SoPH BULLETIN
The UWC School of Public Health Newsletter
July 2012

Celebration in Honour of Emeritus Professor David Sanders

David and Sue Sanders with sons Ben (left) and Oscar (right)

On the 9th July 2012 the School of Public Health and the University of the Western Cape hosted a celebratory event to honour Emeritus Professor David Sanders. The event was arranged to honour and celebrate David’s contribution to the University of the Western Cape - and specifically his role as the founding Director of the SOPH - and to acknowledge his contribution and influence to the field of Public Health more generally.

Scheduled to coincide with the 3rd International People’s Health Assembly which was held at UWC the event was attended by approximately 250 local and international colleagues, friends and family members.

The event also marked the first of the annual David Sanders Lecture on “Public Health, Politics and Social Justice”. As Prof Brian O’Connell, Rector and Vice-Chancellor, formally announced the Annual Lecture he noted that its theme emphasizes the values of UWC, the Community Health Science Faculty and SOPH and, importantly, anchored scientific work and professional practice in a commitment to social transformation and social justice.

As part of the celebration, past and current colleagues of David’s were invited to share a few words on a PowerPoint slide about what working with David had meant in their lives. A series of reflections, good wishes, and some interesting anecdotes (some of which were shared at the event) have been gathered together and are in the process of being compiled into a booklet that will be given to David as a memoire of his working life.
People's Health Assembly (PHA3)
6 -11 July 2012, UWC

Delegates from over 90 countries have descended upon the University of the Western Cape in Cape Town, South Africa with one goal: Health for All Now! This Third People’s Health Assembly is a time of reflection, analysis and planning solid action for a way forward.

After gathering in Savar, Bangladesh and Cuenca, Ecuador PHM activists were led to action by a strong understanding of the failings of governments, the suffering of communities, and the
struggle of people to achieve the human right to health. From these Assemblies came the People’s Charter for Health and the Cuenca Declaration.

In Cape Town, hundreds again came together, now with a deeper understanding of the issues faced and new opportunities for achieving change.

**International People’s University**

This meeting was preceded by a two-week training entitled "Action for Health". The training held from June 24 to July 4, 2012 according to the scheme of the International University People's Health (IPHU) of MPS, welcomed about fifty young health activists from around the world, and was followed by a meeting of PHM South Africa on 5 and 6 July 2012 on national issues and in particular on the proposed national health insurance in this country.

**Proceedings**

The Opening Plenary for the PHA3 got off to a great start in Cape Town. The plenary gave the stage to PHM activists and South African locals alike.

David Sanders opened the plenary with a welcome to all delegates and highlighted the connectivity of nations through movements and struggles such as those against the excess of wealth and the current rise in health disparities across the world. He also stressed that since Health for All did not happen in 2000 PHM must press on until the goal is reached.

PHM Activist Pat Anderson discussed the relationship of aboriginal people in Australia with their land and the impact of land rights and colonization on their health. Leaders from the University of the Western Cape including the Vice Chancellor and the Chancellor expressed solidarity with PHM’s mission and with the PHA. The Chancellor (through a speech delivered by a representative) noted that he is a strong advocate for the social determinants of health. In his speech he emphasized that “change occurs through sharing, learning, consolidation and making ways forward.”

The South African minister of health spoke about the state of health in this country and focused on South Africa as a “country of contradictions” from the “very rich and very poor to the ‘extremely healthy and extremely unhealthy’”. He firmly stated, “health systems around the world are designed for the rich, not for the poor”. The Minister called on his own government and governments around the world to address these staggering inequities.

The opening plenary closed with a wonderful showcase of South African talent in a dance performance that amazed everyone in attendance!

