WEDNESDAY, 12 MARCH 2026

____

PROCEEDINGS OF THE NATIONAL COUNCIL OF PROVINCES

____

The Council met at 14:02.

The Deputy Chairperson took the Chair and requested members to observe a moment of silence for prayers or meditation.

ANNOUNCEMENT

The DEPUTY CHAIRPERSON OF THE NCOP (Mr P Govender): Hon delegates, I would like to remind delegates that Rules, in particular subrules 21, 22 and 23 of Rule 103 would apply. In accordance with Council Rule 2291, there will be no notices of motion or motions without notice.

Before we proceed to questions, I would like to take this opportunity to welcome the Ministers from the Social cluster, specifically the Minister of Health and the Minister of Social Development. Hon Ministers, you are always welcome in the NCOP,

UNREVISED HANSARD

and we thank you for joining us here today. I also want to welcome all the permanent delegates, MECs, all special delegates and Salga representatives to the House.

I would like to remind delegates that, in terms of Rule 229 of the Council Rules, the time for reply by Ministers to a question is 5 minutes. Only four supplementary questions are allowed per question. A member who was asked the initial question would be the first to be afforded an opportunity to ask a supplementary question. The time for asking a supplementary question is two minutes. The time for reply to a supplementary question is four minutes. The supplementary question must emanate from the initial question. I now call upon the hon Minister of Health to respond to Question 25, as asked by the hon Fienies, and the question deals with the recruiting and/or retaining skilled staff.

UNREVISED HANSARD

QUESTIONS FOR ORAL REPLY

CLUSTER 2B - SOCIAL SERVICES

Question 25:

The MINISTER OF HEALTH: Hon Chairperson, hon members of the House, hon member, in your question, you are alluding to the

failure to absorb new medical graduates. I want to assure you that there is no failure at all. Every newly qualified medical student is placed to do internship in a hospital accredited for that purpose by the Health Professions Council of South Africa, HPCSA. This internship is statutory for all South Africans who have studied medicine.

Without internship, the life of a doctor ends abruptly. You cannot go into private practice. You cannot work in a public hospital. You cannot study further. You are simply stuck forever. For this reason, every South African who studied medicine has to do internship and the state is obliged to make money available for their salaries.

After they have completed the internship, which takes two years, they are then obliged to do community service. This was introduced early on in our democracy, because doctors had so many choices of jobs that they refused to go to rural areas. So, in order to make sure that every hospital in the country, whether urban and rural, does have a doctor, the concept of community service was introduced, whereby each doctor after internship will be obliged to do community service, which is also statutory.

UNREVISED HANSARD

And we made sure that this community service is never practiced in an urban area, but only in rural areas, sometimes maybe peri-urban areas, but not really in the centres of cities.

Now, the problem we are having about employment is not internship and community service, because those are statutory. Even Treasury knows about that. The problem we have is after community service, because then, in terms of the law, a doctor must then apply for a job just like any other graduate, any other. However, we have soon realised that society does not get used to that fact, but also because our populations are growing. We are trying our best to make sure that we advertise doctors' jobs, so that they don't remain unemployed.

Now, on the last question about whether we are using any measure to ensure that unemployed health professionals, such as doctors and nurses, are recruited to serve rural areas, I can assure you that is no longer happening. Yes, it used to happen some years back where people refused to go to any rural area. There is no doctor who will dare do that now, because jobs are in short supply. Any job you advertise, it does not matter in what part of the country, the health worker will have to pack and rush there, because that is a job.

UNREVISED HANSARD

So, we no longer ... Therefore, as I am speaking in front of you today, we have put together a team to review some of the HR policies that we used to have. One of the HR policies was something called rural allowance, where we had to pay health workers a special allowance for working in a rural area, because nobody wanted to go there. Now, we believe it no longer has a function, because not only doctors, but all health workers go wherever there is a job these days. Thank you very much.

Ms D W FIENIES: Greeting to the Chairperson and hon members. Thank you, hon Minister, for your response to my question. How effective is the department in distributing new qualified health care professionals to respond to service delivery needs?

The MINISTER OF HEALTH: Just come again.

Ms D W FIENIES: How effective is the department in distributing newly qualified health care professionals to respond to service delivery needs? Thank you.

The MINISTER OF HEALTH: Oh, sorry. I can assure you without any equivocation that we are very, very efficient in that regard. We start as early as February. Even now we have started for next

UNREVISED HANSARD

year. We get a list of all the final-year medical students from our universities, and we start placing. It is very difficult, because even though I am saying doctors go anywhere because it is a job, they prefer urban areas. And I can tell you with my eyes closed, they choose Cape Town, they choose Johannesburg, they choose Pretoria. After that, you start having a bit of a problem. They will tolerate eThekwini, Gqeberha and East London, etc. From there, it is a disaster.

All of them want to be crowded in one area. Remember, those central areas are the areas that are accredited, mostly by the Health Professions Council of South Africa, because that is where the equipment is. You cannot do internship in an area where there are no senior people and there is no equipment, because what are you going to learn? So, they crowd in those areas.

So, what we do, we give them three choices. This is choice number 1, choice number 2, choice number 3. Some, when they come to choice number 3, they already refuse. But after the three choices in the first round, we give them a chance to lodge a complaint. It might be a complaint. Some of them lodge it on religious grounds, others on social grounds. They say that I

UNREVISED HANSARD

have a mother who is very sick and is about to die. I cannot leave this area. I am the only one taking care of her. I am just giving you an example. Some quote marriage, you know, and many other social things as to the reason why they cannot take the choice we have given them. However, in the final analysis, we complete that. And by September every year, the young, newly qualified doctors must know where they are going to acclimatize themselves.

We have been able, I must accept, after many years of trial and error, to finally get it right. For the past two to three years, by September, they already have letters of appointment. So, that system is very effective, because people got used to it and they know exactly what happens.

However, I must warn, we have people who prefer not to work for six months because the intake for internship is in January and the second intake is February. Some, obviously, those who come from richer families who can go without a salary, prefer to wait that six months for the second round, until they get the place they want. But they will not say so. They will come to you and the press and say, I have not been placed for a job. And of

UNREVISED HANSARD

course, you will always believe them, because we will always get attacked.

There is nobody will say there is a job, but I don't want to go there. They will say, I have not been placed. Many of them go to their unions. They have lots of unions who go to the press and the press always writes about the state lying. But I want to assure you, internship is statutory. We cannot afford to have an intern not working, because their life will come to an end. And that is the biggest evil that we can ever do to anybody. Thank you very much.

Mr M BILLY: Deputy Chair, Minister, very troubling and contrary to what you are saying, provinces like KwaZulu-Natal still have a number of unemployed, qualified doctors who are protesting. Now, the question also raises other challenges, Minister. And the follow-up question to you is, in 2009, the staff of Chris Hani Baragwanath Hospital had a meeting with you about - this is over 10 years ago - staff related issues. However, your response make it sound like it is a new issue. Why did the department not do more at the time? The question to you, Minister, is that there were issues that were raised with you by the staff of Chris Hani Baragwanath Hospital in 2009, 15 years ago. Why have

UNREVISED HANSARD

you not done more to address some of those challenges raised at the time at a meeting that you had attended at that hospital?

The MINISTER OF HEALTH: I am not sure what you want. I have just told you that over time, we perfected this system, because of meetings like those where we met doctors, and where they told us their problems. Now, we eventually designed an electronic system of placements. That is why I can stand here confidently in front of you and say each and every intern is placed. As to whether they would like to go there, that is the second question. But we do place them. We make sure that they have got a job.

It is true that in KwaZulu-Natal, doctors toyi-toyied and elsewhere. And two weeks ago, because of this problem, I asked to meet the Premier of KwaZulu-Natal, the MEC for Finance, and the MEC for Health. And we spent four hours with them and their teams. This is one of the things that we are discussing with them. We discuss how to solve them and how they affected the health care system.

So, we did. So, about your 2009 question, surely you cannot accuse me for not having done something some years ago, when it has been resolved. I am telling you now that it has been

UNREVISED HANSARD

resolved. In September this year, every medical student who is a South African will get a letter about their placement. That I can assure you, as it happened this year. You never had any intern complaining at the beginning of this year, because they were placed last year.

And unfortunately, last year, I must concede, we placed them in October, not in September, because KwaZulu-Natal was delaying. That is why I had to go and see their premier, to show them the effects of that delay. Because of their delay, we only placed them in October. By October, they already had their letters. Thank you.

Ms M SIWISA: Deputy Chair, Minister, despite the means to recruit more nurses and staff, it cannot be addressed without having proper health facilities, especially in rural areas. The question that comes to mind is, are our health practitioners equipped to handle the advanced equipment? What plans are put in place to ensure that our health practitioners can operate the latest equipment, despite them being recruited to work in rural areas?

UNREVISED HANSARD

The DEPUTY CHAIRPERSON OF THE NCOP (Mr P Govender): Hon Minister, that question does not really relate to retention and appointments, but if you want to answer that, you may answer it.

The MINISTER OF HEALTH: I can answer it. Hon member, it depends what equipment you are speaking about. Therefore, we have four types of hospitals in the country. We have the district hospital. That is the smallest hospital you can ever have in the country. We have the regional hospital. Those are the hospitals ... Unfortunately, the terminology seems to be confusing. Those are the biggest hospitals in each of the 54 districts of the country. We call them regional hospitals. Then we have the tertiary hospital. That is the biggest hospital in that province. Then we have central hospitals or academic hospitals. Those are hospitals attached to medical schools where doctors are trained.

We have none. We have two of such hospitals in the Western Cape. We have one in the Eastern Cape. We have two in KwaZulu-Natal. We have four in Gauteng, but we have none in Mpumalanga. We have none in Limpopo. We are just building it and it is at 40% completion. We have none in North West, we have none in Northern Cape.

UNREVISED HANSARD

Now, those 10 academic hospitals are the ones where you find sophisticated and very expensive equipment that can only be operated maybe by professors. For instance, with equipment such as magnetic resonance imaging, MIR, can see a tumour in your brain with the size of a head of a pin. It is not every doctor who can operate that. You need to be highly trained as a specialist radiologist in order to do that.

So, you will not go to a small district hospital and find a MIR machine. It has to be where they are well-trained people, but we do have what you call, point-of-care technology, as technology gets advanced, which you can even put in a clinic, for instance, to diagnose TB. It used to take us many weeks. even up to months just to diagnose TB, but since a GeneExpert technology, you can put a small GeneExpert machine even in a clinic. All the nurse needs to do is to get your sputum, put it in the machine and wait for results. In the past, you needed a specialist to get to your sputum, do what is called a spectrum culture, do what is called Gram staining, and look into the microscope to see those organisms. Only a well-trained eye could do that. But as technology moves, that has passed.

UNREVISED HANSARD

So, the answer to your question, it depends on the level of technology. And you cannot put a very highly sophisticated technology in a hospital where there is no trained staff member or there is no trained specialist for that technology. However, you can put a point-of-care technology even in primary health care clinics and centres. Thank you very much.

Ms T BREEDT: Hon Deputy Chair, hon Minister, you have said a lot and everything is quite worrying. You have spent a lot of time talking about how we place interns. And I can still to this day tell you from experience and from people that it is not so easy and so clearcut and so effective as you yourself are admitting to this House today. Let me get back to the initial question. And it was, how do we retain staff and how do we absorb the new medical staff? And my problem is, I come from the Free State. It is very rural. We have a problem with retaining our medical professionals in our rural areas, in Qwaqwa at Boitumelo Hospital, to list all of those. And one of the main reasons is due to poor infrastructure, bad infrastructure, telephones not working, equipment not being up to date, certain operations that cannot be done, because we don’t have the technology in those district hospitals or in those clinics or wherever. So, my question to you is: What concrete steps are you and your

UNREVISED HANSARD

department taking to ensure that we are upgrading these facilities in our rural areas, to assist our doctors and to help retain them? I think that is our biggest problem. They don't want to work there because they have nothing to work with. I thank you.

The MINISTER OF HEALTH: Hon Chair, hon member, I can assure you, and I insist, the system of placement of interns is working very well now. What I cannot guarantee is to put an intern where they like to be. That one is difficult, because I told you about the fight for particular places. I know interns from here, in the Western Cape, particularly, who were known to wait for six months and not work at all for the next intake because they don't want to leave Cape Town and go elsewhere. That one we cannot solve. And I have alluded to that, but we are able to place each one of them. At the moment, they are close to 2 800 who qualify every year. We are able to place them.

Secondly, we are also able to place those who have completed their two-year internship and do community service. And I have considered that the problem starts after community service, because it is no longer statutory. It is a person who go for a job like any other profession, who must look at the newspapers

UNREVISED HANSARD

for a job that is advertised and apply for it. That is how the system works.

Now, about the issue of having no equipment and all that, hon member, you know, we discuss that issue every day when we meet with MECs. Everybody believes health is a concurrent competence. And they will say it is concurrent, meaning it is practiced nationally and provincially. I want to assure you; there are four functions that are never concurrent. They are pure provincial competencies. That is HR, who you hire and where you put them and all that. It is not concurrent. It is a pure provincial function. It works like that in Health and even in Education.

The second thing that is never concurrent is financial management of equitable share. Once the money that you read in equitable share is sent to a province, I have no control over it. The province can say whatever they want to do with it. The third thing is procurement. I don’t control procurement in any province except to nudge. And the fourth one, as you are saying, is maintenance of infrastructure. We try our best to make sure that we discuss these issues when we meet in the National Health Council, which is our Health MinMEC, because it is a problem.

UNREVISED HANSARD

And we have tried in the NHI Act to reverse this type of things, because over the years, we have seen how problematic they are - the federalisation of health.

And yes, I was also a doctor and I know, I have always informed them. Please, put good infrastructure, even accommodation. Many young doctors are attracted by accommodation. If the accommodation is good, there is TV, even good food, I can assure you, you may believe it is a small thing. I remember, when I was in my final year, I spent two weeks at Nongoma Hospital and I was alone. Sorry, there were two of us medical students. There were no doctors there except one army doctor. It was very comfortable to stay in Nongoma, because they gave us good accommodation and good food. You are always looking forward. And you realise here I can serve.

So, it is small things like that which sometimes provinces just ignore that makes doctors to go away. And we discuss them every day and we keep on doing that. Thank you.

Question 41:

The MINISTER OF HEALTH: Hon Deputy Chairperson, yes, the hon member is asking that now that in the past decade that the

UNREVISED HANSARD

leading causes of morbidity not mortality that they are changing. The hon member is very right. The leading causes of morbidity in our countries is changing. Ordinarily, in underdeveloped countries like ours and countries in the Global South, it was generally known that morbidity is caused by communicable diseases like HIV/Aids, Tuberculosis, TB, Malaria and Cholera. All the infectious diseases are known to be the leading causes of morbidity in developing countries.

Whereas in the Global North, in highly developed countries, the pattern is the other way round. They are generally suffering from noncommunicable diseases like high blood pressure, stroke, cancer, diabetes, and chronic respiratory illnesses like Asma.

Now hon member, a developing country like ours are undergoing what scientist call epidemiological transition. We are in a middle of a transition meaning that we are starting to get the diseases that were regarded as diseases of rich people in the Global North who are also starting to get them. So, while we are used in South Africa for instance to be having the highest rate of HIV infections, but we can now pick up that cancer is developing very fast and becoming our new HIV/Aids and is killing our people. Diabetes is developing very fast. High blood

UNREVISED HANSARD

pressure is also developing very, very fast. So, we are in the middle of that transition meaning we need to change certain things. What do we do? For your next question is measures that we are taking to strengthen confidence in the public health service.

Hon member, there are measures taken to control diseases. The top of the range is prevention and control especially of noncommunicable diseases. The mainstay of solving cancer, diabetes and high blood pressure is to make it not happen. For that reason, it needs prevention of diseases and promotion of health, screening early detection.

Secondly, we do the screening every time and around this time. Cancer, hypertension, diabetes, etc. These activities are supported by community health workers. I am happy to announce to you that since December last year, we are in a process that must end at the end of March to absorb 27 000 community health workers and make them permanent. For previously they were coming through NGOs.

UNREVISED HANSARD

We are also implementing a mass communication strategy. If you watch TV these days, we have quite a number of adverts about stopping these diseases in the mass communication.

Thirdly, we have a programme called Central Chronic Medicines Dispensing and Distribution, CCMDD, to try and reduce a number of people who have to queue every day. People who are on chronic disease especially, HIV/Aids and TB who are sort of stable who do not have to be seen by a doctor. We discourage them from coming to hospital every time. How do we do that? They give us an address of an area where they can collect their treatment that is why it is called the Central Chronic Medicines Dispensing and Distribution. We give their names and medicines to the service provider who packages the medicine, look at the address and go to deliver it there. As I speak in front of you, 3,5 million South Africans are on this programme of Central Chronic Medicines Dispensing and Distribution.

We have just implemented a new programme called Six-Month Multi-Month Dispensing, SixMMD, where people have to go to a clinic or hospital only twice a year because we give them their treatment which will keep them for the whole six months.

UNREVISED HANSARD

The last issue we are doing, which is the centre of controversy and war coming to you soon. It is control of things like sugar, salt, smoking and alcohol. When we do that because we know their effect on human health, we start fighting with people because some are lobbied about them. Loss of work and collapse of factories and all that – I am saying it is coming to you because we are debating a Tobacco Bill and we are going to hear all these stories. However, we know that tobacco has 7 000 chemicals. When you light a cigarette, it produces 7 000 chemicals. Seventy of them have proven to cause cancer. Thank you. [Time expired.]

Ms N S DU PLESSIS: Hon Deputy Chairperson and hon Minister, thank for that answer. It seems that a lot has been done. However, in the past 20 years, noncommunicable diseases have increased by 58,7% in South Africa. I also think that using a developing country or the fact that we are a developing country as an excuse is not enough of an excuse when countries like Spain in the 1950s were seen as developing countries and within 20 to 30 years of shifting their health care system they were able to exponentially decrease noncommunicable diseases as less, as well as trauma related diseases. This works when a public

UNREVISED HANSARD

health care system is run by Ministers who implement international best practice.

Hon Minister it is a difficult question to ask. However, how can South Africans trust a public health care system that is not improving in morbidities with the Minister leading it? Thank you very much.

