SUBMISSION TO:	**PARLIAMENTARY PORTFOLIO COMMITTEE ON HEALTH**
CHAIRED BY:	**THE HONOURABLE, THE MP, MS MARY-ANN DUNJWA**
COMMITTEE SECRETARY:	**MS. VUYOKAZI MAJALAMBA**
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SUBMISSION BY:	**THE SOUTH AFRICAN MEDICAL RESEARCH COUNCIL (THE "SAMRC")**
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REQUEST TO APPEAR AND ADRRESS THE COMMITTEE:	**YES (DESIGNATED TEAM TO BE ADVISED TO THE COMMITTEE SECRETARY IN DUE COURSE)**

IN RE: COMMENTS ON THE NATIONAL PUBLIC HEALTH INSTITUTE OF SOUTH AFRICA ("NAPHISA") BILL, [B16-2017]

1. OPENING REMARKS

1.1 We note the purpose of the NAPHISA Bill which is described as ***"To provide for the establishment of the National Public Health Institute of South Africa in order to coordinate, and where appropriate to conduct, disease and injury surveillance; to provide for specialised public health services, public health interventions, training and research directed towards the major health challenges affecting the population of the Republic; and to provide for matters connected therewith."***

1.2 We welcome and appreciate the opportunity to provide input on the efforts to improve the capability of South Africa in tracking and monitoring (surveillance) and intervening in health challenges that affect the population of the Republic.

1.3 It is our understanding that imperative that the Bill is intended to address is to provide a rapid response mechanism to disease outbreaks and health emergencies. In this regard, the NAPHISA is said to be modelled on the American Centre for Disease Control ("CDC"). In contrast, the SAMRC is said to be modelled on the American Institute of Health ("NIH"). There is an appreciable amount of overlap between the CDC and the NIH, but there is also stable and sustainable demarcation of primary focus areas for each. If true to the analogy set out in this paragraph, it is to be expected that there would be some overlap between NAPHISA and SAMRC. However, it is also desirable that stable and sustainable demarcation of primary focus areas for each, is set out in the Bill so as to be able to determine if the overlap / differences would constitute a conflict or a balanced co-operation and co-existence between the two entities.

1.4 Efforts to co-ordinate and strengthen disease surveillance and public health services, training and research to address major health challenges in the country are a critical necessity.

1.5 The main source of funding to enable these (2) statutory bodies to perform their functions effectively is the South African National Department of Health, with the Public Finance Management Act being the guiding instrument. The challenge that the legislature would need to be seized with then, is, with regard to Budget and resource and fund allocation by Parliament towards the fulfilment of these similar functions;

(a) Whether or not there will be an **increase** in the total budget and allocation of funds awarded to the SAMRC and NAPHISA?; and/or
(b) Whether or not there be some form of **budget sharing** between the two entities?

1.6 The current fiscal environment may not be fertile for the establishment of a new entity. Therefore, the legislature may want to consider setting up a surveillance division within the SAMRC. This could consist of all the areas that cover surveillance currently housed within the SAMRC as well as additional areas that can be added as and when funds permit for the broader mandate of the NAPHISA. This approach could be adopted as an interim measure.

1.6 We thus, wish to highlight that in preparing the submission, it became evident that the proper context of refining the NAPHISA Bill must be considered in the light of entities already in existence in the Republic, carrying out similar mandates. Thus, we see the introduction of the NAPHISA Bill as a way of closing the gaps emanating from the constraints in both the focus and operation of those entities already in existence.

2. THE NEED TO AVOID DUPLICATION

2.1 We would like to highlight that the SAMRC, established by the **South African Medical Research Council Act, 1969** (Act No. 19 of 1969) and its continued existence further enacted by the Medical Research Council Act No. 58 of 1991, has a broad mandate to conduct health research. The objectives of the MRC are, "through research, development and technology transfer, to promote the improvement of the health and the quality of life of the population of the Republic and to perform such other functions as may be assigned to the MRC by or under this Act."

2.2 The Revitalisation of the SAMRC, from 2010-2012, has shaped the organisation towards more robust leadership and custodian roles in health research in South Africa. The Revitalisation plan endorsed the continuity of both intramural and extramural research covering the quadruple burden of disease in South Africa: HIV/AIDS and TB; maternal, new-born and child health; non-communicable diseases; and violence and injury.

2.3 The SAMRC contributes to the national health research initiative by supporting specialised Research Units and specific projects through open competition and capacity development funding opportunities, comprising its Extramural Programme.