**The Crusade for Health Equity**

*Tessa Richards, assistant editor, BMJ trichards@bmj.com*

The financial crisis makes it increasingly urgent for countries to protect the most vulnerable people, and social movements are setting the pace. *Is the economic crisis marching us towards Armageddon? If so, what’s driving us? Is it a limited understanding of the political and economic forces that are widening wealth and health divides, catalysing civil unrest, stoking climate change, and damaging the environment—or a reluctance to counter those forces?*

Four years ago the World Health Organization’s Commission on the Social Determinants of Health said that “social injustice is killing people on a grand scale.” It recommended tackling the inequitable distribution of power, money, and resources within and between countries and implementing cross sector policies to improve the conditions in which people are born, grow, live, work, and age.1
Over the past year the “Occupy” movement has taken up the baton in the protest against corporate capitalism and its imperative that 99% of the population “pay for the sins” of the wealthy 1%. Some criticise the movement’s idealism as fluffy, but even the elite that meets each year at Davos in Switzerland now admits that too much inequality may be bad for growth as well as for society.

When the Alma Ata declaration on primary healthcare for all was signed in 1978, most people who lacked access to healthcare or who risked impoverishment by paying for it lived in developing countries. Now nearly three quarters of the “new bottom billion” live in middle income countries. The financial crisis in Europe has brought poverty to its front door.

Many countries have seen progressive cutbacks in health and welfare services and an increase in cost shifting to patients. In the most indebted, austerity measures have resulted in draconian reforms. In Spain, for example, measures have been criticised as undemocratic and inequitable. In Greece their effects have been linked to rising rates of depression, suicide, and HIV infection.

“People are angry about the barbarously unequal society we are living in,” Alexis Benos, professor of primary care at Thessaloniki medical school, told the BMJ. “The unemployed [25% of the population] have lost social security benefits, and many can’t afford care, as the copayments levied are high. Last year 300 people went on a hunger strike about this. In response we have set up social solidarity health centres across the country, manned by doctors who provide free services. Essential drugs have been obtained by putting out a call to people to hand in unused medicines.”

Benos is a member of PHM, the People’s Health Movement (www.phmovement.org), an international network of health professionals, non-governmental organisations, community advocacy groups, academics, and activists whose European members have just signed a “Right to health” charter.

Since its inception in Bangladesh in 2000, the profile and influence of PHM has grown. It has an active presence at the World Health Assembly, and its Global Health Watch reports are widely used in public health education programmes.

These reports don’t hold back. They criticise the organisations involved in global health governance for lacking a coherent agenda for developing health systems, WHO for allowing policy to be shaped by rich donors, global trade regimes, transnational corporations, privatisation of healthcare, rich countries for their failure to provide enough debt relief and aid to poor countries, and poor countries for not doing enough to protect their citizens’ health.

Next week PHM is holding its third global assembly in Cape Town (www.phmovement.org/en/ph3) and, in response to concern about the NHS reforms in England, a parallel meeting in Nottingham (www.phm-uk.org.uk).

The Cape Town meeting has been organised by David Sanders, a paediatrician and longstanding PHM member. His powerful advocacy for an “alternative Rio declaration,” which includes a recommendation for progressive taxation to fund action on the social determinants of health, attracted much support at WHO’s 2011 meeting in Rio de Janeiro. His fire against the official declaration was directed at its failure to mention the impact of free trade agreements on undernutrition and obesity, climate change, or the financial crisis—which, he said in his closing speech at Rio, was “a crisis of capitalism for which the poor, including those in southern Europe, are paying the price.”

Evidence from an interim report of a review of health inequalities in Europe conducted by Michael Marmot, who chaired the 2008 WHO commission on social determinants of health and now heads the UK Centre for Heath Equity, certainly backs the view that the social gradient in health is getting steeper and that gaps in life expectancy and health outcomes are widening.

These trends, Marmot argued, make it urgent for Europe’s politicians to “get serious” about adopting a cross sector and whole government approach to reducing health inequity, as Norway, Finland, Canada, Australia, and Brazil have done. Although he does not endorse the view that capitalism is the root of all evil or that the food industry is the biggest threat to health, he agreed, when we talked last week, that PHM’s voice is an important one to listen to.

Outside Europe, countries such as Thailand, Brazil, and Vietnam have been lauded for their progress in establishing equitable, publicly funded universal healthcare services, having seen the value of eliciting and responding to the health concerns expressed by public and social movements. Progress in India, the economist Amartya Sen has underlined, has come from public discussion—and agitation.

Policy makers in Europe could learn from the approach of these countries, and health
professionals could learn from absorbing the passion and following the debates in Cape Town and Nottingham.