The MINISTER OF HEALTH: Hon member, I do not know what excuses you are talking about. I gave no excuses. I gave you facts. These facts were given I think at the United Nations in 2015 where they put two types of diseases together, country-by-country to show which country is suffering what pattern of a diseases. It came very clear, that the Global North countries are suffering from diseases of lifestyle, diabetes, etc. The Global South are suffering from diseases of infection. That has been outlined at the United Nations, UN. It is not an excuse; it is a fact.

Now, even at that time South Africa was already straddling in the middle. We were already going through this transition. It was starting. Now we are in middle of that transition. That is why we are doing something about it. I do know understand why

UNREVISED HANSARD

you say it is an excuse. We are doing something about it. We are saying instead of waiting for instance for people to get cancer, let us look at things that cause cancer. Number one of them is smoking. Let us control and regulate it. For we know as I was about to finish here hon Deputy Chairperson, I ran out of time. I wanted to illustrate this: Here we have a cigarette which when lit releases 7 000 chemicals and 70 of them cause cancer. Why should we go on with that type of thing when we know that treating cancer is so difficult and expensive?

Then comes diabetes, then come things caused by alcohol, etc. All those things, we are putting in front of you and say hon members, help us in controlling these things. Why are we now having a new Tobacco Bill when there was a Bill passed by the first Minister of Health in a democratic South Africa, Dr Nkosazana Dlamini-Zuma? It is because after she came with that Bill, industry found something else. They found new ways of nicotine delivery called vaping. You know the vaping thing killing our kids. They now say no, the Act does not say vape, it says cigarettes. So, we are coming back to say let us include the vapes because they are destroying our people.

UNREVISED HANSARD

Then salt. High blood pressure is mostly driven by salt which also cause kidney diseases. So, we started long ago. It is not now; we started long ago and called industry. We found out that South Africans are eating four times more salt than their body needs. So, they are eating what their boy does not need but what they desire and not what is necessary. We gauged in which food staffs do we find salt. Six food staffs were identified.

The first of them was bread. Many of us would not even know that bread has more salt than it supposed to have. Then it was brine in chicken. Then it was soup, spices and things like peanuts and all other things. So, we called industry and said to them please you are going to destroy our people.

At that time in Gauteng only, there were 500 people waiting for dialyses because of kidney damage. We said please control the amount of salt. They said no Minister; we give it to you to regulate us. For the smaller ones will hide behind the bigger ones. We regulated it and agreed with them that we will reduce salt in those food staffs or every three years and over a nine-year-period we have done so. Bit-by-bit we were reducing so that people do not riot when they believe they are eating saltless food. And we have arrived there.

UNREVISED HANSARD

In September last year, the United Nations by the way gave us a price for that. At the UN in New York, we received a prize for the work done for reducing salt because we are dealing with noncommunicable diseases. Thank you very much.

The DEPUTY CHAIRPERSON OF THE NCOP (Mr P Govender): Hon Minister, that was a very good information for us to take back.

The next follow up question is from the hon Feni.

Mr M FENI: Hon Deputy Chairperson and hon Minister, thank you very much for capacitating and empowering responses.

IsiXhosa:

Mphathiswa, ihashe ungalisa emlanjeni kodwa ukuba alifuni kusela soze lisele.

English:

Hon Minister, is there any improvement in service delivery since the implementation of the National Strategic Plan for the prevention and control of noncommunicable diseases? Thank you very much.

UNREVISED HANSARD

Hon Minister, please come again.

The MINISTER OF HEALTH: Hon Feni, did you say noncommunicable diseases?

Mr M FENI: Hon Minister, I said noncommunicable diseases.

The MINISTER OF HEALTH: Alright. Yes.

The DEPUTY CHAIRPERSON OF THE NCOP (Mr P Govender): Thank you very much, hon Feni.

Hon Minister, your response please.

The MINISTER OF HEALTH: There is somebody here who believe you gave me these questions before. I heard that in the National Assembly. You cannot just believe that we know answers to these questions. I heard a similar thing. Nobody is given answers before. That is why even everybody from any party can ask a question. I am inviting you to do so. We will answer them. If we do not know we will tell you that we do not know. We will not lie. Yes.

UNREVISED HANSARD

Alright. Thank you.

Yes. Anyway look, there is progress, but it is very slow all over the world. Hon member, it is a problem.

Noncommunicable diseases are lifestyle diseases. Noncommunicable disease do not really have a direct cause. We actually gave them a nickname and said they are diseases of five-by-five because they are mostly five. The factors that encourage them not directly cause them are also five. The noncommunicable diseases are high blood pressure, diabetes, cancer, mental health and chronic respiratory diseases. The factors that drive them are also five. Top of them is cigarette. Smoking followed by alcohol. Then diet as I mentioned sugar or salt. Then you also have environmental factors. The environment in which you are staying.

Now those things are very difficult to change because they are entangled in people's lifestyle. For instance, we cannot burn sugar because it is needed in our bodies. However, the problem is the relationship with sugar which has changed. What do I mean by that? Hon members, when we grew up, some of the sugars we use to see them only on Christmas. Those who are my age will

UNREVISED HANSARD

remember we only saw exa squash drink only on Christmas. Do you remember exa squash drink? Yes, then you will see it the next Christmas.

These days you go to a funeral and wedding you are served soft drinks. You are at Parliament after meals you are served soft drinks. People do not know that those soft drinks are dangerous, and they ask you when did they become dangerous? A 300ml tin of Coca Cola can has 12 teaspoons of sugar in it. If you now go home and find your child hiding behind the house with 12 teaspoons of sugar in the hand licking them, you are going to assault them when you were at Parliament and you took the Coca Cola can and swallowed 12 teaspoons of sugar. However, you are going to shout at the child and say ...

IsiZulu:

... uyasangana wena, wenzani?

English:

You know, these are problems we are faced with, and the world is faced with.

UNREVISED HANSARD

Let me tell you where our fear is. We had the pandemic of HIV and Aids. We got a lot of help from other countries. The US President's Emergency Plan for Aids Relief, Pepfar, even if they pulled out, they did help us for 20 years, the global fund, etc. I can assure you when it comes to noncommunicable diseases there is no country that will help you. No country that is going to give anybody money to deal with diabetes, cancer or high blood pressure. It is not going to happen. That is why we need to solve the problems now because we are not going to get help like we did with HIV and Aids, especially in that they are not communicable. With HIV and Aids, countries help you sometimes not because they love you but because they are scared you will infect them like you saw what happened during COVID-19 where we had to close borders and all that. So, they only help you for that. Why should anybody help you when you are diabetic it is yours only. You are going to go down alone not with any other person on your own. That is why we need to be very careful how we deal with these diseases. Thank you.

Mr M M MAMPURU: Hon Deputy Chairperson and hon Minister, you have partially responded to my question. However, I would request that you give further clarify on whether despite existing policies and awareness programmes: Which specific

UNREVISED HANSARD

interventions have you implemented in the past five years to reduce the burden of noncommunicable diseases in the public health care facility and whether you have conducted any assessment to determine why these diseases remain prevalent among the poor and working class communities who rely on the public health care system. Thank you.

The MINISTER OF HEALTH: Hon Deputy Chairperson, let me start with the last part of the question.

Why they affect poor people? It is because you know trying to solve the noncommunicable diseases can be expensive. When treatment is started - do not eat this eat that. Now you can choose, poor people cannot choose if you understand what I mean. They eat what is available and not what the doctor has told them to choose. That is where the key to the problem is. That those who are well to do have a choice and those who do not eat whatever is available. Even when they are told that look - you are not going to tell a poor person not to drink Coca Cola or soft drinks. If they are served at a wedding, they are going to drink it. You are not going to tell them not to drink excessive alcohol, if there is alcohol bottle at a party and all that they

UNREVISED HANSARD

are going to drink it. That is one of the problems we are faced with. That is why we must go on a good communication strategy.

Now you asked what we have done in the past five years? I have just told you before that we reduced the amount of salt in six food stuffs. We are very proud of that. For it has reduced a number of people who get high blood pressure, kidney diseases, strokes, etc. We have done that.

We also came with a sugar levy. We were attacked because people said we are raising funds by taxing people. The sugar levy was not for raising funds. We do not even care much about that money. It was for discouraging people taking a lot of sugar as I have told you. For sugar is becoming a new poison to our people. Unlike in the past when sugary things were so scarce. So, we have tried to tax it.

Hon member please just get into a supermarket and see what has changed there, which you have to deal with. In the past we use to get into a supermarket fill your trolley and go directly to the pay point and pay. Now it no longer happens like that. It looks like a decoration; it is not a decoration. They want to Pavlov you. When you finish filling your trolley you move in the

UNREVISED HANSARD

passage this way and that way until you reach the till. Just look what is there in that passage. It is sugar which on your list of groceries is not there but they Pavlov you. Pavlov is a Russian scientist who came with what is called conditioning. He noticed that people get conditioned. You can condition a dog and even a human being by enticing them. So, they entice you by putting chocolates; everything that is there is sugar. Even if you do not like it if you have a child you are going to buy it by force. That child will not leave you when moving into that passage. So, try to leave them at home because they are going to make you buy stuff not on the list. You see now. Yey yeh yeh! Thank you. [Laughter.]

Mr F J BADENHORST: Hon Deputy Chairperson, on a point of order!

The Minister is using props in the House!

The DEPUTY CHAIRPERSON OF THE NCOP (Mr P Govender): Hon Badenhorst, do not disturb the Minister, please.

The MINISTER OF HEALTH: She is Pavloving me. That is how they Pavlov you in a restaurant. Thank you, hon Deputy Chairperson.

UNREVISED HANSARD

Ms D W FIENIES: Hon Deputy Chairperson and hon Minister, the public health care system in South Africa remains highly unequal. Serving approximately 84% of the population, while the private sector caters for the remaining 60%. However, consumes over 50% of the country's total health expenditure. Is the government making progress in engaging all stakeholders to explain the need for an urgent move to fully implement the National Health Insurance, NHI, to address the too tired system which continues to several limit equitable access quality to health care and perpetuates deep inequalities in access to health between the poor majority and the well off? I thank you, hon Deputy Chairperson.

The MINISTER OF HEALTH: Hon Deputy Chairperson, the hon member is right. According to the World Health Organisation, if a country spends at least 5% of their total gross domestic product, GDP, not budget but GDP, the World Health Organisation's calculations are you are likely to cover all your citizens. Yes, but that is only in the books. In the real life, it is not like that because South Africa is already at 8%. We are very far above a lot of countries in our total health care expenditure as a percentage of the GDP.

UNREVISED HANSARD

For instance, in Brazil, Russia, India, China and South Africa, Brics, we are number two. We are bitten only by Brazil which is spending 9,8% of their GDP on health. We are number two at 8,5%. Very rich and developed countries like Russia and China are below us. Russia is still at 7,6% and China, I think it is six point something percent. India is even worse; they are not even at 5%. However, all of them bit us in terms of the health outcomes like mortalities.

Hon Deputy Chairperson, the mic has stopped.

So, I can speak forever?

The DEPUTY CHAIRPERSON OF THE NCOP (Mr P Govender): Table staff, please help.

The MINISTER OF HEALTH: That is why I am warning them. I am being honest. Yes. So, the reason in South Africa is because in that 8,5%, 51% of that goes to only 16% of the population as you said. In fact, in our figures, it is 14% but not much difference between 14 and 15%. The 49% has to be shared by a whopping 66% of the population. That is what is called gross inequality. If you want to see why we say South Africa is the most unequal

UNREVISED HANSARD

country in the world come to health. There is gross inequality which makes it very difficult to meet what we want.

Now people tell me that this is private money. The money in private care is private money why do I have to meddle with it. It is not true the state subsidises private health care very heavily. For everybody who get their salary from the state starting from the President, anybody who receive their salary from the state it does not matter where you are working starting from Parliament to a factory, as long as your salary is from the state, that person is heavily subsidised. The total subsidy is R70 billion.

On top of that each person who is on a medical aid it does not matter who their employer is, they get tax rebates or tax subsidy. Before last week, when the Budget was read the total tax rebates from SA Revenue Service, Sars, was R33 billion. In other words, every year R103 billion that help the private sector is from the state. The poor do not have any access to it. My heart was bleeding last week during the Budget, when this tax rebates of R33 billion was increased. I am sure it is going to go to R35 billion or R37 billion. So, these are the things that we seek to respond to.

UNREVISED HANSARD

Well people will tell you, no, no, no, you are lying, it is corruption. I am not going to sit here and argue that there is no corruption. We have seen it and we fight it every day.

Some will tell you that no, it is incompetence. We have seen some of these incompetencies and mistakes that happened, but we cannot deprive the majority, 86% of the population.

Now, because of this screwing, hon member, people go and queue and we get insulted. Let me give an example, 80% of all the psychiatrists of this country are in the private sector. They are only 870 of them in the country. The 80% is in the private sector because it is natural that people follow where there is money.

There is a private hospital in the centre of Johannesburg. It has 57 gynaecologists. What is the significance of that number? Mpumalanga, Limpopo and the North West, all added together do not have 57 gynaecologists. They cannot raise them. For all these senior gynaecologists go there is money. So, this gross inequality is causing problems in South Africa. It is one thing we need to sit down and resolve. We cannot run away from it. Thank you.

UNREVISED HANSARD

Question 26:

The MINISTER OF HEALTH: Yes, on the issue of medico legal cases, the following information collected from the provinces provide an update on the matter. In the Eastern Cape, the National Prosecuting Authority, NPA, is considering evidence. The Directorate for Priority Crime Investigators are gathering additional evidence as instructed by the NPA prosecutors.

Maybe let me start here, hon members. You will remember that in August 2024, we had a joint press conference with the Special Investigating Unit, SIU, about this case of medico legal. Medico legal cases stems from negligence in the health care system, but I can tell you we found that some of them is just absolute fraud, unfortunately, by lawyers. When I said so some years ago, they were saying, I'm hiding behind them. It has been apparent now, some lawyers have been struck off the roll because of this practice.

There is a lawyer in the Eastern Cape who put in claims for 15 children, who he said they have cerebral palsy. What made me suspicious is that, cerebral palsy is not a uniform condition. It doesn't cause uniform disability. There are different disabilities, but you are charging the same amount of money.

UNREVISED HANSARD

Same amount, R25 million for each. We send the SIU there to investigate. Firstly, they visited the schools where these kids are. The teachers were surprised to hear that so and so is supposed to be disabled.

Then they went home to the magogo [granny]. They found that most of these kids are staying with the magogo. Magogo, you signed the power of attorney for this lawyer to sue the state because you said the child is disabled. Magogo said: Me, the things I've signed for here are for the people who came here from SA Security Agency, Sassa. They told me they're from Sassa, I must sign here for the child to get child support grant. So, I mean, I signed. She doesn't know that she's giving power of attorney.

They went further to investigate and found that some of the kids were never born, they don't exist. But they are taking advantage that it is in the Eastern Cape and that is happening in other provinces but the records cannot be found and all that and all that. That's why we are even trying to repair this issue of records. We have now to try - as part of fighting that hon members - we have gone to the Council for Scientific and Industrial Research, CSIR, to ask them to give us an information technology, IT, system that can help us trace a patient from one

UNREVISED HANSARD

doctor to the other, from one health care system to the other and from clinic to the hospital.

We said, do a system where we don't have to pay tax. I mean, not tax, rent. You know, all these IT systems you are paying rental for the owner. We said we want a system owned by South Africans. The CSIR went to work. It took them eight years, but I'm proud to mention they've now finally designed such a system. Yes, we have tried to pilot it in Dihlabeng in the Free State. We are now rolling it out. That system is directly linked to Home Affairs. When you go to a hospital, you just give them your name and ID, we press, Home Affairs will tell us immediately who you are and, you know, where you come from and all that.

So, those are the systems that will help us trace. At the moment, we are still struggling from time immemorial. That's why people can go collect medicines from one health care system to the other and from one clinic to the other. They just collect medicines. The doctors and nurses won't know that this person was next door collecting that medicine.

So, it makes this medico legal also worse because lawyers know. Some of the lawyers even know that you can go and sue in one

UNREVISED HANSARD

court and sue for the same patient in a different province, in another court, they've got no way of knowing. That system is going to help us and that's why we are so excited about it. Thank you very much.

Ms S MASUMPA: Thank you Minister for responding to my question. Does the department have any mechanisms in place for early detection of stopping corrupt law forms from instituting illegal claims against the department? Thank you.

The MINISTER OF HEALTH: Yeah, hon member, in 2015, we called all the role players; private sector, public sector, doctors associations, nurses and even the legal profession. We had a conference about this medico legal. What do we do with it? And we drew a series of points that need to be followed. One of them was that, we need to make people as safe as possible inside hospitals so that there is no medico legal. In other words, make sure that we reduce the number of mistakes we do.

Nevertheless, the reality ... and I'm just giving you this reality as a fact, the World Health Organization once disclosed that, when you are inside the hospital ... sorry, let me put it the other way around. When you are inside an aeroplane flying in

UNREVISED HANSARD

the sky, you are 300 times safer than when you are in a hospital because in a hospital, anything can happen. Any mistake can be done. You can be given an overdose. Somebody can be doing a diathermy and burn you. Somebody can cut where they were not supposed to cut. These are the dangers. However, we said, we must put mechanism to resolve them.

Now, as I'm speaking in front of you, we have chosen hospitals in each province where we realised a lot of this medico legal is coming from. We will visit them one by one, just to see what is that which they can do in this hospital. Why are so many cases emerging from there? For instance, as I'm standing here in front of you, in the Eastern Cape, we know, is Nelson Mandela Academic Hospital in Mthatha. Very unfortunately, a hospital named after Madiba. That's where some of these things are happening more than in any other. We will visit there and see.

The second thing is this filing system which I've spoken about. That's why I'm telling you CSIR took eight years because after that conference, which took a resolution that makes sure that you resolve the issue of filing so that it must be electronic, you just press and you follow this patient throughout the system. Whether the patient today went to a public hospital and

UNREVISED HANSARD

tomorrow went to a private, they must be able to know he's the same patient and be able to link them. We are doing it.