2.4 The Revitalisation plan focused the 11 Research Units of the Intramural Programme on research that addresses the major burden of disease of the country and the associated risk factors. These Intramural Research Units are:

- Alcohol, Tobacco and Other Drug;
- Biostatistics;

- Burden of Disease;
- Centre for Tuberculosis;
- Cochrane South Africa;
- Environment and Health;
- Gender and Health;
- Health Systems;
- HIV Prevention;
- Non-communicable Disease;
- Violence, Injury and Peace.

2.5 Unique competencies and skills have been developed over time by these Research Units to conduct relevant health research. Some of the research activities include surveillance and strengthening health systems. Using examples, and not providing an exhaustive list, some of the public health contributions that have been made by the SAMRC include:

2.5.1 ***Impact of non-communicable disease surveillance and research***

- Research conducted in the SAMRC was instrumental in persuading the Minister of Health to introduce regulations to reduce the sodium content of certain foodstuffs. The SAMRC, in collaboration with universities, led the research that revealed that daily salt intake in South African adults was on average 7.8 grams for Black, 8.5 grams for Mixed-ancestry and 9.5 grams for White persons; of which 45.5%, 32.8% and 42.2% respectively were derived from processed food. These averages were higher than the 5 grams per day recommended by the World Health Organization (WHO). Bread and cereals were also major contributors to the daily salt intake from processed food in South Africans, with meat products, soup powder and brick margarine as other important sources of salt. Through successive demographic health surveys (DHS) conducted by the SAMRC, and through participation in global studies such as the INTERHEART study, the SAMRC demonstrated the harmful effects of salt intake on deteriorating blood pressure profile and risk of myocardial infarction in South Africa. The evidence, together with those independently generated by researchers at universities, and advocacy paved the way for the national legislation on salt reduction in foodstuffs.

- The Eastern Cape Cancer Registry is an established population-based cancer registry that contributes profiles on cancer incidence regionally and internationally. By tracking the incidence of all cancers that burden a population of just over one million people who live in eight rural magisterial areas of the former Transkei regions of the Eastern Cape Province, the changes in the distinctive cancer profile highlights are monitored. There are consistently high rates of oesophageal cancer and cervical cancer in this region. In addition, the incidence of breast cancer and prostate cancer has increased. Initial comparisons with other international population-based cancer registries suggested that the survival of cancer patients in this region was much lower relative to high-income countries.

- In 1996 the SAMRC set up the South African Community Epidemiology Network on Drug Use (SACENDU) with funding from the WHO. The purpose of SACENDU is to monitor trends in alcohol and other drug (AOD) use and associated consequences on a six-monthly basis from specialist substance abuse treatment centres and other sources. The system, which for over 15 years has received funding from the National Department of Health, has been used to inform substance abuse policy at local, provincial and national levels; to inform the siting of new treatment centres and prevention programmes; as well as the training of health care

workers. SACENDU has also been used as an early warning system regarding potential changes in drug use behaviour (types of drugs and drug combinations, modes of use, and user groups) that could occur in other parts of the country and beyond. SACENDU makes a substantial contribution to data used in completing the UN Annual Reports Questionnaire (Part III): "Extent and patterns of and trends in drug use" and has been used extensively as a platform to build capacity amongst researchers and others in Southern Africa in alcohol/drug epidemiology. More recently, it has been used as a model to guide the development of drug epidemiology networks in West Africa, particularly in Nigeria.

- The mortality trends produced by the 2nd SA NBD highlight the continued decline in mortality for HIV and TB, with non-communicable diseases coming to the fore and now contributing the highest number of deaths in South Africa. The study found that the overall NCD mortality rate decreased over time, but that there was a mix of increasing and decreasing trends for specific diseases. The profile of causes of death based on years of life provide the provinces with information about the conditions that need to be targeted with health promotion and disease prevention initiatives.

2.5.2 ***Impact of violence and injury surveillance and research***

- The SAMRC hosts the National Injury Mortality Surveillance System (NIMSS) providing, in partnership with selected Provincial Forensic Pathology Services, accurate and reliable data for a range of Government ministries and other injury prevention and research stakeholders across the country. The NIMSS injury mortality surveillance collaborations have focussed on clarifying populations most at risk and the circumstances to injury mortality, especially to firearm and sharp object homicide, adolescent homicide victimisation, homicidal strangulation, fire and burns death, traffic crash and pedestrian mortality and drowning. Since 2001, the NIMSS has had, for varying periods, full coverage in a number of cities (including Johannesburg, Tshwane/Pretoria, Durban and Cape Town), and from 2008–2014, full coverage for the provinces of Mpumalanga and Gauteng (excluding Pretoria). The NIMSS is currently being modernised using e-innovation, and is in a process of being refined in Mpumalanga as an e-NIMSS system where the reporting and management of mortality data involves electronic capture and collation for rapid, accurate dissemination.