References
3. García Rada A. New legislation transforms Spain’s health system from universal access to one based on employment.

Cite this as: BMJ 2012;344:e4414; http://www.bmj.com/content/344/bmj.e4414

I-TECH Representatives Discuss Partnering with SOPH

I-TECH Country Director Dr Albert Bakor and Head of Health Systems Strengthening Programmes Ms Claudia Shilumani visited SOPH and held discussions on possible ways to partner and collaborate between SOPH and I-TECH

Dr Albert Bakor And Ms Claudia Shilumani
“Winter School 2012” took place from the 18th June to 6th July 2011. In total we had 288 delegates who attended the Winter School over the 3 week duration. Below is a summary of the 18 courses presented during the Winter School:

1. Current Thinking and Practice in Health Promotion
2. Computerised District Health Information Systems: an Intermediate course
3. Information Systems for Human Resources for Health
4. Quantitative Research Methods
5. Epidemiology and Control of Non-Communicable Diseases
6. Research, Health and Ethics in the African context
7. Using Geographical Information Systems (GIS) for Analysing and Mapping Health Care Issues
8. Using Health Information for Effective Management: an Intermediate Course
9. Health Management
10. Monitoring and Evaluation of Primary Health Care Programmes: Programme I (2 weeks)
11. Qualitative Research Methods
12. Globalisation and Health: Key Aspects for Policy Makers, Managers and Practitioners
13. Epidemiology and Control of HIV/AIDS, Tuberculosis and Malaria in the Era of Antiretrovirals
14. Community Participation in Health
15. Computerised District Health Information Systems: an advanced course
16. Research, Health and Ethics in the African context
17. Survey Methods for Health Research
18. Understanding and Analysing Health Policy

In general participants found the Winter School very well organised, informative and structured to meet their expectations. I especially would like to extend my sincere appreciation and thanks to all the Support staff who put in a lot of hard work and dedication in ensuring that everything behind the scenes fell into place and that we could function as a team to resolve everything that came our way and ensuring all aspects of the School was taken care of. Most participants found the administration
of the Winter School well organised and professionally done.

Looking forward to Winter School 2013, which should be even better and more successful!

Interview with Beulah Newhoudt-Arendse

Shun: What is your professional background?

Beulah: I started my nursing career in 1980 at Groote Schuur Hospital and the Nico Malan Nursing College in Athlone. After completing my Diploma in General Nursing I opted to go to St. Monica's Hospital, where I was born, for the Diploma in Midwifery. In 1984 I was one of the first Professional Nurses to be appointed at the new Psychiatric Hospital in Lentegeur, Mitchells Plain where I spent 18 month; the first 9 month at the Dr AJ Stals Care and Rehab Centre and the following 9 months at the new hospital receiving patients that was moved from Valkenberg to Lentegeur. Being ”institutionalised” got the better of me and after only 18 months I resigned. October 1986 I joined the City of Cape Town’s Health Department as a Clinic Sister. After spending one year in the clinic, and 2 days before the closing date, I was asked to complete the application forms for Peninsula Technikon. In 1988 I studied full time at ”Pen Tech” to complete my Diploma in Community Health Nursing Science – this changed my perspective for life! After working for the City for 10 years I resigned to spent 3 years in the Bone Marrow Transplant Unit at Wynberg Hospital and Constantia Berg Medi-Clinic. October 1999 I returned to the City and coordinated TB/HIV for 10 years. After 13 years I realised it was time to move on, but declined an offer as facility manager and opted for a post with MDHS as Clinical Program Coordinator for Community Based Services.

Shun: What has been your experience of attending the Winter School 2012?

Beulah: I attended the Community Participation Course with other Health Professionals e.g. Environmental Health Practitioners, Social Workers, Professional Nurses, Occupational Therapist, a Researcher, Clerks, Facility Counselors, a Pharmacist and many others. Collaboration on the course was well practiced in role play. We had the ability to share both knowledge and experiences of working in different communities in Cape Town and other Provinces. We realised again that the top down and prescriptive approach is no longer effective and that the community should be part of the multi disciplinary health team.

Shun: How does the Winter School course relate to your work? Will you be able to apply the insights you gained?