The other things we are doing, which is a bit difficult in court, we've just lost a case in the Eastern Cape two weeks ago, that this lump sum payment ... you see, what lawyers will do is say, this child is now disabled because of what the health care system has done to this child. They write for future medical care. That future medical care is calculated on what a private hospital will charge. And, you give that lump sum of money. While the money is paid, that child will never see the gate of a private hospital. They come to the same public hospital.

Yes, some write housing, that this child is disabled, the wheelchair, need a ramp and you need a house worth R4 million and all that. And when the judge agree that family will never see that type of a house. The best they can do is an Reconstruction and Development Programme, RDP, house from the state, we know. So, we have all these types of things and that's why we are working with the SIU forever, not only like calling a press conference once. We work with them every day and say that money must go to the people who are sick.

UNREVISED HANSARD

We are saying, if a child is disabled, give us as a court what we need to do for that child and let the public do it. Because if they go private, that money will just disappear there. There's no question about it. It's the truth. Many of you have been to private hospitals, you know that. So, we're trying that. But the bottom line is, can we reduce the level of negligence inside the hospital such that there's no medico legal? Thank you.

Mr P J SWART: Good afternoon, hon Minister. Welcome to the House. Chair, I'm glad that the member has asked this question, the cases that was being referred to the NPA. Minister, you know that the case of the three health department officials whom the President suspended recently, I think it was yesterday or the day before yesterday, that he has made to the NPA.

While we welcome the suspension, even though it took the President to intervene for the Minister to act. Can you, as Minister, indicate whether these suspensions will carry with full pay until the matter is finalised within the criminal justice system, which could take years? Or, whether the Minister will ensure internal disciplinary matters? Thank you.

UNREVISED HANSARD

The MINISTER OF HEALTH: You are aware that this has nothing to do with medico legal, but I'm prepared to answer it. Yes, I was laughing because I told somebody that this is what will happen. There is a newspaper called *News24*, which has a gripe with me because of the National Health Insurance, NHI. And everything that happens in my department, they twist it. I laughed yesterday because I issued a statement about this suspension. And I know the words they've used, but they used the words, after directive from the President.

I, wrote a letter to the President, me. I said, Mr President, this is what happened in my department. In terms of the law, ... remember, this even came from the courts, Ministers cannot deal with director-generals, DGs, to employ them or to suspend them and all that. Only the President can do so.

We then met in the Cabinet and said, the President cannot do so much work alone. He has other issues of heads of state. What he must do is to delegate. And we developed a delegation pattern, you know, whereby the President must sign that delegation and give it to you. I wrote to him last week and said, Mr President, give me delegations because I need to suspend my DG who unfortunately has been arrested.

UNREVISED HANSARD

I got those delegations formally on Friday evening, and I decided to get the weekend to pass. After the weekend passed, on Monday, I had to do what the laws of the country demands. Do an audio letter, the Promotion of Administrative Justice Act, PAJA. There's a law called PAJA in this country. We passed it in Parliament, where a thug has to be asked if you must act on them. That's what PAJA says, yes. Can you tell me why I shouldn't do this to you? This is how Bushiri destroyed us, because when I was in Home Affairs, the moment I discovered that his permanent residence is fraudulent, somebody tipped me that even Omotoso, who is being charged in Eastern Cape, has got a fraudulent document.

We wrote to Bushiri immediately because we proved that it was fraudulent. Now, PAJA force you, hon Bushiri, can you tell me why we shouldn't take back? Something that is yours, you are asking a thug who stole it. He immediately rushed to court and said, the Hawks have arrested me. I'm going to appear in court. Now, this department wants things from me which are my defence. And the judge agreed and said, no, don't take that permanent residence. Even today, he's still keeping it. He's a permanent resident of South Africa because I couldn't get it.

UNREVISED HANSARD

So, anyway, that's PAJA. So, I had to do it on Monday and you give them some time. They responded on Tuesday, and on Wednesday, which was yesterday, I issued a statement. And the newspaper which you read, which I suspect they were going to, saying, "after a directive from the President" in other words showing that, no, this Minister was not willing. He had to be directed. That's not true. They do that all the time. Even when a problem happens somewhere, they put my head there.

When in the Free State they hired a guy who has been in jail as a chief executive officer, CEO, of a hospital, it was my head that was there. Yet, it had nothing to do with me. And that goes on and on and on, especially with *News24*. Whenever they write a story about me, they skew it in such a way that I must be seen as some piece of rubbish and all that. So, I laughed when I saw their story about this suspension that I was instructed by the President when I'm the one who asked him to give me the delegations to do so, then I did it. Thank you.

Mr V GERICKE: Good afternoon, Minister. I must say it is commendable that you understand the issue of delegations of power, and it is commendable that you requested the President to give you the delegation. We've been struggling with many

UNREVISED HANSARD

Ministers that do not understand the delegation. They're just there in the chairs and they don't understand.

Now, having said that, the DG in your department is in serious trouble because I see the charges are fraud and corruption together with other senior officials. Can you unambiguously this afternoon, not in the by the way, tell us that his suspension has got nothing to do with medical? I know that you've mentioned it now, but you've mentioned it in the by the way. Nevertheless, state emphatically, it's got nothing to do with medical. And also, that there was no undue influence from his side, for instance, on the NPA to delay the matter that we have at hand here.

Having said that, Minister, given that these matters are long outstanding and repeated requests for responses have fallen on deaf ears, and that these matters are in the interest of the public and deserve to be treated with urgency, what measures have you put in place to receive regular updates from the NPA and what were the responses? Thank you very much.

The MINISTER OF HEALTH: You are aware that we have formed an anticorruption forum in Health, which takes all these law

enforcement agencies. That anticorruption forum meets quite often. Health is part of that and they inform us. But these suspensions were specifically based on the charge sheet which was brought by the Hawks to me in my department on Monday afternoon, after my DG and two other officials appeared in court. They've put the charges there of fraud or corruption, etc.

It is on the basis of that that I went to ask the President to give me delegations for the DG. For the other officials, because they are deputy director-generals, DDGs, is a chief finance officer, CFO, and a DDG, both of them are at a DDG level, I needed no delegation from the President. I did it on my own. Yes, I did it on my own because I've got the rights to do that. But this newspaper that is crying about the NHI all the time, will never say so. Yes, "after a directive ..." and all that, there was no directive. It is something that I needed to do because I'm the one who knew what happened.

The other case which you seem to be talking about, which has been postponed by the SIU, you are aware that we don't interfere with the SIU decisions. We are also waiting to hear what the SIU is, I mean, the NPA, is saying because you are aware that the

UNREVISED HANSARD

NPA might decide to charge or not to charge a person. They are supposed to be taking that decision independently without us interfering. Thank you.

Ms L P MHLONGO: Greetings to you Minister once again. I believe you've covered most of the questions that were answered. However, but I'd like to know with regards to the issues that we are facing in the Eastern Cape, where there are illegal matters that are arising from medico legal. Has the department managed to create a programme to ensure that you educate people from the rural space? Thank you.

The MINISTER OF HEALTH: We are trying our best to educate people about these things, but you can imagine it is a very difficult thing because poor people are dealing with lawyers who are highly educated, if you understand what I mean. Like this poor gogos [grannies] who ... which gogo [granny] will refused to sign if you tell him, gogo, I'm coming from the SA Social Security Agency, Sassa. They don't know what colour Sassa people are. They just see an official wearing a suit and a tie and say, I'm coming from Sassa, sign here. That gogo will sign.

UNREVISED HANSARD

So, it is us who are educated to make sure that we don't use our education to cheat the poor. In the Northern Cape, hon member, we had a lawyer who went to court on behalf of this child and was granted R19 million, R19 million! But he was paying that family R6 000 per month out of the R19 million, which he has kept in his trust account. The family gets only R6 000, if you understand what I mean.

We had very heartbreaking cases of a man who is on a wheelchair and a lawyer claims the money for him and he is given millions. And you give that poor man on a wheelchair, you give him R50 000 or even R100 000, which he has never seen. We had heartbreaking cases where the poor old man takes part of the money to buy a cow and thank the lawyer. The same lawyer who stole his millions. Now, these are very painful things which happen. When I say so it's not because I'm bashing lawyers. The fact remains that it is true, it is there. Why do they do that?

Even cheating children who are disabled. You remember the other painful thing, hon Chair, let's say this child has cerebral palsy. The judge gives R35 million, which is the amount that attracted them some years ago, R35 million. The lawyer is entitled to 25% of that money. Yes, in terms of the laws now,

UNREVISED HANSARD

25%. Many of them don't take that 25%, they take much more. My question has been this, who will enjoy life here? This child who suffered a cerebral palsy, whose brain is damaged? The R35 million will not bring the brain back, he will not enjoy this money. It is the legal representative. And why do they even go on to cheat when they've already got an advantage of this? We do have and it's happening now, I'm not lying.

The case of this R35 million I'm quoting is what was charged by a judge in Gauteng who was angry because the province was not responding very well to the charges and he gave R35 million. That lawyer came out with R9 million from that man. From that case, lawyers are going to schools and places of disabled, looking for disabled children to come and sue. Especially, that the Constitutional Court had a ruling that cerebral palsy cases don't transcribe. That means they don't expire until after 20 years. Meaning it will have happened 20 years ago, you are still allowed to mitigate, whereas, other cases they tell you that the period is transcribed.

Since they have known that, oh! I can go for the past 20 years, they are busy searching. They even have scouts, people who move around the villages scouting for disabled children in order to

UNREVISED HANSARD

sue the state and knowing very well that they will take part of that money. So, that's the problem that we are faced with, with human beings unfortunately. Thank you.

Question 45:

The MINISTER OF HEALTH: Hon member, I wish to clarify upfront. There is no HIV vaccine currently approved for public rollout in South Africa or anywhere else in the world. We do not have an HIV vaccine.

Scientists are still searching. There are, however, several candidate vaccines that are going through trials at the present moment. I am not very sure; I am just guessing whether this issue of a vaccine could have been confused with lenacapavir.

Lenacapavir, which we are going to rollout, is a game changer in the fight against HIV and Aids because clinical trials have shown that for the young girls who are the ones that are, you know, victims of HIV/Aids in large numbers, it protects them 100% as long as they take that injection every six months. That is why the President had to announced it in the state of the nation address because we want the nation to take interest. Very soon, he is personally going to launch lenacapavir.

UNREVISED HANSARD

As long as young girls takes the injection twice a year, they are protected. Men having sex with men, they are 96% protected. So whichever way is worthwhile.

But it is not a vaccine. It is a PrEP; it is Pre-Exposure Prophylaxis. Vaccines, we are still looking for them.

But when we look for vaccines, they follow stringent procedures. We even have a special committee of ethics that must decide whether you can go and do trial with these people on human beings.

We have got serious protocol approval issues, informed consent, adverse event monitoring, and independent oversight as set out in the SA Good Clinical Practice: Clinical Trial Guidelines. It is there and it is regulated by SA Health Products Regulator Authority. So, we are not just going to do tests with human beings without going through all these things.

So, at the moment, all the HIV/Aids vaccines are still what you call candidates. They are going through these phases, and every vaccine must go through phase I, phase II, and phase III. Only at phase III does it go into the bodies of human beings in a

UNREVISED HANSARD

form of a clinical trial. So that one is very strict, and it is something that scientists follow very closely. Thank you very much.

Ms L P MHLONGO: Thank you, Minister, for the clarity. Thank you, Chair.

The DEPUTY CHAIRPERSON OF THE NCOP: So, there is no follow up question. All right, we then move on to the hon Sibande for his follow up question.

Mr M P SIBANDE: Thank you, Minister, for your superb responses, which pushes me to suggest to the Chairperson that to allow you to give us a free lecture every month, if possible. But nevertheless, let me go to my question. Has there been any breach of ethical and scientific standards in clinical trials that took place in the past? That is my question.

The DEPUTY CHAIRPERSON OF THE NCOP: Hon Sibande, I know that the Minister would not mind giving us a free lecture, but you will have to take it to the Programming Committee first. Hon Minister, your response, please.

UNREVISED HANSARD

The MINISTER OF HEALTH: The reason that science have come up with these protocols is because it is tempting, hon member, for a scientist who wants international fame to make use of human beings as their guinea pigs in order to come with something that they believe will save the world and is in their name. For that reason, they put up these very clear protocols. I cannot, off my head, hon member, remember that, but there are many cases.

I cannot remember a specific one off my head. There are many cases. That is why they are taking to statutory bodies, to scientific bodies, et cetera.

If you remember last week, we had a press conference with scientists, regulatory bodies, including the World Health Organisation, about that scared that was sent out, if you remember, about sanitary pads and panty liners. You remember the scared that took place two weeks back. I mean, yes, about more than two weeks back, we had to call that press conference.

Professor Ntobeko Ntusi, who is the President and Chief Executive Officer of the SA Medical Research Council, complained there and said scientists ought to know the protocols and procedures when they do research and how do they make it come

UNREVISED HANSARD

out to human beings. Because remember, that thing caused a lot of anxiety and fear among women for no apparent reason. He said it so. He said, there are protocols. There are steps. There are ethical things. That is why there are ethical committees.

Maybe we do not know, no scientist is allowed to do research on something that affect human beings. Maybe the problem with that study in the Free State, it had nothing to do with human beings. It did not even come from medical school.

It came from a Department of Analytical Chemistry, which has got nothing to do with human beings. Maybe that is why. But for those which have got a lot to do with human beings, you do not just start doing research.

You apply to the research committee in each university or to SA Medical Research Council. And you say, you want to do this type of research. The Ethics Committee will look at the ethics you are going to follow, and they may say no. They may not allow you to go on. So, no research is just done where human beings are concerned, where you just wake up and say, I am going to research on human beings because that will be very dangerous because human beings are not the same. I am sure many of you

UNREVISED HANSARD

know the story of a gentleman called Basson. Yes, Worter Basson. Many people will say, no, no, no. That man is very brilliant. We must use him somewhere. There was nothing brilliant. All the things he was doing was to kill people in Namibia.

I know them because we use them in theatre. But because we are using them ethically, I cannot do what he has done. All the things he was doing was injecting people; we inject people under controlled conditions in theatre when you put them to sleep.

You know, you do not just inject a person who is not under oxygen because you know they are not going to breathe, they are going to die. So those things scientists know, the question is, are you ethical? That is why we have got to apply to Ethics Committee before you do any research. Thank you.

Ms N S Du PLESSIS: Hon Minister, it is reported that Lenacapavir has been approved by the SA Health products Regulatory Authority, SAHPRA, as you have stated and the rollout will happen in April this year. What is the rollout plan and how will it be implemented and monitored to ensure fairness and efficacy? Thank you very much, Minister.

UNREVISED HANSARD

The MINISTER OF HEALTH: We said, fortunately, late last year in what you call a round table, where we brought all stakeholders including international partners, philanthropists, we said and say this lenacapavir, how are we going to do it in a way that is fair, as you say, because the first 988 doses are going to be donated by the global fund.

That is a donation. I will tell you why we have to have that donation. Lenacapavir is brutally expensive. It has been there in the United States. It costs US$28 000. Which is close to a million, yes.

So global fund negotiated from the company that produces Gilead to give it to them, and they are buying it for us for $29 million. Those are the first doses, which means they will cover about 450 people only. If there are 488 doses for about 445 or 448 people, they will cover them.

So, the question is, who do we start with? After that round table meeting, we agreed that we start with young girls, not young boys. Young girls, because they are the ones who are carrying the brunt of HIV/Aids infection from sugar daddies, we know that.

UNREVISED HANSARD

We have got graph statistics that have shown that. So, the young girls are the ones who are going to be the first. Then after young girls, we are going to give it to pregnant women so as to protect the unborn child, pregnant women and lactating women. From there, we are going to go to bridging populations. Bridging populations being what? Sex workers, men having sex with men because they are also the one that are a bridge between our communities.

So those are the ones we will start with. Fortunately, the question was then, after this donation, where do we go to? We have already chosen 350 facilities where we are going to start. These are facilities in very high burden areas.

Now, the next question is, what do you do after that? Fortunately, when we were in New York during United Nations General Assembly in September, the Clinton Health Access Initiative headed by former President Clinton, plus a company called Dr. Radice, plus our own Wits RHI, they came together to sponsor a motion whereby Gilead will give a voluntary license to companies that will produce this lanacapavir at a cheaper rate. Maybe then the question will be, what would be a voluntary license? If a pharmaceutical company has researched a particular

UNREVISED HANSARD

medicine, be it an injection or whatever, or a vaccine, they are given 20 years intellectual property rights. For 20 years, they are the only ones who can manufacture that and sell it at whatever price they choose.

After 20 years, that intellectual property lapses, anybody can produce it, and that is called a generic, which is usually cheaper because you never spend money on research. So, on this one, Gilead was approached by many people around the whole world on the basis of ethics and say, look, you have got this thing that costs R28 000, that can save humanity. Why make it so expensive? So, Gilead agreed to give voluntary licenses, and six companies were given voluntary license.

They are going to produce it at US$45 from 28,000. You can imagine. They are going to produce it at US$25, so that will come in the market in 2027 or 2028, and it means as many South Africans as possible will now be able to get it. Thank you.

Ms M KENNEDY: Hon Minister, talking about that scare, it reminds me back of during COVID time where we were told that this is a method of killing black people. I did not sleep that day of my vaccine because my whole hand was sort of numbness.

UNREVISED HANSARD

I said, this is the way now. So with reference to the vaccine hesitancy peaking during COVID-19 at around 30 to 50%, Minister, how does your department plan to address potential social harms because our mind were harmed, like the stigma, the discrimination, the fear that may arise from the vaccine trial participation in our communities, and in the event of serious side effects, what legal and medical support structure are in place for the volunteer? Thank you.

The MINISTER OF HEALTH: Yes, hon member, volunteers are very highly trained people. They train them what to expect and what is going to happen, and nobody is forced into volunteerism. For instance, there is a very promising vaccine for TB. TB has never had a vaccine for more than centuries. Centuries, not decades. There is a promising vaccine that is being tested in seven countries or seven centres. They are testing it on 20 000 people - 13 000 of them come from South Africa. It is South Africa who volunteer and say, we want TB to go, and they sit with them. They sign agreement.