- The SAMRC conducts injury mortality surveillance in collaboration with the Western Cape Department of Health to assess the impact of reducing firearm mortality through stricter gun control.

2.5.3 ***Impact of infectious disease surveillance and research***

- SAMRC led research was instrumental in refining the paediatric-related targets in the 2011-2016 and the 2017-2022 National Strategic Plan for HIV/AIDS, TB and STIs. Additionally, the three national surveys and one national cohort study, led by the SAMRC, were the first surveillance activities conducted in South Africa to monitor the short and long-term impact of the programme to prevent HIV transmission from mother to child (PMTCT). These surveys demonstrated a decrease in early MTCT to 3.5% in 2010, 2.7% in 2011-12 and 2.6% in 2012-13, and demonstrated that 18 month MTCT was 4.3%. Additionally, data were collected on key maternal and child health indicators. This research translated into national policy and guidelines on the re-testing of HIV negative women, strategies to prevent HIV transmission from mother to child, uptake of breastfeeding and breastfeeding support, uptake and quality of antenatal care and adherence to antiretroviral treatment. The results were discussed at provincial and district levels thereby facilitating dialogue at provincial and district levels, and resulting in the development of district implementation plans to eliminate HIV transmission.

- Analysis of the South African TB care cascade was undertaken by the US/SAMRC Centre for TB Research and, for the first time, quantified patient loss at each level of the care pathway. This information has been adopted by National TB Programme to target deficiencies and interventions. They also plan to use this framework prospectively going forward.

- Researchers have described the emergence and spread of extensively drug-resistant tuberculosis (XDR-TB) in both the Eastern Cape and the Western Cape. The follow up of patients with XDR-TB showed that the long-term outcomes were shown to be very poor.

- The SAMRC Health Systems Research Unit conducted the first evaluation of decentralised management of drug-resistant TB (DR-TB) and emanating from this, assisted in drafting the policy guidelines on decentralised and deinstitutionalised management for DR-TB. The SAMRC has also been involved in the TB Think Tank that supports the National TB Directorate and in defining the TB research agenda for the country.

- The GIS group has been part of the activities aimed at meeting the target of the WHO relating to malaria: *Getting to Zero by 2020*. The National Department of Health has been supported by participating in planning meetings in Southern Africa relating the malaria elimination across several countries in the region (ie South Africa, Mozambique and Swaziland), as well as participating in a network amongst these states to track progress, identify challenges and bottlenecks, share data and strategies in malaria elimination.

3. **POSSIBILITIES FOR EFFECTIVE COLLABORATION**

3.1 It is imperative to ensure complementary structures and activities to harness the limited resources and skills in South Africa and to avoid undesirable duplication and competition.

3.2 Collaboration at a project level and the sub-contracting of activities will drive the effective utilisation of scarce skills in South Africa. Appropriate contractual arrangements will be required to formalise such arrangements.

3.3 To help facilitate collaboration with the SAMRC, and other research entities, it would be ideal for the NAPHISA to establish its new domains as “National Programmes” that function as “institutes without walls.” They should engage key partners, particularly research councils and universities, through the development of a strategic programme of action and set up funding mechanisms to support collaborative and sub-contracted research activities. The NAPHISA would require a core team to drive the “National Programmes”.

3.4 There is a need for alignment with the National Health Act of 2004 in terms of co-ordination of research and minimising overlapping mandates. Firstly, Section 23. (1) (g) in Chapter 3 of the Act requires the National Health Council to advise the minister on an integrated national strategy for health research. Secondly, Section 69. (3) (d) in Chapter 9 requires the appointed National Health Research Committee to coordinate the research activities of public health authorities.

4. SPECIFIC OBSERVATIONS AND PROPOSALS

In response to and by addressing specific provisions of the NAPHISA Bill, we have listed our proposals. In addition, we have made comments on a word version of the NAPHISA Bill to reflect our alterations in the body of relevant provisions of the NAPHISA Bill.

