inform its policy directions and to ensure mass-mobilisation within the country for a broad women's movement.

O. WOMEN'S MINISTRY

150.	The gender machinery, that existed prior to the establishment of the women's ministry, was unable to adequately respond to the programme, policies, the needs of women and institutional preparation for women in critical positions. Experiences from women's ministries from Chile and Tunisia have provided useful lessons on the strengths and weakness of the approach.

151.	The ANC's 52nd National Conference had resolved that there should be a thorough assessment of all the available instruments, including their relevance, strategies and areas of focus, on matters of women and that such an assessment should guide whether there is a need for any more institutional mechanisms to be put in place, or not.

152.	The assessment was done and indeed there was agreement that this ministry was necessary, hence the ministry for women, children and persons with disabilities.

153.	The investigations confirmed that there is a need to streamline and consolidate all interventions and programmes aimed at changing the socio-economic and political landscape on gender issues. Abundant evidence exist showing a multitude of private, public, community-based and non-governmental institutions and formations that conduct work on women's matters. The challenge with this set-up is a lack of coordination of these efforts. This explains, to a large extent, the partial rather than total achievements in this field.

154.	The creation of the national institution, the Women's Ministry, is meant to strengthen the existing uncoordinated national gender machinery at the **highest level of government**, with clear defined mandate and authority, adequate resources and the ability to influence policy, formulate and review legislation that would potentially assist in the fight for the total emancipation of women.

155.	Taking the lessons from Chile, for example, the country managed to achieve equal representation of both genders in cabinet. The biggest challenge facing the country with regard to women matters is the class-divide among women.

156.	As a way of tackling the problem of gender inequality, the people of Tunisia went back to instituting and improving the definition of the women's role within the family. The role of women and their rights within the family was reshaped to ensure that there are equal responsibilities between the genders in the household. Their view of women empowerment was based on the principle of gender equality, respect for women's rights and equality shared responsibility in the conduct of family affairs.

157. With this approach, it has been reported that the status of women was raised to the status of fully-entitled partners within the household. This has also lead to other spin-offs, such as the raising enrolment rate of women in schools. During 1995-1996, the enrolment rate among rural girls aged between 6 and 12 years was 89.4%,41.7% for girls attending primary school, and a 44%rise in secondary school enrolment. Noting the rise in enrolment among women, the school curricula were changed to anchor the principle of gender equality at a young age.

158. The Women's Ministry in South Africa, informed by our specific context, was envisaged to focus, among other things, on developing a thorough understanding of women matters in South Africa. This would be necessary for the Ministry to be able to ensure that women of all social status are included in the policy decisions and programme design processes. Failure to observe this could potentially lead to class differentiation among women. The Ministry is also envisaged to coordinate and monitor the implementation of projects/programmes aimed at women's empowerment.

159. A number of policy guidelines, legislative frameworks and institutions doing credible work on women matters exist in South Africa. However, lack of coordination of these efforts renders them ineffective, or only partially beneficial.

160. We await a clear policy position as to how the Ministry will propose to package the gender mainstreaming machinery, including clarity on the roles and responsibilities between the Ministry and the Commission for Gender Equality. This must take into consideration the general recommendations contained in the Ad Hoc Committee Review Report on Chapter 9 Institutions that "the Committee believes that in the interim a strong and effective [Gender Equality] Commission acting on its own is absolutely necessary for the transformation of gender relations in our country", including:

• While empowering women in the broader society, their roles and responsibilities within the household should not be diminished, but rather the extent of support should be cognizant of the dual role;

• Offer critical support for women in poverty; The ANC through government should ascertain that women in different social situations are catered for, not only through social development, in terms of grants, but also by addressing their need for growth as women and their participation in the development programmes;

• Forge links between NGO's and CBO's currently focusing on women matters. There is a need to coordinate and consolidate administration and information sources pertaining to women issues. In this way, the Ministry would not have to implement programmes or projects, but form links with institutions dealing with such issues on the ground. There is a great need for coordinated interventions and also ensuring that proper support is offered; and

• Develop and perform policy analysis, review and formulate legislation in accordance with the Ministry's areas of focus. This means that the Women's Ministry must develop gender policies in line with development interventions desired for the broader society, taking cognizance of the needs of both rural and urban women.

This is one of the key areas that the National General Council would need to pronounce on in order to further strengthen the work of the Women's Ministry.

Recommendations

161.   There is therefore a need for coordination and ensuring that all available programmes are looking at addressing the problem holistically. This would also ensure that no duplication of previously undertaken processes takes place.

162.   It is key that this aspect be elevated into an Act that clearly defines the institutional mechanism for gender transformation. The development of the Gender equality Act must therefore be accelerated.

P. CONCLUSION

163.   Like the brave patriots of 1956, we are saying to the 2010 National General Council of the African National Congress, 16 years into our cherished democracy: "We shall not rest until we have won for our children their fundamental rights of freedom, justice, and security".

164.   The Women's Charter clearly stipulates that women do not form a society separate from the men. There is only one society, and it is made up of both men and women. The founding members of the Federation of South African Women embraced their male comrades by acknowledging that there is only one society, and it is made of both men and women.

165.   Gender inequality and other patriarchy related social ills should continue to be an integral part of the transformation agenda of the African National Congress and its alliance partners. As a collective, we have a long walk to sustainable gender parity and together we can do more.

166.   We support the proposed Gender Parity Bill and expect the Minister of Women, Children and People with Disabilities to give it the priority it deserves. Admittedly, the impact of our laws and policies will be evaluated against the quality of life of all women of South Africa, especially those in rural areas and other impoverished sections of our society.

167.   We are striving for a better life for all women!

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