They do not just meet you on the streets. They sign agreements. They know what they are going to get into. They actually are taught what to expect, and they are followed up because the

UNREVISED HANSARD

company that is producing this is going to be required when eventually that thing is registered. It is going to be required. You know, when you take a packet, let us say a box in which there are pills or a bottle, inside it there is a small leaflet, right, scheduling category and all that.

That leaflet will have a list of side effects or possible side effects. You cannot put that medicine on the market. Every human being must read.

Even Panado, go and read. It has got that scheduling, what you call, pamphlet, which mention how does it work, what is it going to do to you, what are the possible side effects, anything that, even if it happened once in a million, they put it there for you to know. So that company must monitor all the side effects because they are going to be required.

When they register that medicine with the SA Health Products Regulatory Authority, SAPRA, this question SAPRA is going to ask, it is going to ask you, did you do this? What are the possible side effects? How are they going to be counteracted? You as a company must answer. That is why researching some of these medicines can take as long as 20 years. It can.

UNREVISED HANSARD

The measles vaccine that was produced many years ago took 40 years to develop because of this type of things. But now because science is getting more and more advanced, it takes a short period as possible. But the issue of side effects is very important.

After all, hon member, when doctors give you a medicine, they weigh. In economics, you call it a cost-benefit analysis, whether when I do business this way, I am going to gain more or lose more. In medicine, we also weigh, is the damage that this medicine going to cause, is it bigger than the benefits? If yes, then we would not give you that medicine.

But if we know that the benefits are higher, even if there is a possibility of a damage, we give you. Just like the drugs that they give you for chemo. You know chemo? Yes, you are getting lean, your hair, you know. Yes, lose appetite, you lose and all that and all that. But we have got to give you it because the cancer is going to kill you. If on the other hand, we realise that this chemo is going to be more dangerous than the cancer itself, then the doctor should not give you that medicine. So, he is trying to reach a balance about these things. Thank you.

UNREVISED HANSARD

Question 47:

The MINISTER OF HEALTH: Hon House Chairperson, this is about the backlog of orthopaedic cases in Cecilia Makiwane Hospital. Hon member, I said earlier that hospitals differ. We have got district, regional, etc. Cecilia Makiwane Hospital is a regional hospital which means it manages only non-complicated trauma cases requiring orthopaedic intervention. Currently, when I developed this question last week, there were 25 trauma patients who were admitted and awaiting surgery. All the other cases are referred to Frere Provincial Hospital because it is a higher-level hospital as Cecilia Makiwane Hospital cannot do complicated things.

Now, orthopaedic surgical procedures are divided into two. We have got emergency procedures. Ordinarily, there should be no waiting period to do emergency procedures because an emergency is an emergency. Now we have got elective procedures. Elective is where you go and book and say, I want to do a new replacement or a hip replacement, et cetera. There is no emergency hip replacement or emergency knee replacement. It is a procedure for which you can book and there is waiting time.

UNREVISED HANSARD

There are people who believe that there is a medically determined waiting period. Waiting periods, unfortunately, depend on availability of resources, both human resources, infrastructure and equipment and it differs from hospital to hospital. But at the moment, for Cecilia Makiwane Hospital, a waiting period in the case of adults, that means anybody who is more than 13 years old, is two to three weeks. That is what the question is asking. For children under 13, there is nobody in Cecilia Makiwane Hospital who is skilled to do orthopaedic surgery on such children. So, they are all sent to Frere Provincial Hospital. So, the question does not apply in that case. Sometimes limited theatre time, as I said, mainly due to shortage of nurses.

Now, hon members, let me say this to you, which is a very painful thing for all of us in the world. There are four types of specialist nurses who are in demand all over the world. They have got the critical skills. It is an Intensive Care Unit, ICU nurse. A nurse that works in ICU, all over the world, they are chasing them because they are highly skilled. It is a theatre nurse who is a nurse in charge or works in theatre. It is a high care nurse and a psychiatric nurse. These four are in high demand.

UNREVISED HANSARD

Now, theatre nurses are in such a high demand in both public and private medical institutions. Many of them actually refuse to be employed. You will never give them a job, even if you advertise 100 times, they don’t. Rather, they join agencies. Agencies look around the country, which hospital wants that nurse that night or that week or that day. So, they give them to the highest bidder and they choose. In other words, they have got the free choice, that I want to go there and there I cannot go. So, they do not usually want to be employed and that is one of the biggest problems we are having. If they want to go overseas, they are grabbed immediately, especially in the Middle East, where they have got a lot of money of oil, but they do not train a single nurse. They just come to our country and grab them.

So now, this is what Cecilia Makiwane Hospital is suffering from. However, they have appointed six additional general nurses. But these are not theatre nurses, they are general nurses, which means ...

IsiXhosa:

... bayazama ... [they try]

English:

UNREVISED HANSARD

... to make sure that these operations go on because the theatre nurse you will not easily get. But they have also approached the agencies that are keeping these nurses to make sure that they do help so as to clear the backlog. You ask a question about surgical implants. Cecilia Makiwane Hospital does not do procedures requiring surgical implants because that is an advanced surgery. So, the question does not apply to them. Thank you.

IsiXhosa:

Ms M MAKESINI: Ndiyabulela Mphathiswa ngokukhomba indlela nangokusifundisa. Umbuzo wam olandelayo uthi, nenza njani ukuncedisa isebe ...

English:

... to educate people to know the role of the regional hospital versus the provincial hospital because they expect operations when they are in a hospital.

IsiXhosa:

Kufuneka aba mongikazi bangagqibelanga nibasebenzisayo bafundise abantu ukuba sithunyelwa njani, xa kutheni isigulana kwisibhedlela esingentla. Enkosi kakhulu.

UNREVISED HANSARD

English:

The MINISTER OF HEALTH: Hon Chair, we try our best and it is ironic that the question is about Eastern Cape. People in other places know but they do not like it. For instance, there was a time when Eastern Cape, I suspect even now, has got more hospital than any province. When we checked, we found that they actually named any facility where somebody is wearing white clothes, a hospital even if it is very tiny.

So that is why in 2010, we sat and said, let us have a scientific classification of an hospital. We said any facility that has got less than 50 beds must not be classified as a hospital. Those who are classified so, must lower their standard to a health centre. I can tell you it is difficult because communities will tell you to go to hell. When you tell them that we made a mistake, they say we all want that hospital. Everybody wants the hospital of the highest order even where people are very few. So, it is a very difficult thing for which we should not make mistakes because once you do it, you will never correct it. People will go up in arms.

I remember in my own area where I came from, in Sekhukhune District Municipality, there were two hospitals there, 10

UNREVISED HANSARD

kilometers from each other. One was then built by the former Lebowa government. You know, they put up new walls, they renovated and all that. In the other one, they did not do anything and it is the one that was a regional hospital. So, we had Dr Joe Phaahla becoming the first MEC in Limpopo. He had to tell them that the hospital was well built and had a lot of infrastructure. It must be a regional hospital. I can tell you, there was war. They thought it has got something to do with me and him, even though I was not in health, because we once worked in that hospital.

Dr Phaahla at some stage sat as the superintended. We all worked there. They said:

> Yeah, these two guys were there. Now they are in government. Because they worked in that hospital and want to make it a regional hospital.

Why make it a regional hospital? Because it had facilities, it was rebuilt, they bought new things and they renovated it. It was Dr Phaahla who was in St Rita's Hospital. Yes, I am talking to him because he is from there. When we moved Jane Furse Memorial Hospital to be a district hospital because it did not

have the facilities and St. Rita's Hospital to be regional, there was nearly a third world war in that area. But these are how human beings are. They all want to have the highest but we are trying our best. So, the solution is, let us not make mistake when we classify hospitals just to please our people because when you come to change, they are going to get very angry. Thank you.

Mr M FENI: Thank you once again, hon Minister, for your capacity session. Hon Minister, are there any norms and standards for the waiting period of the patients waiting for these operations? That is my question.

The MINISTER OF HEALTH: Ordinarily, we would not like anybody to wait. There is no human being who would like to wait in a queue. You do not want that. Whether it is in the home affairs offices, in a bank or a SA Social Security Agency, Sassa, waiting in a queue is just something that human beings do not want and it is naturally so. And so, we try our best that we reduce it. Nobody wants to have a waiting time but unfortunately, reality has it that if you do not have enough staff and enough equipment, what do you do? For instance, at Steve Biko Academic Hospital, they have got only one professor of cardiology and he does not have

UNREVISED HANSARD

anybody below him. The whole of Mpumalanga is referring to that Steve Biko Academic Hospital. So, there is going to be a waiting list.

Now, as I said, there are no norms of how long people must wait, except for an emergency. In an emergency, there should not be any waiting whatsoever because an emergency means exactly that. But in elective surgery, there is unfortunately a waiting period but it differs from facility to facility. A waiting period in central hospitals in Gauteng cannot be the same as a waiting period in Eastern Cape because there are most specialists and people with skills. A waiting period here in Western Cape cannot be the same as in Eastern Cape, because here we have got very clean well-equipped hospitals. But some of the things depend on the procedure. For instance, Groote Schuur Hospital is the first hospital, as you know, here in Western Cape, not the first in South Africa but the first in the world that did a heart transplant in 1967. Even now, it is the only public hospital that is doing a heart transplant. So, if you need it, everybody, regardless of which corner of the country you come from, you’ve got to come to Groote Schuur Hospital.

UNREVISED HANSARD

Even in the private sector, for that matter, it is the same thing. As far as I know, there are only two private sector hospitals, in the whole country, that can do a heart transplant. It is the Netcare Milpark Hospital and Netcare Christiaan Barnard Memorial Hospital, just here down the road. They are the only ones. So, on that one, even in the private sector, you are going to have to wait. So, there are no norms except that it depends on facilities, on the skills and on availability of resources. But emergencies should not have a waiting period. Thank you.

Dr I SCHEURKOGEL: Hon House Chairperson, Minister, in relation to the backlog of orthopaedic surgeries, Mr Itumeleng Mofokeng from Vanderbijlpark has been waiting for six months from the Free State Department of Health to finalise his medical negligence claim from the failure by the Fezi Ngubentombi Provincial Hospital, in Sasolburg and Pelonomi Regional Hospital. The department was supposed to finalise the claim on 6 February 2026. To date, he has not received any feedback and the poor services rendered by these hospitals has caused Mr Mofokeng to become unemployed, needs a hip replacement and suffered greatly bodily deformities. So, with his case that thousands of people faced, this has been in the forefront since 2021. Why is

UNREVISED HANSARD

the Minister not addressing this so that Mr Mofokeng and thousand others can get the dignity they deserve? Thank you.

The MINISTER OF HEALTH: Hon member, it will be difficult to respond to you because I do not know that case and I do not know the facts. Please give it to me so that I can go and check what could have happened. We do sometimes correct these types of things and I usually tell hospitals when I correct them or my fellow MECs, because sometimes they believe I am interfering, that we correct them to help the patient. Also, as I said earlier, to avoid medico-legal because that very same person you are talking about can go and sue if there is anything wrong that they have done in terms of waiting. So, please give me that case. Let me go and check to see what we can do. Thank you.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Minister. I think Dr Scheurkogel will do that accordingly. The next follow-up will come from hon Breedt from the Free State.

MS T BREEDT: House Chair, hon Minister, with all due respect, I do not think this question asks for us to be given a lecture on what the different hospitals are. Question number C says:

UNREVISED HANSARD

What specific steps have been taken to address reported shortages of theatre times, specialised nursing staff and surgical implants at such facilities.

I want to know from you because as my colleagues from the Free State have mentioned to you, we are seeing backlogs. It is the end of the financial year and not referring to surgical backlogs, but we have seen availability of medicine, because it is the end of the financial year, also not being available. We are seeing anaesthetics not being available. So, hon Minister, what concrete steps have you taken to address backlogs of orthopaedic surgeries and the likes? Thank you

The MINISTER OF HEALTH: Hon member, I am not giving you any lecture. I am just stating facts on how hospitals are classified. Those who want to hear and appreciate the knowledge, they will. If you do not appreciate that knowledge, just throw it away. That is as simple as that. So, do not get angry that I am giving information because other people need it. Yes. Now, what are we doing? The reason I was giving you this information is because it cannot be one-size-fits-all. I cannot put solutions in Bongani Regional Hospital in Welkom in the Free State. The same solutions I put for Universitas Academic

UNREVISED HANSARD

Hospital in Bloemfontein because the two hospitals are at different levels.

So, what are we doing? We try our best to make sure that we buy enough equipment for them. And we have discussed that, equipment for an appropriate level. But we also try to push provinces to create specialist posts because it is one of the weaknesses that we are faced with that we do not have enough specialists. But we also push them to hire enough registrars. Registrars are specialists in training. This particular matter, I have gone around the country talking to premiers.

As I said, the first premier I visited, is the premier of the Eastern Cape with his MEC for Finance and MEC for Health. I put this on the table that the reason that there is this serious backlog is because we do not have enough registrars from your province and not enough specialist posts and you did not buy enough equipment. So, I put it in front of them. From there, I went to Northern Cape. From Northern Cape, I went to Gauteng. From Gauteng, I am going to KwaZulu-Natal. From KwaZulu-Natal, I am going to Northwest. I have already warned them that I am coming. We are putting these things in front of them and say,

UNREVISED HANSARD

look, if you do not hire enough registrars, this is what is going to happen.

So, those are some of the steps we are taking. And those steps, cannot be the same for each and every hospital. That is why I was explaining to you the types of hospitals which you call a lecture. Well, whatever you name it, but I have to tell you that, because the solutions cannot be the same for all levels of hospital care. Thank you.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Minister. It is true that more information is better than less information. And when you are addressing us here, you are actually addressing the country as a whole. So, it is highly appreciated.

Question 28:

The MINISTER OF HEALTH: Hon member, the question is about whether the President is taking a decision to reverse implementation of National Health Insurance, NHI, as allegedly reported in the media. I know which media he is talking about. Yes, I have already told you. Yes, they usually do that. That was propaganda. Hon member, the President has never taken any

UNREVISED HANSARD

decision to reverse the implementation of NHI. The National Health Insurance Act is an Act passed by Parliament. It was passed by this House in 2024. The President, for that reason, has got no power, no right, to unilaterally reverse an Act passed by Parliament. That cannot happen. Yes.

What actually happened, which they call it a reversal, deliberately as a propaganda tool to demoralise people, what happened is this. It started with a directive from the Chief Justice, because at that time we had 14 cases against NHI. The first of those cases was by an organisation called BHF, or Board of Healthcare Funders, which is an association of a number of medical schemes. They were saying that the President should not have ascended the NHI Act into law because there were many objections, he should have sent into Parliament. The judge ruled that the President must give all the documents he used to ascend. We appealed that case. And fortunately, the Constitutional Court allowed us to go directly to them, not through the Supreme Court of Appeal. They set a date of 26 February to hear our appeal in the Constitutional Court. At the same time, we went to the judges and said that we want all these cases to be consolidated. There are many of them - there were already 14, and they are all challenging the same issue.

UNREVISED HANSARD

Why are we hearing them one by one? We told them to consolidate, and they refused. The judge then said that she was obliged to hold a hearing in open court. She set the dates for the hearing from the 24th to the 27th. Whilst things were like that, something happened that changed everything and caused the Chief Justice to act. The Western Cape government, through its premier, filed a case in the Constitutional Court challenging the NCOP, arguing that the process followed here to pass that Act was flawed. They said the NCOP did not pass this. Yes, they said it’s flawed and they are challenging it. At the same time, the Board of Health Care Funders only also put their second case to challenge the National Assembly.

They say the public hearings are a fraud. We suddenly have two cases in court that are challenging the process. The Chief Justice asked why we should hear all these 14 cases. The reason is that the outcome of these two can change everything. For instance, if the Western Cape wins only a challenge here in the NCOP, it means there is no Act. So, whatever we would have had before, it doesn’t matter who won. It has been moved. It’s cancelled, you know. If BHF also wins in the National Assembly, then it means there is no Act. The Chief Justice then asked why she should hear a case on 26 February, that might soon become

UNREVISED HANSARD

irrelevant. And she did not stop there. She said that, to bring certainty, she would set dates from 5 to 7 May to hear the case against the NCOP and the case against the National Assembly. She has a date. She also said that, before that, she did not see why any other case should be heard, because she could hear a case and deliver a judgment that might be affected by the outcome in May. She then said that she was indefinitely postponing the hearing of the BHF case, which had been scheduled for the 26th. She said nothing about the High Court cases. There was going to be a High Court case on the 24th and 27th. The judge there asked why they are not following the example of the Chief Justice. We are going to hear the case now from the 24th and 27th, covering everything that might be affected by the May hearing. The opponent said that they don't trust the Department of Health. If they stop, they will implement NHI.

We want to put it in writing that during that period, they won't go on to proclaim. The President was about to proclaim certain parts of the Act. I advised the President that he should not proclaim this. We have agreed that we are waiting for the challenge against the NCOP and the National Assembly. From there, we'll go forward. That is what happened. Is that called reversal? I don't know.

UNREVISED HANSARD

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Minister, for the comprehensive response. The next follow-up question will come from the hon Mokwele from Limpopo.

Sepedi:

Mna M F MOKWELE: Modulasetulo, ke leboga Tona ya tša Maphelo ya mo Afrika Borwa ka bophara. Tona, le hlalošitše batho ba tletše gore ke nnete gore le le Tona ya tša Maphelo mo mmušong wo o etilwego pele ke Ntate Ramaphosa, le ikemišeditše go šireletša seriti sa batho gore ba kgone go hwetša tša maphelo go lekane. Tona, potšišo ya ka ke ye tee, le ge e le gore le lekile go hlalosa. Ka mokgwa woo le e hlalositšego ka gona, ke tshepha gore ga go na phošo gore le le mmušo le eme ka go phethagatša Inšorense ya Maphelo ya Bosetšhaba ka lebaka la gore le sa emetše sephetho sa Kgorotsheko ya Molaotheo. Ke a leboga.

TONA YA TŠA MAPHELO: Ga ke kgolwe gore ke potšišo yeo, ntle le gore ga se ka e kwa gabotse. E be e le potšišo moo goba o be o no bolela?

English:

UNREVISED HANSARD

Mr M F MOKWELE: No, let me just rephrase it better. I am saying thank you for responding to the question. My question to you is that: Is there any...