Beulah: Community Based Services or Home Based Care takes me to right into the heart of the community. Matters currently on the agenda are the TB/HIV integration roll out, strengthening the Chronic Disease Lifestyle support groups and the great focus on the 4
seasons e.g. the past diarrhoeal season and the pending women’s health season. Currently I am expected to arrange Community Dialogue forums; and after spending a week at the SOPH I am fortunate to leave with a “master copy” of guidelines.

*Shun: As a result of attending the Winter School, do you have plans to study further in a specific field of public health?*

*Beulah: The week at the SOPH gave me time to reflect; I realised I am at the right place at the right time.......a Community Health Nurse cannot be” institutionalised” her role and responsibility is with the people on the ground to enable, to listen and to create dialogue opportunities. Yes, I plan to register for the post graduate diploma in public health.*

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**Jennifer Coetzee Launches Clinic for Men**

I met Jennifer Coetzee at the 2012 Winter School through Corinne Carolissen, the SOPH Student Affairs Administrator, and asked her about her men’s healthcare Initiative.

*Shun Govender: Is the idea of a clinic for men something new?*

*Jennifer Cloete: The City of Cape Town is embarking on this concept. Males are not accessing our health facilities. Also when you look at the HIV statistics you will find that the positivity rates amongst females are much higher than males. The reason for that is that males are not coming forward to be tested so we don’t really know. We are not testing enough males. Also when we send out the partner notification slips we find that males are not coming for STI treatment.*

So the rationale for opening the Men’s Clinic is to have a setting where males feel free to access the services. Also where they can speak to a male because the staff that is working there are all male. The intention therefore is to get more men to take the test and increase the treatment of STIs.

*Shun: How did the Men’s Clinic start?*

*Jennifer: The Man’s Clinic opened officially on 1 June 2012. It began with my initiative. When I looked at the monthly HIV and STI stats and saw how many of the partners came for treatment. When space in another building not too far from this clinic became available I approached my manager.*

*I made contact with different stakeholders in the area and developed partnerships. We have a partnership with Anova Institute though their project Health For Men. Out other partners are Touching Nations, an NGO, and City Health. I also involved the community. They were involved from the planning stage through the Health Committee of Bellville South I also brought in the local politician and the sub-council.*

*We set up a Project Team and held regular meetings. Having the building made it easier to plan and start. In order to fit out the staff rooms and the consulting room we received assistance with furniture, décor, electricity, telephones from Anova Institute, community members and the City. The medicines and staff come from this clinic in Kasselsvlei. At the moment we run the clinic once a week on a Thursday. On three days Touching Nations do the HIV testing. We will monitor uptake of the service for a year and if attendance grows I will advocate for more days to run the clinic.*
Shun: Are you seeing a rise in attendance since opening?

Jennifer: Yes, indeed. In the first four weeks – being open one day a week – we have had over one hundred men who came to the Men’s Clinic. Not all of these are STI or HIV cases as we had initially thought. We attended to other issues as well, like referrals for male circumcision which is also one of the services we render. We’ve also referred patients to Tygerberg Hospital for prostate and other problems. For the future we will be guided by what issues are actually coming up.

Shun: Up to what level of treatment will you be offering at the Men’s Clinic?

Jennifer: We offer complete treatment for STIs with the HIV testing at the moment. We are going to initiate an initial stage CD4 count on patients, because we want to make sure that we do not lose a patient in the system once a referral is made. I believe that once a patient knows what his CD4 is he will have to come back to the clinic because he knows that treatment is necessary.

Shun: What does running a facility at the level of a clinic mean for you on a day-to-day basis? I see that you are a qualified nurse with several badges. Does this mean that you have to also double-up as nurse and as manager?

Jennifer: My role and function is straightforward managing the facility. I will intervene at the operational clinical level only when there is a desperate need for me to do so. My staff know: this is my manager, and they need to call me if they run into trouble.

As manager I face a lot of challenges. The clinic is full on a daily basis. We are working with two organisations in one building: City Health and Provincial Health. We have a day hospital as well as a clinic. I have a provincial counterpart who is responsible for the province’s health programmes, while I take care of the clinic and the building. We are adequately staffed for the moment, but my human resource needs are assessed every quarter depending on the head-count patterns. An increase in this regard is an indicator that the population has grown, and influx of people into the area, especially from the Somali community. The other critical challenge for me is that the building is too small to adequately run all the services. We have drawn up plans to extend the building and expand our ARV services. Funding is the critical issue.