Specific comments on the NAPHISA Bill

***Ad* Purpose of the Bill**

1. It is recommended that **"research"** be qualified so to minimise overlap in the mandate of the NAPHISA and the SAMRC. It is suggested it be changed to **"conduct related research."** We further propose that the following be inserted to the Purpose provision of the Bill before the phrase: "… ***and to provide for matters connected therewith."***
   "To establish a regulatory regime for co-operation, collaboration and hierarchy of precedence in the areas of work and relationships with Science Councils, Universities and Schools of Public Health".
   ***Ad* PREAMBLE**

2. **It is recommended that a third bullet be added:**
   "RECOGNISING the South African Medical Research Council's statutory mandate to conduct, fund, innovate and oversee health research; and it being not the intention of the NAPHISA entity to duplicate the mandate of the SAMRC;"

3. **It is suggested that "such as surveillance and research" be changed to "such as surveillance and public health interventions."**

4. It is recommended that a further bullet is added under the paragraph beginning with **"MINDFUL…":** Such additional bullet to read:
   "equitable sourcing, utilisation and retention to the scarce of skills and limited funding available from co-operating and collaborating entities; and"

***Ad* section 1: Definitions**

It would seem that the definition of **"public health"** was in fact intended to be **"public health service"**

***Ad* section 2: Establishment of NAPHISA**

5. It is recommended that (c) be changed to **"Occupational and Environmental Health".** This is proposed in order to encompass concerns about the impact of water quality, air quality, climate change on health, it is essential that appropriate surveillance systems are developed.
6. It is recommended that a **6th division described as "Evidence, Information and Policy"** be added to the list. We foresee that there will be a need for a cross-cutting division to provide policy research, cross-cutting health statistics and synthesis of information to address the specified functions of the NAPHISA.

***Ad* section 3: Functions of NAPHISA**

7. We propose that section 3(1) be amended to read as follows:
   "The NAPHISA must, on its own or where another public entity has concurrent statutory jurisdiction, then in consultation with such entity, must-"

8. **It is recommended that Environmental Health is added to the functions of the NAPHISA.**

9. **Given the critical role of cause-of-death information in disease surveillance, there should be a specific requirement to undertake mortality surveillance to inform local public health actions.** While Stats SA compiles official cause-of-death statistics, it is unable to provide the National Department of Health with identified information due to confidentiality requirements of the Statistics Act, thus restricting public health surveillance and actions. The NAPHISA would be well placed to connect mortality surveillance with other disease surveillance and ensure that the information can be used to inform public health actions at a local level.
10. **Given that the National Health Research Committee has the mandate to co-ordinate research in public entities, the wording of function (o) should be changed from** "**coordinate research and, where appropriate conduct related research** to inform policy and guidelines on communicable diseases, non-communicable diseases, cancer surveillance, injury and violence prevention and occupational health, and must develop processes for **dissemination of research findings to key stakeholders**" to "**utilise research** to inform policy and guidelines on communicable diseases, non-communicable diseases, cancer surveillance, injury and violence prevention and occupational health, and must develop processes for **dissemination to key stakeholders**."
11. In respect of 3(3)(z), we propose that the provision be altered to read:
"pay gratuities, form such Pension Fund entities or make such contribution as may be allowed under the Pension Funds Act and , 1957, as amended."
The reason for this proposal is that Pension Funds Act regulates the formation of Pension Funds which funds become juristic persons on their own right. Therefore, pensions would ordinarily be paid not by the Employer but by the Pension Fund, based on the particular rules of the fund and the category of membership (DC or DB) to the fund. There is no indication on the Bill that NAPHISA intends to, on its own, register as Pension Fund, hence it cannot be technically correct to make a provision for NAPHISA to pay pensions.

***Ad* section 5: Composition of the Board**

12. **Given the desired close working relationship between the SAMRC and the NAPHISA, it is recommended that the Bill provides for an SAMRC official / employee to serve on the NAPHISA Board.**
13. **Given the reliance on information that will arise in the NHLS, it is recommended that the Bill provides for an NHLS official / employee to serve on the NAPHISA Board.**
14. In respect of 5(1)(a), it is not clear from the Bill whether the official from the National Department of Health would be a deliberative and voting Board membership, or an observer Board membership. It is suggested that it be an observer membership so as to be consistent in demarcating the distinction between the role of the Accounting Authority (Board) and the Executive Authority (NDoH / Ministry).
15. In respect of 5(1)(d)and(e), it is proposed that a distinction be drawn between these two as Executive Board Members, as opposed to the others being Non-Executive in that they are not involved in the day to day running of NAPHISA.

***Ad* section 6: Appointment of Members of Board**

In respect of ***subsection 6(4), we propose that, consistent with other research councils, the term of Board membership be 3 years and the envisaged reappointment be limited to one further term.***

LEGAL AND COMPLIANCE SERVICES

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