The HOUSE CHAIRPERSON (Mr B A Radebe): I didn't give you a chance to speak. I didn't. Your time has expired, actually. I think it was a comment. You are not the co-Chairperson, Mr Badenhorst. I think it was a comment affirming the work done by the department and your government.

The MINISTER OF HEALTH: No, no, no. As I am saying, we are not stopping our preparations for the NHI, by the way. We just stopped proclaiming. The President was about to proclaim certain sections. That is what the demand was all about. But preparations cannot stop. In fact, you will remember that the President announced the building of three academic hospitals, which are mainly serving universities that were previously exclusively for blacks, including Sefako Makgatho Health Sciences University, which used to be called Medunsa. Yes, that hospital called George Mukhari Academic Hospital has never been built. It is in tatters. King Edward VIII Hospital, which is now Victoria Mxenge Hospital in Durban - that's where I studied - has never been built also. Nelson Mandela Academic Hospital has

UNREVISED HANSARD

never been built. Yesterday, I was still speaking to the Minister of Finance. He has opened a BFI, a budget facility for infrastructure programme, which we are going to apply for money to build these hospitals. We won't stop.

The second thing I told you is that we are going on with a roll-out of a system called Health Patient Record Registration System. I told you about it. That registration system, which NHI cannot work without, traces every patient from one hospital to the other, from one clinic to the other, from public to private. We will continue with all those initiatives. We can't stop. In the risk budget that was ready last year, we were given a sum of money - R1,3 billion. We said we are going to do four things. Among the things that we are doing, we are buying hospital linen. We are buying beds and mattresses, including pressure mattresses, as well as bath nets for children.

In total, it's R1,4 million articles that we are buying for public hospitals to spruce them up. We can't stop doing that as they are all part of our preparations. What the President has been asked to pause is the proclamation of a section of the Act that would allow us to establish the NHI Board. That's what we

UNREVISED HANSARD

have stopped for now, and there are several other proclamations that will follow in due course.

We can’t stop preparations. The claim that the President has reversed the decision comes from the same newspaper that has been saying that, in order to suspend people, the President must direct me. It is the same newspaper making those claims. Because of the war against the NHI, it is also the same newspaper that places my name in the headlines whenever someone hires a person from JE. Whenever there is something that sounds negative, they attach my name to it. And that’s exactly the same thing. It’s deliberately misleading. Thank you.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Minister. The next follow-up question comes from the hon Britz. Over to you.

Mr J H P BRITZ: Thank you, House Chair. Minister, given the profound economic implications of the NHI, the serious concerns raised by economists, the private sector, health care professionals, patients, National Treasury, and the Minister of Finance, and given that the parties to the ongoing litigation - including the President himself - have agreed to a court order

UNREVISED HANSARD

staying the implementation of the NHI pending a ruling on its own constitutionality - as you have just alluded to, on what legal basis do you persist in proceeding with preparatory steps towards implementation, as if constitutionality were a mere formality. Furthermore, how do you justify these actions in light of the risk that they may undermine the court order, violate your oath of office, and proceed without clear support from partners within the GNU? Thank you.

The MINISTER OF HEALTH: I can see you are acting like a judge now. Yes, you are giving a judgement on things that are already in court, because you are talking about economic implications, etc. We are challenging them. For instance, everyone tells us that NHI is going to cost the country R1,3 trillion. And, of course, we swallowed that lock, stock, and barrel. Where does that R1,3 trillion come from? And you are saying economists and all that, yet we have world-class economists in the world who have actually initiated the whole concept of NHI. They have written an affidavit for us against what you are saying. Now, let me come to this R1,3 trillion. It is even in the court papers that NHI will cost R1,3 trillion. Who came with that R1,3 trillion? It's Momentum Life. I am not going to hide it. Yes, it's Momentum Life.

UNREVISED HANSARD

Ms J S MANANISO: Chairperson, I want to rise on Rule 47. Delegates may not converse aloud. The Minister is trying to respond to the question, and the hon Britz is busy interjecting.

The HOUSE CHAIRPERSON (Mr B A Radebe): Alright. Thank you, hon Mananiso. I think that we should observe that protocol. Let us not be disruptive. Over to you.

The MINISTER OF HEALTH: Yes. Even the people who are making these claims have different figures. Momentum Life says it's going to cost R1,3 trillion. Health Funders Association, to which Momentum Life is affiliated, quoted a figure of R930 billion. Another places the figure at R450 billion. These are huge differences. When Momentum Life brought this figure, I mentioned it deliberately so.

In a meeting of doctors in Durban, I said what they have done is mathematical hooliganism. Because I wanted to call attention to this. Of course, they were beaten by my words, and they came to my office to complain why I said they are doing mathematical hooliganism. I said, how did you arrive at R1,3 trillion? This is what they said to me. That's why I can say it publicly. They said they were putting various scenarios in their own workshop,

UNREVISED HANSARD

and the media picked it up and ran away with it. I said, why don’t you correct it? They said they issued a statement, and no media house is prepared to print it. I asked them how did you arrive at 1,3 trillion when you are doing this scenario planning. It was very simple - simple high school mathematics, which shows that it can be true. They went to the Council for Medical Schemes, took an average of what a person is charged when they go to private hospitals - which we all know are very expensive - then multiplied that figure by 63 million South Africans and arrived at R1,3 trillion. Does this mean that every South African - all 66 million of us, not just 63 million - will go to private hospitals? What about the large hospitals that provide better care? If you go to a private hospital today, you quickly run out of money, and they refer you to public facilities.

This R1,3 trillion estimate assumes that we would close all public hospitals, which we have never said. We asked them to write us an affidavit to court to explain this thing. You can shake your head a million times, but I am giving you the facts. You are not a judge. What you are saying is what I am challenging. You want me to admit defeat even before the matter

UNREVISED HANSARD

is heard in court and say they are right when I know they are very wrong. As I am talking here today in front of you ...

Ms J S MANANISO: Chairperson, please save us from the hon Britz. Save us from hon Britz. I am standing on the same Rule that I stood on.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Mananiso. I think hon Britz that is true. You fielded a question to the Minister ... Give the Minister a chance to respond. Even if you don’t like the response, a response is still being provided. Let us ... [Interjections.]

The HOUSE CHAIRPERSON (Mr B A Radebe): Alright. Thank you, hon Mananiso. Hon Britz, please.

The MINISTER OF HEALTH: Yes, I am left with 13 seconds. Well, there are human beings ...

The HOUSE CHAIRPERSON (Mr B A Radebe): What are you rising on, hon?

Mr F J BADENHORST: I am rising on Rule 47, Chair.

UNREVISED HANSARD

The HOUSE CHAIRPERSON (Mr B A Radebe): Yes.

Mr F J BADENHORST: Rule 47.

The HOUSE CHAIRPERSON (Mr B A Radebe): Yes.

Mr F J BADENHORST: Chair?

The HOUSE CHAIRPERSON (Mr B A Radebe): Yes.

Mr F J BADENHORST: Just be consistent, please. The whole House is making a noise. Not just the hon Britz. Everybody is conversing while he is answering a question. The whole House is doing it.

The HOUSE CHAIRPERSON (Mr B A Radebe): Your point of order is not sustained. I have made a ruling on that. [Interjections.] Continue, hon Minister.

The MINISTER OF HEALTH: Well, there are individuals who do not want to hear the truth. There is nothing you can do about that. You just don’t want to hear the truth because you believe that

UNREVISED HANSARD

what you believe in is the golden truth. But that’s not. You better listen to other people. Thank you.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Minister. The next follow-up question will come from the hon Kennedy from Limpopo.

Ms M KENNEDY: Thank you, Chair.

Sepedi:

Re a leboga ...

English:

... hon Minister. You know, we understand that the complainants came with different discrepancies. Again, in light of the so-called sanction agreement of between 24th and 27th February, where the state agreed to suspend the NHI, what specific binding legal actions are being taken to address the public participation failures highlighted by the applicants in their complaints? Thank you.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Kennedy. I don’t know whether the Minister will be in a position to answer

UNREVISED HANSARD

that because it's like prejudging what is going to happen in the court. But you can ...

The MINISTER OF HEALTH: Well, as far as I know, hon member, the challenge about process is a challenge against the NCOP. It is you, the NCOP, who must answer that. The challenge is to the Chairperson. Yes, the papers were served to the Chairperson of the NCOP and all the speakers and all the MECs of provincial legislatures. It is up to you because you are the ones who are being challenged that you did not follow normal procedures.

In the National Assembly, the challenge was given to the Speaker of the National Assembly, the President, the Minister, et cetera. As far as I know, they are responding. For my part, as the Minister, two weeks ago—because we were given a deadline—I signed a 1,000-page affidavit explaining all these issues to the judges. Yet someone here has presented himself as a judge and has already passed judgment on the matter. I want the court to decide. I did not mention him by name - I didn't.

Mr J H P BRITZ: Hon House Chair, I am going to object to that because that is not correct. I have never purported myself to be a judge in this House or anywhere else. I am a lawyer, but I am

UNREVISED HANSARD

not a judge. I have never said that. That, sir, the Minister is telling lie.

Ms J S MANANISO: Chairperson, I want to stand on Rule 48. [Interjections.] On a point of order, please.

The HOUSE CHAIRPERSON (Mr B A Radebe): On what Rule?

Ms J S MANANISO: Thank you, Chairperson. I would want to stand on Rule 48 which states that delegates may not be interrupted. I want to read this one along with Rule 47 because here, what the other member is doing is interrupting the hon Minister and is also addressing the Chair. So, please, can you rule on these two points of orders with regards to what the hon Britz is doing? I thank you.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Mananiso and hon Britz for what you have just raised. But to be fair to the Minister, he didn't refer to any person here. He didn't refer to any person. He just said there is a man standing as a judge. As to who's that person is, I really don't know. I don't know whether you know. I really don't know. Let us give the Minister a chance to finish his speech. Okay.

UNREVISED HANSARD

The MINISTER OF HEALTH: Hon Chairperson, there is a man here who is presenting himself as a judge in this very House. I don't know why he believes he is a judge, because he is not. I have written my affidavit of 1 000 pages challenging some of the things that are being said there. It's up to the judges to sit and listen and make a ruling. Thank you very much.

Mr M BILLY: On a point of order. On a point of order, Chair.

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Minister. On what are you rising, hon Billy?

Mr M BILLY: I am rising on Rule 61, House Chair.

The HOUSE CHAIRPERSON (Mr B A Radebe): Yes.

Mr M BILLY: Chair, I think it is incorrect for the Minister to refer to ... to members of this House because he specifically says that there is a man here and there are not men here, there are Members of Parliament here, there are hon Members of Parliament here. It would be incorrect for you to allow him to refer to members of this House as just men, that can't be correct and I want you to Rule on that.

UNREVISED HANSARD

The HOUSE CHAIRPERSON (Mr B A Radebe): Thank you, hon Billy, your point of order is sustained. Over to you, Minister.

The MINISTER OF HEALTH: Yes, hon Chair, I withdraw. There is an hon Member of Parliament in this House who is passing himself as a judge and he is not. Thank you very much.

The HOUSE CHAIRPERSON (Mr B A Radebe): Are you done, Minister?

The MINISTER OF HEALTH: Yes.

The HOUSE CHAIRPERSON (Mr B A Radebe): Hon members, without further ado, we have come to the end to the question session. Hon members, it's confusing because it's always the ANC. That's why .... The next follow up is for the hon Fienies.

Ms D W FIENIES: It was supposed to be a question of the UDM. Hon Minister, thank you for your response. In terms of the pausing of the proclamation of the first session, you have indicated that it won't have any impact on the reparations of the NHI. My question is: Can you please clarify if it's going to have any impact on the delivery of services from the government? Thank you very much.

UNREVISED HANSARD

The MINISTER OF HEALTH: No ways! We can't stop services from government under no conditions. Can we do that? We will continue providing services mandated to us, whatever they may be. In fact, there has already been a case like that. You will know that NHI is a branch incubated in the Department of Health, which is headed by the deputy director-general. When that deputy director-general advertised post, Solidarity went to court and stopped them and said the NHI is still in court, we are still challenging it, you can't hire these people. The court said no, you can't stop the government from preparing and strengthening health care system and providing health care. That judgement has already been out and said no. Those 400 people were hired because the judge said you can't stop government from providing health services because we are in court. So that one will never happen, hon member. Services will still be provided - every day.

The HOUSE CHAIRPERSON (Mr B A Radebe): Hon delegates, we have come to an end on the Minister of Health's session. I would like to thank him for availing himself to answer the question and providing so much information in the few hours he was in. Thank you, hon Minister, you are free. Hon delegates, I now call the Minister of Social Development, hon Minister Tolashe, to respond to Question 29 of the hon Fienies.

UNREVISED HANSARD

Question 29:

The MINISTER OF SOCIAL DEVELOPMENT: Hon House Chair, good afternoon to yourself and to all hon members in the House, as well as people who are here to come and hear more on the work that you’re doing. As you would know, the Gender-Based Violence Command Centre is an essential first point of contact in our response to the scourge of gender-based violence and femicide.

The provision of psychosocial support services for survivors is critical to the reduction of the effects of crime and help them to heal, recover, and rebuild their lives.

The decision by the President, Cyril Ramaphosa, to declare gender-based violence a national disaster has made it even more urgent than ever before. We have to improve the operational efficiency of this kind of a scourge. Accordingly, hon member, we have embarked on a nine-point plan to address operational issues that, if left unattended, may hinder the effectiveness of the gender-based violence behaviour change communication, BCC.

The plan involves, amongst other things, refurbishment of the building, procurement to fit the purpose, office furniture, installation of bulk power and backup water tanks, to minimize

UNREVISED HANSARD

operational disruptions as well as appointment of service provider to be on standby for maintenance related issues.

We're also upgrading fire extinguishers and addressing mental health issues such as stress and burnout in line with the occupational health and safety requirements.

Plans are currently underway to transfer the building from the Department of Public Works and Infrastructure to our own department so that it can be user friendly and we must use the user agreement. This will ensure that we have full control and management of the facilities to address any emerging issues.

With regard to payments of service providers, I have directed the accounting officer to ensure that the payment of all valid invoices within a period of 30 days, as according to the Public Finance Management Act, should be honoured. I thank you, hon House Chair.

Ms D W FIENIES: Greetings to the hon Minister and thank you for the response on my question, hon Minister. Can you please provide a time frame for the implementation of these remedial actions that the department is busy with?

UNREVISED HANSARD

The MINISTER OF SOCIAL DEVELOPMENT: Hon House Chair, even though we did put timelines, this is extremely urgent, as it deals with the one that is now agreed by the world, that South Africa is rating as one of the worst countries in so far as this scourge is concerned. And as a result, we have tried and put every effort to make sure that the latest in 30 days, we should be able to put things in place, especially those that are in our purview, to make sure that there's no hindrance in the work that is being done by people whose better life is spent into those areas.

We are saying this intervention will ensure that gender-based violence operation centres are optimally made to be effective without any disruption. We are quite committed into this because of what we all know now, what South Africa is going through, what we have put in place, and what then sometimes become a challenge, which all the time, as a responsible executive authority, should make sure that I move with a little bit of agility to resolve those. I thank you, hon House Chair.

Ms N S Du PLESSIS: Hon Minister, with these interventions, why is the GBV rate increasing in South Africa this year, when in other developing countries that have implemented the same

UNREVISED HANSARD

interventions for GBV and Intimate Partner Violence, IBV, such as Congo, Philippines and Cameroon, the rate has decreased?

The MINISTER OF SOCIAL DEVELOPMENT: My apologies, House Chair, I couldn't hear the question.

The HOUSE CHAIRPERSON (Mr B A Radebe): Can you repeat your question?

Ms N S Du PLESSIS: With the interventions that you've done as a department, why has the GBV rate increased in South Africa when in other developing countries such as Cameroon and Congo and Philippines that have done similar interventions, the GBV rate has decreased? Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: Hon House Chairperson, the hon member might be aware that gender-based violence and femicide is informed by a lot of issues. For instance, the crime rate in South Africa has created this, us having to go through the most traumatic area of where our people just die like flies, the COVID-19.

UNREVISED HANSARD

The fact that there are social ills that you are going through on a daily basis, we learn other new issues that are coming through. As we are employing all this, at the same time learning out of it. We are still confronted with some of the things that have articulated... and this is why the gender-based violence cannot be addressed by one department.

It is now a gender-based violence scourge that is now being dealt with almost all the departments. For instance, you would know that the President has just set up an inter-ministerial committee that must deal with issues of legislative framework that exist within our laws that seeks to confront gender-based violence.

For instance, you would know that all of us, we have issues with the bail processes, a bail application on perpetrators. Majority of women and progressive people are suggesting that our legislative framework is too lenient when it comes to bail, which is what now, as we implement everything else, we should be able to look closer at the existing legislative framework and be able to amend them.

UNREVISED HANSARD

So, this is why it takes a little bit longer for us to be able to resolve this. And, because of all other factors that we all know and are aware of, the gender-based violence takes longer to be addressed. Not because you are not doing anything as the House, lawmakers, not because our people are not doing anything that is mobilisation of the society, but because we are learning new things that are coming our way as we are trying to make sure that we deal with those that have been there but who have not been able to pick them up.

The last one, the issue of paroles. Nobody ever came closer to the process of paroles, that sometimes the serial rapists are not just coming out in one time. When you do your follow-up, you realize that these perpetrators have been doing this for more than two, three, four times. And you realize that they get paroles because the department is following its own processes.

And now we're bringing that closer to say, let's look at the processes that are followed when people are given parole, whether themselves are not contributing into what we are going through on perpetrators that are coming out of jail and repeatedly rape people.

UNREVISED HANSARD

We did pick this up in the northern areas in KwaZulu-Natal, KZN, uMkhanyakude that a serial rapist is in fact now going back to jail because again he has raped.

So, this is what I'm saying, that it's not even one or two or three things that you must put in place for us to confront. It is about looking at the legislative framework that exists and make sure that what we have introduced with many hands on the deck, we are able to resolve this matter. Thank you, hon House Chairperson.

Ms A M SIWISA: Greetings, Minister. Minister, social workers are overworked and underpaid, while shelters which survivors are being referred to are falling apart.

Given that social workers play a significant role in ensuring that survivors of GBV receive counselling, and given the recent promise made by the President, at his Sona that there will be social workers at every police station to ensure a proactive response to survivors. What urgent steps have you taken to ensure the availability of these facilities? Thank you very much.

UNREVISED HANSARD

The MINISTER OF SOCIAL DEVELOPMENT: Hon member would be aware of the fact that as a department, we are embarking on establishing these shelters. Of course, we have not covered all districts because we took the approach of district development model, DDM. But in this new financial year, we have planned ahead once again to have more.

On the shortage of social workers. That is a fact. And this is why the President have announced that every police station must have a social worker. And now the process as members would be aware, will be awaiting now for a process of departments themselves to pronounce on how many social workers for that particular financial year, which is 26, 27, will they be able to absorb.

Of course, social workers in South Africa are not a scarce skill. They are available, they were taken through by government, hence they are now readily available. But we are now waiting for a process wherein SA Police Service, SAPS itself will then take its share according to their budget to make sure that they absorb social workers.

UNREVISED HANSARD

Ourselves, we’re working with the institution that deals with that so that we can be able to work together with all departments to recruit and help social workers for the purpose of confronting gender-based violence and femicide, but also for all other social ills that you are going through. This is the approach, hon House Chairperson. Thank you.

Ms T BREEDT: Hon Minister, let me start by telling you a story of Joyce. Joyce is a social worker in Qwaqwa. I was fortunate enough to meet her and hon Noe as well when last year we went on our provincial week oversight there. She is specialised in dealing with children and children from households of abuse, yet she is unemployed, has been unemployed for multiple years.

She is trying to keep up with the latest developments in social work and is trying by all means to find employment. She wants to serve her rural community of Qwaqwa that has a need for social workers like her, but she is purely not finding employment.

You have now, hon Minister, and it’s very welcomed that you will go through a process with other departments and with SAPS to identify what need they have for social workers. But are you looking at having a database or asking these unemployed social

UNREVISED HANSARD

workers to register to be taken up in these projects and your GBV centres, because it doesn't help. We know what our need is, but we can't find these unemployed social workers. Thank you, House Chairperson.

The MINISTER OF SOCIAL DEVELOPMENT: Hon member, you would know that social workers in South Africa are registered, so you don't have to go and look anywhere else. There's a database available. So, it's something that, as I said earlier on, once again to say, in fact, this government provided bursaries for majority of them to acquire what they have. Now the process is, how do we then absorb them to come and do the work that we have articulated?

But again, I must say, provinces are doing far better than all of us because in their provincial budgets, to an extent, they are able to recruit that. I can send to the House submit on the statistics, stats of provinces, but at national level, we are trying to make sure that we take some where we can in making sure that we have an impact in fighting gender-based violence.

What the hon member is saying is what I said earlier on. They are unemployed social workers, trained. I'm not saying they are

UNREVISED HANSARD

social workers by how they look. They are trained social workers, registered by the responsible institution. And therefore, this recruitment that is going to start is not going to be everywhere else. It’s going to be a targeted recruitment. Thank you, House Chairperson.

Question 40:

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson. On the policy and legislation framework, South Africa has several policies and legislative frameworks that are aimed at strengthening efforts to end gender-based violence in femicide, GBVF. These policies and pieces of legislation guide us in the implementation of programmes and interventions that are aimed at strengthening prevention, response, care and support services for survivors of gender-based violence.

Key amongst these is the Domestic Violence Amendment Act 14, 2021, the Sexual Offences and Related Matters Amendment Act 13 of 2021, the National Strategy Plan on Gender-based Violence and Femicide, and the policy provision on psychosocial support services, to mention but a few. In addition, we will soon be tabling the Gender-based Violence and Femicide Support Services Bill before the Cabinet.

UNREVISED HANSARD

Hon Chair, the mandate of the department, as expressed in these policies and pieces of legislation, is to render care and support services to survivors of GBVF. This mandate we do not take lightly, because for many survivors of GBVF, having access to a safe space and receiving psychosocial support is the first step to break the cycle of sub-abuse. The timely provision of shelter services can save women in abusive and life-threatening situations.

In terms of the national strategic plan on gender-based violence, the department is responsible for Pillar 4. This focuses on strengthening the existing response care and support services by government and civil society in ways that are victim-centred and survivor-focused to facilitate recovery and healing.

Other interventions under Pillar 4 include the expansion of the Khuseleka One Stop Centre model through partnership with other Departments of Public Works, in particular. This involves the repurposing of dormant public facilities and shelters for gender-based violence survivors. Scaling up the Boys and Men Championing Change programme through the District Development

UNREVISED HANSARD

Model. This is a social behaviour change programme that promotes positive masculinity.

Appointing and deploying gender-based violence champions in areas identified as gender-based violence hotspots but also providing financial support to community-based organisations that render prevention and front services to support GBVF survivors. These packages of services are complemented by the Gender-based Violence Command Centre that provides telephone, professional psychological support, and trauma counselling services to victim-survivors of gender-based violence.

The GBVF offices operate in a national 24/7-day call centre facility, staffed by qualified social workers. The centre has an emergency line number, which is 0800 428 428, supported by a “Please Call Me” facility. In addition, we have a national emergency response team to provide immediate and positive response in the form of psychosocial services following an incident of trauma within 72 hours. Thank you, hon Chair.

Ms N S Du PLESSIS: Thank you very much, hon House Chair. Hon Minister, all of these have been implemented, but gender-based violence has increased, while violent crime is reported to have

UNREVISED HANSARD

decreased. Between July and September 2024, three months in recent history, 957 women were murdered by their intimate partners. There are numbers, and there are humans behind each one of these numbers. 1 567 women survived attempted murder. Again, behind each number is a person.

Fourteen thousand three hundred and sixty-six assaults with grievous bodily harm and 10 191 rapes were reported. These incidents did not just occur; they were also reported. Behind each number is a person, a woman. Was the budgeted money spent correctly, or are the plans failing the women of South Africa?

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson. The hon members would be aware of the fact that, as individual departments, we put our prayers before the National Treasury on what we would love to have in each financial year, looking at the mandates that we have, of course, you still get a particular amount of money, which is what you will be getting in that particular year. So forever, you will have to look forward to getting more. Even in the medium-term, you would want to get more. However, you still get what is dedicated to yourself.

UNREVISED HANSARD

Hon Chairperson, "Behind every number, there is a person." We will not stand here and claim otherwise. We all agree that gender-based violence in our country has now moved from being a scourge to a disaster. This is why the President has described it as such. This is also why we are all working hard to ensure that each strategy we have implemented not only works but also yields positive results, so that we can effectively address this issue.

Yes, the statistics will be there, but you also think about those who are not even able to reach the police station. for them to be able to register their cases. This is what we are going through as a country. This is what we are dealing with. This is why we are even introducing programmes that are talking about behavioural change, because this is in the mindset of a man. Of course, you would articulate the environment and everything else, but at the centre, like the hon member is articulating, there is a warm body behind that number.

So, we are very hard at work in partnership with the other sister departments, relevant nonprofit organisations, NPOs, working with us and other international organisations that are also assisting us to deal with the scare. Yes, we are not going

UNREVISED HANSARD

to compete and really talk about the stats and so on, even to start to say no, it is lower or it is up, because one is rather too many.

We wish to live in a country where women can walk the streets without fear. They should be able to feel safe in their own spaces and homes, without worry. Those who are meant to love them have, in some cases, become their constant enemies. As a department at the centre of this issue, working with other departments, this is the change we want to see. We are doing everything possible to achieve this. It is a challenge, as it requires everyone in this house to commit and say, "I will not be counted among those men who are alleged or confirmed to be involved in gender-based violence." However, it cannot stop there. We must take action to confront this issue, and the Council should have programmes – which I know you do – that make a real impact on our people's lives, so there is no excuse for men to engage in gender-based violence.

The young men must also be included, and as I have mentioned, we now have programmes that bring them closer, allowing us to engage with them directly so they can understand why they should support women, not hate them. So, I am saying to the member, the

UNREVISED HANSARD

realisation of the seriousness of gender-based violence and femicide has triggered the president to declare it a disaster. Thank you very much.

Mr M P SIBANDE: Chairperson, through you, ...

IsiZulu:

... ngivumele ukuthi ngibonge kumama uNgqongqoshe, umama uNokuzola, obuye futhi abe umongameli wami, ngezimpendulo zakhe ezinohlonze ...

English:

... therefore, my question is how the department ensures effective co-ordination and legislative implementation in addressing gender-based violence and femicide?

The MINISTER OF SOCIAL DEVELOPMENT: Thank you, hon member, for the question. Hon Chairperson, as I said earlier, we are working closely ... The Department of Social Development, DSD, was never part of the Justice, Crime Prevention and Security Cluster, JCPS cluster, for example, a structure that drives and monitors the safety of the country. We are now part of that because the

UNREVISED HANSARD

gender-based violence became a sketch to start with, and now it is a disaster.

This shows and demonstrates the commitment of this government and our department in making sure that we make a point to everyone else who might sometimes not understand because they are far from these issues, to say this matter is now a threat to the country, not only to women alone. When you have a threat to the country, the country must be able to consider it and make sure that it employs a strategy that deals with that.

Indeed, we are now part of the JCPS cluster. In there, we can give feedback daily whenever we may to get to hear more about when those women were able to get to the police station. Because I repeat this to say, not all women get to the police station. Some die at home, some die on the way, and some are never able to report this. Because the person who is embarking on this is sometimes the so-called breadwinner. It becomes difficult for women to go and report a breadwinner because the next morning, she would not know how to look after her family.

This is why we are part of Pillar four. Because our intention there is to make sure that not only do they forever become

UNREVISED HANSARD

victims of gender-based violence, but they can be assisted to get out of those relationships and be able to lead and live their lives. This is why we are doing this.

Chair, I am not going to report on things that I said earlier, but I just want to articulate strategic interventions that we are employing in making sure that we deal with this matter.

We are saying we are now part of the JCPS cluster, which means even in police stations, we must see to it that decisions and laws that are put in place are now implemented. When they get to the police station, there should be a room that is dedicated to them to be able to speak closer to the responsible people without fear of being exposed. So, this is what we are doing beyond us as the DSD, with sister departments that are there working with us.

Hon Chairperson, I said earlier that we brought strategic departments to even make sure that they will look at the legislative framework that exists, and where there is a need, we are calling for the review of those. We are working with capable NPOs and NGOs that have a history of fighting gender-based

UNREVISED HANSARD

violence. And of course, with limited resources, we do share with them in several cases.

So, we do have a coherent approach that seeks to deal with gender-based violence and confront it systematically to an extent of saying this negative masculinity must be dealt with at a tender age, so that when he grows, he grows up knowing that their responsibilities will be to defend their sister and make sure that he makes the environment safer for both of them. This is how far we have been able to go. Indeed, there is a problem of GBVF in South Africa, which is now disastrous. Thank you.

IsiXhosa:

Nksk. M MAKESINI: Mphathiswa, mandibulele ngempendulo yakho ecacileyo kwaye ndiyaluva ungenelelo enilwenzayo namanye amasebe anxulumene neli lakho. Kukho aba mama basweleka bephethe amaphepha esiThintelo seNkundla (Protection Order).

English:

How effectively are you doing to make sure that courts assist?

IsiXhosa:

UNREVISED HANSARD

Iinkundla zamatyala zinomkhuba wokuphinda zithume lo mntu wenze isicelo ukuba ibe nguye odlulisa isiThintelo seNkundla eso kumenzi wobubi.

English:

What are you doing to assist and make sure that ...

IsiXhosa:

... aba bantu bayakhuseleka. Ixhoba linoxanduva lokudlulisa eli phepha ngokwalo kumenzi wobubi nto leyo embeka esichengeni sokuphinda ahlaselwe kuba enze isiThintelo seNkundla. Senza njani ukusebenzisana neenkundla zamatyala ...

English:

... to intensify and strengthen that system? Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: Chairperson, as an ordinary department of social development, we might not realise that, in fact, the protection order can be a death sentence. To put it that way, once she holds that paper, it means the next thing that could happen is her death.

UNREVISED HANSARD

This is why we are now working more closely with the Minister of the Department of Justice and the JCPS cluster to examine the issuing of such orders. As you may know, the victim is responsible for seeking him out to serve the order, which already exposes her to the risk of being killed.

IsiXhosa:

... enzakale.

English:

... We are now at the stage where the Minister is closely examining the legislative framework to determine whether the process leading to the release of the document to her is appropriate, and whether it is correct to say she must be responsible. I do not wish to pre-empt her work, but when she is ready, she will be able to see that I have redesigned it so that it is no longer a death sentence for her, but rather a document that can genuinely protect her during this process. We have taken note of this. Women and others, particularly NPOs and NGOs, have expressed concerns that this is now even more dangerous. We have considered this and are working within the JCPS cluster. The Minister of Justice is addressing the issue.

UNREVISED HANSARD

Dr I SCHEURKOGEL: Thank you, Chairperson. Minister, often, the lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, LGBTQA plus, community is overlooked when GBVF is addressed.

How does the department collaborate with SAPS to support GBVF victims and to ensure that SAPS officers are properly capacitated to deal with the trauma a GBVF victim is undergoing, especially with the LGBTQA plus community, so there is no additional trauma through discrimination?

The MINISTER OF SOCIAL DEVELOPMENT: Thank you, Chair. The hon member would know that this sector of people is being recognised in South Africa. For that reason, every piece of legislation that has been taken through these two Houses will take care of that sector. This is why the Department of Women, Children and People's Disability, in their arrangement, is working very closely with them.

Hence, we, as DSD, are working very closely in all branches that we have in the department, whether you are in the youth or people with a disability, but in the centre of people who are part of the HIV and aids programme.

UNREVISED HANSARD

I am saying that all the laws or pieces of legislation that are being processed are taken into consideration, because by law we had to recognise them. They are not so smart because if you do not do it, there is a possibility that they can take you to court.

This is why we work closer with them all the time. To hear from them and make sure that every new law or piece of legislation that is being processed it must have considered their input so that you have a complete South African law or piece of legislation or where we think or they have an issue to say, this does not look after our interests. Some platforms are open for them to engage for us to find each other.

Like you are saying, sometimes they are being taken for granted and become targets. This is the crime that we are talking about in South Africa that we must all fight. No one must be judged to an extent, nor must they be hurt because of their beliefs. Thank you.

Question 30:

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson, good afternoon to you. The proliferation and use of

UNREVISED HANSARD

illicit drugs is a serious threat to our national development agenda, with studies indicating high prevalence rates among high school learners across the country. What is more alarming is that more learners start experimenting with drugs at an early age, with some beginning to experiment with drugs at the tender age of eight to nine.

Given the foregoing, the most effective and sustainable approach to reducing demand is building the resilience of young people through prevention. The old-time saying, prevention is better than cure, still holds so much value, especially as we confront the scourge of substance use and substance use disorders, which has now found its way to school playgrounds. There are many measures in place to ensure drug-free schools, including the School Safety Programme and the School Health Programme, both of which are part of and are being led by the Department of Basic Education. One of the mainstay interventions targeting young people is Ke Moja. Ke Moja is a word that appeals to young people, which says I'm fine without drugs, a youth-driven prevention campaign targeting in and out of school children. To make it more relatable to young people, we also collaborate with recovering substance users. Remember those who become victims, it sometimes becomes difficult to come out, but when they've

UNREVISED HANSARD

been able to at least fight the scourge, we then implement this programme with key partner departments, such as the Department of Health, the Department of Basic Education and the SA Police Service, local-based organisations that conduct consistent drug awareness with local schools.

To date, we have reached over 500 000 learners in schools across the country. This work is guided by the National Drug Master Plan, which focuses on prevention, demand reduction, supply reduction and harm reduction. We all know drugs have a devastating impact on our society, leaving a trail of destruction and misery for many families and communities across South Africa. Worst still, it is often the most deprived areas that face the most drug-driven crimes and related health harms that suffer the most. Although it affects all ages, the impact on the youth is particularly devastating. Many of our young people who should be preparing for a future of hope and opportunity are instead drawn into a cycle of addiction, school dropouts, unemployment and violence. Substance use disorders often coexists with mental health issues and homelessness. We know that substance use does not exist in isolation; it interacts with and often fuels other social ills, most notably gender-based violence and femicide. A more co-ordinated whole of

UNREVISED HANSARD

the government and society response is needed to tackle the growing challenge of illicit substance use and substance use disorders with a sense of urgency. This is the function of the Central Drug Authority, CDA, which derives its mandate from section 10 of the Prevention and Treatment of Substance Abuse Act No 70 of 2008. Its role is to ensure that our work is multisectoral, intergovernmental and fully co-ordinated across society.

This work is anchored in the National Drug Master Plan, our national blueprint for building a free society free from the harms of substance use and illicit drug trafficking. The National Drug Master Plan sets out seven national goals, including demand reduction through prevention, treatment and reintegration, supply reduction through the SAPS and our many entities in law enforcement, and cross-cutting goals that address the social and structural drivers of substance abuse. These goals provide the framework for all the government and all of society to approach and to act in unison. I thank you, hon Chairperson.

Mr M FENI: Yes, Chairperson, thank you very much.

UNREVISED HANSARD

IsiXhosa:

Masibulele kuwe Mphathiswa ngengcaciso yakho ephangaleleyo, ngokusixhobisa, usikrobisa kwiindlela isebe elincedisa ngalo ukuqinisekisa ukulwa nale nengxubakaxaka ejongene nabantwana ezikolweni. Ayabonakala amalinge okulwisana nale ngxaki ukuba sowuhambe umgama ophambili kakhulu. Mphathiswa, ingaba nikhe nawujonga unobangela otsalela nohenda abantwana bethu ezikolweni ukuba baqhubeke besebenzisa iziyobisi? Enkosi.

English:

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon member, ...

IsiXhosa:

... okokuqala nje ...

English:

... as you might be aware, ...

IsiXhosa:

... sikwixesha lokuchaphazeleka kakhulu kwiindawo esihlala kuzo. Kwiilokishi ezincinci, ezidolophini, kwiilali nakwimimandla emikhulu ezidolophini ilizwe lethu lambethwe

UNREVISED HANSARD

kukuxhaphaka kweziyobisi. Yinto yokuqala leyo esijamelene nayo singuMzantsi Afrika. Abantwana nabantu abatsha ngabantu bokulinganisa nayiphi na into eyenziwa ngabangaphambi kwabo.

English:

And in this case, if there is this availability of drugs around where people are staying, surely, we won't be able to have a situation where children would not want to try them. But, also, the fact that our people are living in a violent community and society, this also informs that they can also be taking these drugs to make them brave.

IsiXhosa:

Abantu ngenxa yenkohlakalo baye bafune ukuba ibengabantu abakwaziyo ukulwa kuba baneengxaki zokuhlala. Siyafumanisa ukuba kukho abantu abathengiselwa iziyobisi ngabantwana ezikolweni. Sesona sizathu esibangela ukuba sithi amapolisa ...

English:

... the SAPS must create a tighter belt in our borders in making sure that those coming in that way can be stopped even before they get into our country because we believe ...

UNREVISED HANSARD

IsiXhosa:

... ukuba kungcono siyinqade ingekenzeki. Xa behamba isikolo ...

English:

... we are working with the Department of Basic Education for us to be deliberate in talking about the harms that are being created by those who are taking drugs, so that ...

IsiXhosa:

... abantwana ...

English:

... now, it is that time when we must be honest with them, talk to them, so they can understand what the problems would be if they start taking drugs. And lastly, this is why law-abiding citizens must assist in this regard, because everybody knows where the drugs are being sold. In every township and village, one way or the other, there will be this house, an area that is notorious for making sure that they sell drugs.

But lastly, this is why we must, together, fight with undocumented people that are in our country to make sure that we

UNREVISED HANSARD

clean our streets and villages, so that we can be able to make sure that we close these spaces so that drugs cannot penetrate. But when they are found, we want to appreciate the work that is being done by the SAPS, in particular in making sure that ...

IsiXhosa:

... aba bafunyenwe neziyobisi baziswa ngaphambili.

English:

We want that co-ordination to be tighter and the SAPS to be stricter, and the society to link with the SAPS for us to be able to work together in making sure that we avoid this. It is a little awkward and devastating to find that our learners are starting to try at nine years old, and this is why families must take it upon themselves to protect themselves. There is no teacher who can be able to really deal with a ten-year old that deals with drugs.

Families themselves must close up. The government can do everything, but the government will not be able to be in that house, to look after seven, eight, nine, 10, 11, 12, 13-year-olds. So, the parents must take that responsibility to make sure that they look after their families. They look after their

UNREVISED HANSARD

children, in particular. [Time expired.] Thank you very much, hon Chair.

Mr O J MOKAE: Thank you very much, hon House Chairperson, good afternoon to the hon Minister, noting your response, and I think this is a very critical issue when it comes to the future of our country, the young people. The Safe School Protocol was launched by the Minister of Basic Education, Minister Siviwe Gwarube, to address this and other safety concerns in schools. And I note that you have highlighted your partnership with the Department of Basic Education, as well as with the SAPS.

But what I would like to know, and for the purpose of this question, is to understand what the tangible results of these interventions from your department are in working with the SAPS, as well as working with the Department of Basic Education, to address the issue in schools of drugs and crime on our school premises. I thank you, hon Chair.

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson, and thank you to the hon member, of course, hon member, this has not been a new concept. It is not new, but it was just revived and launched just to make it more effective

UNREVISED HANSARD

because now the country is beginning to be overwhelmed. We have not been able to put that assessment tool to say, what end results are we receiving? I will not stand here in this august House and mislead the House. I will just say, we have not been able to put that to say, how far we have been able to achieve, or what impact we are making. Remember, the impact will not be visible with immediate effect. We will see it later in life, whether maybe if this particular school has admitted 500 people, 500 students, whether they are coming out with 500 at the very last, because some of them might have been lost in the process. Then we'll be able to say there's a problem here.

Of course, other sectors, like health, will be able to say, indeed, we are getting a lot of reports from this particular school on children that are embarking on, and the Department of Social Development as well, because it's we that is implementing through the CDA, the National Drug Master Plan. So it is that kind of sectoral approach that will assist us to give you an end result on the work that you are doing.

But I'm emphasising to say, this is not a new concept. It has always been happening, but we want to renew it and reinforce and put more resources where we can and mobilise more stakeholders

UNREVISED HANSARD

in making sure that we become many on this matter, because this threatens the future of the country. And all of us here, I know, can't afford to have that. Thank you very much.

Ms A MATSHOBENI: Thank you very much, hon House Chairperson, good day, hon Minister, the problem here is the drug dealers that are continuing to destroy the lives of our people. We need to deal with the cause as the government. Why are these drugs not banned? Because each and every time ...

IsiXhosa:

... sineengxaki ezijamelene nabazali zabantwana bethu abaphelela eziseleni nababulawa kukusebenzisa iziyobisi. Kutheni ngenye imini, kule Ndlu singakhe sibenoMthetho osaYilwayo oza kuqubisana neziyobisi. Kufuneka zivalwe umphelo kuba ngowona bhubhane ubulala abantwana.

English:

Nonetheless, in light of the reports that about 30% of drug abuse causes are linked to family dynamics and poverty, which is ramped up in areas such as the Eastern Cape province, what progress have you made in filling the social worker vacancies in the Eastern Cape Department of Social Development, so as to

UNREVISED HANSARD

ensure that rural learners that are referred for early intervention received it? Thank you very much, Minister.

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, I'm looking forward to hearing from this House ...

IsiXhosa:

... njengabantu abenza uMthetho.

English:

The lawmakers are seated here to sit and see whether we can deal with what the hon member is talking about once and for all. Whilst I'm a Member of Parliament, I'm also a mother and grandmother. I stay in the township of Mlungisi, in Queenstown. So, I know exactly what we're dealing with here and what the experiences are. However, it's not me as the executive who can impose to say, "this must happen." Even though we are going through a very difficult process, I must agree with the hon members to an extent.

IsiZulu:

UNREVISED HANSARD

Omama, kwesinye isikhathi babethe, cha, isigwebo sentambo masibuye. Sibazwile, kodwa sathi, ngoba siyizwe lentando yabantu, ...

English:

... and we wouldn't want to go back from where we are coming from. Therefore, we should put in place, the government must act a little bit and inject agility to resolve these matters. So, I'm saying to the hon members, what she's saying is not far-fetched. It is happening. But also, as I said, these people are staying in our villages and in our townships. The communities must be able to tell the police that, look, there's something that is happening. It is a house that starts to be busy around nine in the evening until the early hours of the morning.

Therefore, it tells you that something untoward is taking place. So, if you can mobilise our communities to say, in fighting this, let's also be together in reporting things that are a little bit suspicious to us. That is what I would want to say.

IsiXhosa:

Eneneni ...

UNREVISED HANSARD

English:

... we are in trouble. About the social workers, earlier on, I responded to say that the provinces are doing far better than we are in recruiting and absorbing social workers. I committed to say, I can present to this House how far we are in making sure that we are dealing with this. Of course, again, with limitations. Because under the circumstances, every social worker should have been hard at work in helping us reverse what we're going through.

However, we are noting and we are appreciating the progress that we're making and the announcement that has just been made by the President. Indeed, the crisis in the Eastern Cape for obvious reasons. As Minister Motsoaledi said, I was listening to him and heard that ...

IsiZulu:

... zonke izinto ezimbi ziqala kubantu abampofu, ngoba ngesinye isikhathi, bacabanga ukuthi ububha buzophela uma sebebhemile. Ububha buzohamba uma imiqondo yabo ingasebenzi kahle.

English:

UNREVISED HANSARD

So in that way, it proves the fact that, we must effectively make sure that the resources that we put into our society in making sure that there's bread on the table, like the SA Social Security Agency, Sassa, grants, the project that can assist our people like what the National Development Agency, NDA, is doing, must be kicking in making sure that our people don't lose what they would want to do or what they can do. But the government is always there to assist them, train them, those young ones, in making sure that they are ready to establish their own NPOs and NGOs and be able to have their small businesses being trained and join the economy or be the employers themselves.

This is what we need to do, and this is what we are doing as the portfolio because we are the Department of Social Development, Sassa and NDA in making sure that, to an extent, we bump this that is a scourge in our society. Thank you very much, hon House Chairperson.

Ms L P MHLONGO: Thank you so much, Chair, and greetings to you, Minister. As a drug activist on the ground, there are issues that we face with rehab centres.

IsiZulu:

UNREVISED HANSARD

Ngizokhuluma nje la KwaZulu-Natal, umfana omncane okuthiwa uSenzo, owahluleka ukuthola usizo laphaya esikhungweni sokuvuselelwa kabusha.

English:

And I took it upon myself to make this a personal case for me. Only to get there, and the social workers were not willing to assist because they believed he had been an addict for the longest time. Now, my question is, with regard to the Eastern Cape, having reported a problem ...

IsiZulu:

... yokuthi izidakamizwa okuyi-nyaope ne-tik ziyakhula futhi abafundi ...

English:

... are being exposed to it daily. I would like to know, ...

IsiZulu:

... uNgqongqoshe, kumele asibonise yena ukuthi ...

English:

UNREVISED HANSARD

... how many school-based prevention programmes and rehab referrals have been implemented in the rural districts? Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, what the hon member is articulating is correct. As I said earlier, we have a legislative commitment in making sure that the National Drug Master Plan is being implemented and that automatically will look after all the centres that seek to deal with those who are affected. But also, other programmes would make sure that they prevent those who are still clean. I won't say anything except to say, it was out of order for social workers to say, just like that, people must go. I don't think that's the way of doing things. This is why we are preaching Batho Pele to our officials to say, people first, ...

IsiZulu:

... abantu phambili, makusizwe abantu.

English:

No official has the right to say people must go back, especially since you are fortunate in KwaZulu-Natal that you have a centre. There are areas where you don't even have that. So, in areas

UNREVISED HANSARD

where we do have centres, we expect our people, because they are all professional people who are recruited there, people who understand what they are supposed to do, because they've gone through training and are more knowledgeable. So, they are expected to assist all the time. Of course, we know and accept the fact that sometimes they are hindered by the shortage of resources, but provinces and we ourselves we are working very hard. For instance, we have spoken with, and we've been heard by the National Treasury to say that the CDA budget was a little bit and not so significant. And now we have just identified that it has been put in a just a better figure, but it's not a figure that you can all be proud of.

However, it is more from where it was, which was plus R9 million, it is now at 14 million, which then we say at least it will make a bump, but we still need more. This is why we must work with all other departments. So, I'm saying, hon member, with schools, indeed, when they're at school, they end up in our facilities because the Department of Basic Education does not have that. And this is why I'm saying, it is now upon us to sharpen up the resource mobilisation, further training and intensify training to people who are servicing our people. To make sure that those who are lucky to get into our centres, they

UNREVISED HANSARD

get the necessary help so that they be able to come back and be reintegrated into society and assist us because they are better placed in understanding where they were with this kind of a problem and how best they can assist ...

IsiZulu

... ozakwabo. Ngiyabonga, Mgcinisihlalo.

Question 52:

The MINISTER OF SOCIAL DEVELOPMENT: Hon House Chairperson, the function of ECD, that is Early Childhood Development, was transferred from the Department of Social Development to the Department of Basic Education in 2022, as the presidential declaration of 2019. Consequently, all matters relating to one, streamline; two, expedite a registration process for ECD; three, including regulatory issues, now fall under the Department of Basic Education. This is because ECD programs offer significant long-term benefit for families.

We continue to work with the Department of Basic Education to roll out programs aimed at strengthening families and parenting support as per the revised White Paper for families in South Africa. Through this collaboration, we encourage families to

UNREVISED HANSARD

enrol their children in the early childhood education centres because we all know and are aware that education is not a luxury but a necessary investment in the human capital of our nation. That would be my response, hon House Chairperson. Thank you.

Ms M KENNEDY: Hon Minister, reports of 2021 to 2025 in Limpopo ECD centres faced significant challenges of registration. Many centres remain unregistered. In light of this, Minister, you have launched the Bana Pele Mass Registration Drive as well as the eCares platform, yet thousands of centres in rural areas have no digital access or data to use your WhatsApp Bot. In light of this, what other steps of interventions have you taken to manually register centres in rural and township communities, which do not necessarily have access to internet? And what steps are being taken to eliminate the bureaucratic delays and corruption in the disbursement of subsidies, which often leave rural centres without funds for many months? Thank you.

The HOUSE CHAIRPERSON (Mr D R Ryder): Thank you, hon Kennedy. I do believe the Minister has addressed the fact that she's not responsible for doing those things. But, Minister, would you like to have a comment on the member's question?

UNREVISED HANSARD

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, this hon member is fighting with me. Whilst I appreciate and really understand what the hon member is saying, but I don't want to mislead the House, hon member. She's articulating statistics that is for me well researched. So I should not just thumb suck the response, otherwise I will be misleading the House. I can organize that the concerned department should submit that follow-up because in this matter we are working together. Remember, children are our responsibility as per the Constitution of the republic. So if there is that abnormality, then it will concern us. I commit outside all the procedures that I will make it a point to find out what is the problem and send the response. I know the Department of Basic Education will be very keen in wanting to submit that response and it will be responded by myself.

Ms S MASUMPA: Thank you, Minister, for all your response. The ANC won't be making any follow-up question. Thank you.

Dr I SCHEURKOGEL: Minister, either this question was written long before when Julius still had friends or this member has not noticed that the responsibility of ECDs have been moved to the Department of Basic Education some time back. So the real

UNREVISED HANSARD

question is, now that your department has one less responsibility, what exactly have you been doing with your extra capacity? Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: The last part of the question was everything that talks to the ECD has been transferred to the Department of Basic Education. It has been a long and tedious process, but it has been done and concluded. Thank you very much.

Ms T BREEDT: The hon Scheurkogel almost took the words out of my mouth, but let me see, hon Minister, if I have another question for you. In terms of the transfer of ECDs from the Department of Social Development to the Department of Basic Education, did we see any of those ECD centres being at a disadvantage because of that transition? I remember it's been long years coming. How has that been mitigated to ensure that those that were maybe lost in the process have not actually stumbled and fallen off the bandwagon? If that can maybe be clarified. Thanks, hon Minister and House Chairperson.

The MINISTER OF SOCIAL DEVELOPMENT: Hon House Chairperson, the hon members would realise that the decision was taken in 2019

UNREVISED HANSARD

and implemented only in 2022. It informs you that all other processes were followed in between to an extent of where then the implementation took place. I wouldn't want to mislead the House once again and give details into that because I don't have it with me. Surely, if now you have ECDs, all of them falling under Basic Education, you would know that all the logistical arrangement would have been done. Even those who fell through the cracks in 2022, I guess by now we would have resolved them. Hence, I asked the hon member to say if she thinks there is something that we can still do, we can still talk to our sister department and say there is a member in the NCOP who would want to hear more, which we can do. But that one, hon Chairperson, I am unable to give that statistics because it was a 2019 decision, then implemented in 2022. Thank you very much.

The HOUSE CHAIRPERSON (Mr D R Ryder): Thank you, Minister, and I do trust that the questions office has taken note. Minister, we now move on to Question 46.

Question 46:

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson, on this particular question, while we have made considerable progress in the implementation of the seven goals

UNREVISED HANSARD

of the National Drug Master Plan in the last five years, we're the first to acknowledge that much more still needs to be done.

The seven goals of the NDMP are anchored on the three main pillars of the National Drug Master Plan, namely demand reduction through education and prevention, harm reduction through treatment services and supply reduction through law enforcement. The implementation of the NDMP is the core responsibility of the Central Drug Authority, CDA, which derives its mandate from Section 10 of the Prevention and Treatment of Substance Abuse Act 70 of 2008. Its role is to ensure a co-ordinated national response that is fully multisectoral to address the scourge of illicit substance use and substance use disorders in South Africa.

Hon Chair, allow me within the limited time to highlight some of the key successes we have recorded in the implementation of NDMP, which is currently under review. We are currently consulting key departments as we prepare to take the sixth iteration of the National Drug Master Plan to Cabinet in the few coming days. With regard to Goal 1 of the NDMP, we have reached over 500,000 learners through education awareness and prevention

UNREVISED HANSARD

programmes, such as I've alluded to earlier on, "Ke Moja", which means I'm fine with drugs.

It is a campaign targeting young people. We've also partnered with the Department of Higher Education Training, targeting students in the institution of higher learning across the country. Under Goal 2, the law enforcement agencies intensify supply reduction activities, including inspections, seizures, compliance operations, and the disruption of illicit drug manufacturing and distributing networks. As a result of these co-ordinated efforts, we're not only able to disrupt the criminal infiltration of illicit drugs into the country, but also to protect society from its harmful effects.

Under Goal 7: The JCPS cluster, which I'm part of, is currently rolling out the South African National Anti-Gangsterism Strategy to dismantle gang-related criminal activities by addressing the socioeconomic drivers of illicit drugs, such as poverty and youth unemployment. As I said, more still needs to be done. We look forward to working with the incoming members of the Central Drug Authority to address the scourge.

UNREVISED HANSARD

On the question of evaluation, we intend to commission the Department of Planning, Monitoring and Evaluation for this purpose to provide feedback on the impact of the National Drug Master Plan. I thank you, hon member.

Ms L P MHLONGO: Thank you, Chair, and thank you, Minister, for your response. Minister, I'm aware that the CDA and the stakeholders had issues with the draft that you first submitted, because it was not inclusive of the civil society. So, I'd like to know when the CDA is approving the final draft and also what measures are being used to monitor the effectiveness or the success of the master plan? Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson, whilst we appreciate the good work that has been done by the CDA, we don't take it lightly that they've worked under very difficult circumstances. We are now at a point where we are renewing. Within no time, the portfolio committee is going to deal with the nomination of new members. We pray that we would have concluded that process by the end of March, which then informs all of us. Now, the process that, again, as I said earlier on, the Department of Monitoring and Evaluation will also assist us in making sure that we do the right thing with

UNREVISED HANSARD

the necessary speed. We'll be able to have this new body that will be now workshopped and be inducted accordingly, given the challenges that are even more pressing than what we had three or four years ago.

So I want to suggest to the hon member, we are hard at work in making sure that as we renew the mandate of Central Drug Authority, we take along the positive work that they've been able to do under very difficult circumstances, but also engaging the Department of Monitoring and Evaluation so that they can talk closer to us to say we are on point in dealing with this. Remember, when we do it ourselves, the majority of time we are too much inward looking, and we don't find ourselves. But when you put a mirror, you'll be able to have that. This is the process that we are embarking on. We guess by April, latest May, we will have been able to do all this and have the structure that is in demand more than any other time. Thank you very much.

Mr M P SIBANDE: Thank you, Chairperson. Minister, ...

IsiZulu:

... ungihlaba umxhwele ngokuba zonke izimpendulo zakho zihlaba esikhonkosini okusho ukuthi umboso wabantu uyaqhuba.

UNREVISED HANSARD

English:

We understand that the implementation evaluation is only going to be done during the financial year 2026 to 2027. My question: Why is the Department delaying the evaluation of the National Drug Master Plan? Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: Thank you, hon Chair and hon members, I indicated to say we're on it now as we speak. Hence, I'm talking about the other departments like monitoring and evaluation. Hence, I'm saying we're renewing the mandate.

I don't want to say we're doing everything in our power to make sure that this structure exists for the correct purpose. It must also be properly, when you say properly, because if you don't have enough resources to drive this, it's like we are saying things for the sake of saying. So, we also want it to be properly resourced like we did already, and we won that battle with Department of Treasury.

We are also making sure that all departments are playing their individual roles. Remember, it's not a matter of one department, which is the Department of Social Development. It's a matter for all government departments.

UNREVISED HANSARD

So, we encourage them to say they must come and join us to make sure that the CDA is well represented according to the Act, but it also does what is expected of it, and we do what is upon us to make sure that it is properly resourced. Of course, working with the provincial government and local government, which the CDA that is coming out of the office now has done good work in so far as that co-ordination is concerned. We really congratulate them on the good work that they have put in place, and a lot of progress has been registered in this regard. Thank you very much, Chair.

Ms J M ADRIAANSE: Thank you, hon Chairperson, and hon Minister, we are sitting at twice the global norm of substance abuse. We're sitting at 15%. So, what is really important is that we need a successful Drug Master plan, and this is heavily dependent on the swift co-ordination between the multiple departments, particularly Social Development, Health and SA Police Service, SAPS. This especially comes to play when you want to admit a substance abuse victim, calling that by one of a better name in this case. Because if we don't have those systems in place to admit quickly, these people fall through the cracks and end up in the streets again.

UNREVISED HANSARD

So, I want to know what practical, real-time, although it's on paper, although it's in the plan. What real oversights and mechanisms are in place to ensure that the silo working of these departments is going to be stopped, that we can ensure that there's accountability and that they will work in cohesion to the effect and effectiveness of quick admission of patients who need to be treated? Thank you, hon Minister.

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson, indeed, hon Chairperson, what I've just articulated in the oiling of the machinery that is the CDA itself, for it to be fit for purpose. The fact that I made mention of the fact that at least there's little that has been injected in it. Of course, as I said, we would have wanted to see more. However, we managed to get what we wished for. We must appreciate.

Of course, I spoke about the co-ordination between the different departments, strengthening that, but I also registered the progress that has been made by the CDA that is just completing their time span in the office. Those, for me, lay a good basis on what then needs to be done. But the relationship that we have created and being part of strategic committees, because you can't speak to JCPS if you don't talk about the work that is

UNREVISED HANSARD

being done by CDA. They are the ones that are able to tell you at a VD level what is going on, more than the department itself. They are the ones that are in the local municipalities in different wards. Therefore, in different VDs, they are the ones that must fit to this structure for it to be able to understand what the challenges are that they are going through and design programmes that are relevant to what they are going on daily basis.

So, I want to assure the hon members that the renewed structure and the recognition of the work that was done by the CDA that is getting out of office, the intensified co-ordination between departments, the resourcing of the CDA itself, the responsibility of the Department of Social Development is then central into this, which is myself. I have that responsibility and I take it very seriously that I will not really go to bed peacefully if this structure is not doing as according to its expectation. So this is what we have put in place. Chairperson, in realising and understanding the challenges, in realising and understanding where the country is, in realising and understanding the devastation that our grandmothers are going through this because these 16-year-olds, when they got involved in drugs, became a problem at home more than in society.

UNREVISED HANSARD

So, we have got that responsibility because, remember, in those grannies we have got recipients of grants. So, if you don't look after that, you don't make sure that the CDA is up and running, it's fit for purpose, your grand recipients are vulnerable. The little money that you are providing is going to be redirected in one way or the other.

So, whilst you are dealing with this particular challenge, you will be resolving a lot of those challenges that are really devastating our elder person. They want more money because they can't afford. When you listen closer to them, like we always do, you get to hear that now they have to resolve the problems of a homestead, and they are not supposed to be like that. They are supposed to get the little that the government is providing, just for them to get those things that are really demanding of their health. So, if you resolve this particular matter, you would have resolved a number of challenges that our country is going through. Thank you so much, hon Chairperson.

Mr M M MAMPURU: Thank you, Chair, there is a guy called Bangani in Mpumelelo, Devon. I first met him in 2018, and since then he has been in and out of rehab. He said to me it took him six weeks for him to become addicted to drugs. And then after rehab,

it only takes him two days for him to be re-addicted to drugs. Which then tells you that there is enough exposure to drugs in our people.

Having said that, Minister, given that substance abuse continues to destroy families and communities, particularly in poor working-class areas, despite the existence of the National Drug Master Plan. What measurable outcomes have you achieved since the implementation of the current Drug Master Plan in reducing drug abuse, drug-related crimes, and youth dependency on substances, and which failures, gaps, and delays have you experienced in the implementation of this plan at the provincial and municipal level to save young men like Bangani? Thank you, Minister.

The MINISTER OF SOCIAL DEVELOPMENT: Thank you very much, hon Chairperson and thank you, hon Mampuru, for the question. At some point, hon member, we did not know whether we should have a CDA or not. Because we were all overwhelmed with this kind of scenario. Remember, especially Africans, it has never been a norm where an 11-year-old would start smoking, let alone smoking sophisticated things.

UNREVISED HANSARD

At least we have moved as a country to have been able to have an Act that dedicates the government and all its partners to deal with the scourge. But not only have it, we are at this stage where we are implementing it. Of course, with the challenge that we have just experienced, sometimes you wonder whether you are on it. Because the scale of people taking drugs is moving at a speed that I've never seen.

But we should appreciate the fact that, at least having established CDA, according to the Act, means whether I like it or I don't like it. By the Act, it is compulsory for me to implement it. Therefore, the government itself is forced to develop that Act to make sure that it does look at the scourge and be able to resolve it.

But not only that, we are now able to say there's a structure that is now winding up. A structure that has recorded a lot of progress, regardless of the challenges that we are going through. Regardless of the fact that at some point, the very people who are on drugs, unfortunately, hide that they are taking drugs.

UNREVISED HANSARD

For the fact that people who are on drugs sometimes look like me. You won't suspect them. Because they do it in a manner that will make you not be suspicious, which those are extremely dangerous. But also, now we know that at schools, there's a strategy that seeks to address that so that you discourage young people from taking drugs at that age. As such, I was saying, at some point, having established, designed the Drug Master Plan, and have CTA in place. We are now saying, the first cohort is getting out of the office. We have registered the progress that they've made.

They have themselves articulated the challenges that they are faced with. Standing here, I have now a responsibility to drive this a little bit faster, to say the challenges that have been identified must be resolved and addressed with the necessary speed. Now I've got better resources than I had earlier on. But not only that, hon Chair, I have traversed almost five provinces since I came to the office.

When I go and do the two-end programme that is called iCROP, I meet directly with the community, with elder people, people of the medium age, with youth in particular, to talk closer and introduce to them possible processes or institutions that can

UNREVISED HANSARD

assist them. As they get out of this, they can be trained and assisted to be businesspeople or to have their own business or to run their own NPOs for them to be able to talk about their experiences and teach those that might be trapped into this. I am not saying this is perfect. For the fact that we said earlier on this is part of the disaster because if we leave it and if it stays like the hon members were articulating, the majority of people who get involved in gender-based violence and femicide in particular are people who have gone through drugs, especially femicide.

Because femicide talks to the spouses and partners of people who are right in the house, they get involved in gender-based violence. So, I can't stand here and boast that this is perfect. It is dealing with everything. A lot still needs to be done. And this House also has got the responsibility to assist in this regard to say what else needs to be done. Of course, within the legislative framework. Thank you very much.

The HOUSE CHAIRPERSON (Mr D R Ryder): Thank you, Minister, your time has indeed expired. Thank you, hon members. We now move to the last set of questions. Before we do so, I just like to, as usual, acknowledge our visitors in the gallery and tell you all

UNREVISED HANSARD

that you are most welcome. To special visitors today, young leaders. We have Mr Maynard Krier and Mark Kabongo. Mr Kabongo is a medicine student at UCT. So, welcome to our Chamber and it’s great to have you here participating in the People’s Parliament. Minister, the last set of questions, as I say, emanate from ... there we go. Thank you very much.

Question 32:

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, thank you to the hon member for the question. Hon Chairperson, I can safely say, but boast to say, a lot has been done during the devastation that our people went through, especially those that are in Limpopo, KwaZulu-Natal and Mpumalanga. Of course, earlier on, Eastern Cape as well. Remember, Eastern Cape was at some point involved in this kind of a devastation.

I want to report to this House, hon Chairperson, to say immediately when the sad news were communicated to us, SA Social Security Agency, Sassa in particular, as a readily available vehicle that seeks to deal with people's devastations on a daily basis, we went to provinces and were informed that because of the extreme rainfall that resulted in the devastating floods that submerged homes, destroyed crops and disrupted livelihoods,

UNREVISED HANSARD

pushing families into hunger and displacement. In other areas, we lost people and may their souls rest in peace. This happened in Limpopo, Mpumalanga, KwaZulu-Natal and Eastern Cape.

As a portfolio, we wasted no time. We deliver on our mandate by providing a rapid response to meet the immediate humanitarian needs, including psychosocial support to the affected families and communities as they recover and rebuild their lives.

Some of the worst affected individuals and families were temporarily accommodated in shelters, through which Sassa and the department provided cooked meals, trauma counselling and psychosocial services.

In Limpopo, Sassa provided immediate relief through the Social Relief of Distress by providing hot meals three times a day for seven days. We provided mattresses, dignity packs, including baby care packs for displaced people who were placed in temporary shelters in Vhembe, Mopani, Capricorn, Sekhukhune and Waterberg regions. A total of 1 070 people received Social Relief of Distress, SRD in the form of cash assistance and food vouchers.

UNREVISED HANSARD

Chair, working in collaboration with other key partners, one of the most important things we do during disaster is to ensure that learners do not miss out on their valuable school time. Accordingly, Sassa provided school uniform to 113 learners.

Chair, in Mpumalanga, Sassa provided cooked meals for displaced families and immediate human assistance in the form of old age grant for families that tragically lost one of their own to cope with the financial burden. Seventeen learners received school uniform.

In KwaZulu-Natal, the worst hit was Amajuba District Municipality, where Sassa provided humanitarian relief in the form of hot meals again and all the goodies. In addition, Sassa provided food vouchers to a total number of 35 people.

Hon Chair, Social Development is part of the Ministerial Intergovernmental Committee on Disaster Management, which comprises political leaders from across three spheres of government, including SA Local Government Association and the National House of Traditional and Khoisan Leaders to ensure a coordinated response by all sectors to the implementation of disaster management intervention.

UNREVISED HANSARD

Chair, we are grateful to the many partner organisations, including Spar Group, Shoprite, Gift of the Givers, Old Mutual Foundation, faith and community-based organisations, and too many others that I cannot mention, for the time allocated and the resources that they contributed. They joined hands with the government in responding to the humanitarian needs of the affected individuals and households.

IsiXhosa:
Sithi kubo, nangamso. Enkosi kakhulu.

English:
Thank you very much, hon Chair.

Mr M F MOKWELE: Chair, thank you very much hon Minister for your response to my question, very excellent response. Hon Minister, my question to you is that the rain has affected a lot of services in affected provinces, like the Limpopo province where I come from and other provinces. My question to you, Minister, is that, has the rain disrupted the receipt of grants in the affected areas?

I thank you.

UNREVISED HANSARD

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, what we can report in this House is that no one missed his or her grant during the time. Sassa made it a point that everyone received his or her grant in time, unless there were just technicalities of not being able to access the road which was addressed within a very short space of time. No one missed a grant during the devastating time.

Hon Chair, our commitment to our people to make sure that for all our sins, every time, consistently, 19 million people are being paid monthly by Sassa according to its mandate.

Thank you very much.

Mr P J SWART: Good afternoon, hon Minister. You've answered part of my question on the support that you offer. But, Minister, these victims are living in these temporary shelters since the floods in 2022. But now, the other part of my question that I really want to pose to you, given that more than three years have passed since the 2022 floods, then what concrete steps, Minister, and timelines have your department set together within relevant housing authorities to ensure that the displaced

UNREVISED HANSARD

families still living in these temporary shelters are relocated to permanent housing?

Thanks.

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, as I have alluded to the fact that we belong to the disaster management that includes many government departments, and part of that is the Department of Housing and Human Settlement. This is an integrated effort to make sure that we address what the problem is.

Ours is to make sure that during that time, we make sure that the services that talk to us directly are being served all the time, even when people are in awkward areas. We will not be able to give a convincing answer about housing for those people because it is not within our purview.

However, we can assure the hon members that all that Department of Social Development, DSD is supposed to provide is being provided consistently and coherently.

Thank you very much, hon Chairperson.

UNREVISED HANSARD

Mr K CEZA: Minister, during our oversight of floods with the Select Committee on Public Administration in Makhado, in Nkomazi, myself along the hon Makesini found that in Ward 17, Ward 19 and Ward 30 in Nkomazi, there are reports of delays and of distribution in Schoemansdal and Masibekela of social relief support through Sassa in Mpumalanga, which would have been an unfortunate cross-violation of section 195 of the Apex Law of the country, in tandem with section 9, which would provide for the prohibition of unfair discrimination in the delivery of services.

Can the Minister account for the glaring coordination failures, which have left vulnerable households exposed to hunger, trauma and neglect after the floods, considering the mandate of the department to ensure basic nutrition, shelter and its involvement in the disaster management?

Thank you very much.

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, earlier on, I articulated the role of the DSD portfolio on areas where, unfortunately, people have gone through the floods. Having said that, Chairperson, there is no way that we can tolerate

UNREVISED HANSARD

tendencies of wanting to, or having confirmed to, have ignored part of the people who are affected.

In doing this, we are not doing people favour. As the hon member has articulated, the legislative framework that compels us to do what we are doing. So, if there was that kind of untoward, I wish it could have come to us quite earlier, so that we resolve that matter with immediate effect.

The chief executive officer, CEO of Sassa had to be based in Limpopo. I was physically in Mpumalanga. We were in both provinces at the time, because they were affected almost at the same time. We were there not because we wanted to go and demonstrate anything, but we wanted to make sure that during that time of assistance, nobody is being left behind.

If there's any kind of that unfortunate situation, I wish the hon members can write to us, so that we can follow up on this and make sure that there's a tangible answer to give back on what transpired. Because standing here, Chairperson, I'll not be able to give convincing answers on why that was the case.

UNREVISED HANSARD

In Mpumalanga, we have a new regional manager at Sassa, Mr Mahlangu, who is responsible to make sure that Sassa business is run accordingly. We work very closely with the Department of Social Development to make sure that as a portfolio, we provide these services.

So, I encourage hon members, when such situations arise, just talk to us. Talk to me, talk to the CEO of Sassa, so that we can be able to resolve the matter on the spot. I was in an area where it's a farm. Once they were affected by the floods, the owner of the farm was evicting those people. I had to be there and sit there to make sure that that does not happen because the laws of this country do not allow that.

You can't evict people whose roofs have been blown away by the wind or rain, and you say, this is your piece of land so people must go. We are dealing with such tendencies and things that sometimes you cannot imagine. I'm trying to demonstrate our commitment in making sure that when we provide those services to our people, no one is being left behind.

I was in Umtata, Chair, just in closing. We got to understand that in the morning when those people were staying in that area

UNREVISED HANSARD

because there were floods, in the morning, we find more than 80 people. During the day there's no one, we find a few people. In the evening, during supper there are 100 people. During night-time there are fewer people. Those are the things that you must also manage to make sure that your numbers are consistent with what you have registered because there are difficulties sometimes.

Thank you very much, hon Chair.

Ms S MASUMPA: Thank you for the response, hon Minister. My question is, why was the intervention only in Majuba district in KwaZulu-Natal?

Thank you.

The MINISTER OF SOCIAL DEVELOPMENT: Hon Chairperson, we are not the ones who determine where the disaster is. But the structure led by Cooperative Governance and Traditional Affairs, COCTA is the one that does that. Once that has been determined, then we follow that process. And then after having followed that process, we then provide the services that we are responsible for. So, surely, because we were in Majuba, we had this

UNREVISED HANSARD

experience. Our people were taken through the services that we provide. We are now convinced that everything went according to book.

In the process of providing these services, Chair, our audit committees are hard at work in making sure that we don't under or overspend or there's no money that is being spent in a manner that will not be accounted for. We go to areas where there's that kind of a determination.

Under normal circumstances, indeed, Sassa and the DSD portfolio get to areas where we've identified some challenges of the communities through our Community Nutrition and Development Centres, CNDC to make sure that our people are being looked after, even when there is no disaster.

Thank you very much, hon Chairperson.

The HOUSE CHAIRPERSON (Mr D R Ryder): Thank you very much, hon Minister. As you resume your seat, we'd like to thank you for your attendance today. Hon delegates, I'd like to thank the Minister, which I've done. I'd like to thank all members of executive council, MECs. I'd like to thank the permanent and

UNREVISED HANSARD

special delegates in attendance and the SA Local Government Association, Salga representatives for availing themselves for the sitting.

Hon delegates, that concludes the business of the day, and the House is adjourned until next week.

Thank you.

The Council adjourned at 18:04.

UNREVISED HANSARD