Shun: How do you manage your finances?

Jennifer: We are not involved in the development of the budget. Each clinic gets its budget and as manager I am responsible for my budget. I know the amount that I have available. The district manager manages the budget with the facility manager. What I do with my budget is to take an allocated amount in a certain line item and divide it by twelve. I know then what amount I have available to spend per month on that line item. The fact that both City and Province are together in one building makes it possible to share costs (such as cleaning equipment, staff refreshments, maintenance responsibilities), while other expenses are carried separately in our budgets. We are able to things done and paid for because we also have a good working relationship between ourselves as well as between the staff, which is important. We are functionally integrated; only human resources and the budgets are separate.

Shun: How do you find the community response to your work?

Jennifer: I have a very vibrant health committee form the community. I developed a good relationship with the NGOs working in this community such as the Tygerberg Hospice, Ecclesia and Omega. I created a monthly platform of sharing with them in order to get feedback from the community. So for instance, based on this feedback, I conducted a mini-waiting times study to see where the bottlenecks in the flow are. This has shown that patients are not waiting longer than an hour from the time they enter the clinic. I used the waiting
times study to show my manager that we need extra capacity in the TB room, as a result of which we will be getting two extra clerks there.

The NGOs do our home-based care. If we have recalls these NGOs will pick up the slips from the clinic and physically make the calls for us and report back to us here at the clinic. I hold monthly meetings with the area DOT supporters who monitor the TB medication adherence. I also know that the DOT supporter system will be replaced and we will be getting community health workers; interviews are going to be held next week. I will seek good working relationships with them as well. As soon as they are appointed I will have a meeting with them and work out what will be required from the clinic’s side.

Shun: In terms of your career, with a background in nursing, how did you become a facility manager?

Jennifer: I started as a professional nurse and moved on to become a senior professional and thereafter a facility manager. My studies began with a diploma in nursing, and then I did a degree in primary healthcare followed by a diploma in management. I followed most of the courses offered in public by the School of Public Health at UWC. I may come back to UWC for an MPH at UWC, depending on my family circumstances.

Professor Arjun Karki, Vice Chancellor of the Patan Academy of Health Sciences in Nepal speaks at the SOPH 2012 Winter School Graduation

This is my first visit to South Africa and to Africa as a continent. We read a lot about countries in Africa with healthcare challenges, but for us in Nepal this is often in the form of statistics. So obviously it gives one a different perspective to be on the ground, to see people like yourselves who come from different countries in the region. This is an overwhelming experience for me and my colleagues. So thank you very much for inviting me to speak here at you Winter School graduation.

I also want to congratulate all of you who have attended the Winter School, for having taken the take off from your work and your families to come here to learn. I hope that you have found it worthwhile.

In Nepal, one of the very poor countries, we face similar health challenges like you in the region. One of our challenges is the very serious disparities between rural and urban areas both in terms of access to and quality of healthcare services. In Nepal 80% of the population live in rural areas. So when the healthcare
services are not functioning in the rural areas as well as we would like to see, then the brunt of the disease and the outcome resulting from that is very appalling. So much so that the life expectancy difference between rural and urban areas is as high as twenty years. Similarly the infant mortality rate difference is almost one hundred percent. This gives you a sense of the kind of disparities that we are experiencing.

And to make matters even more complicated Nepal has experienced a decade-long violent civil war called the Maoist Insurgency. Nepal was a very peaceful country. Previously a stabbing incident would raise hues and cries among people. But when the violence began people became non-responsive even when fifty or a hundred people got killed. It is amazing to see how the human soul can become insensitive once people get used to reading about and witnessing violence.

The point I am making is that when there are disparities of this nature in Nepal and given our globalised world where people have access to radio, TV and internet people migrate in search of employment. They see what is happening in other countries and begin to ask why the situation in Nepal is so terrible. This leads to a lot of resentment and frustration. When a political party comes a sells the dream and encourages people to take up arms and fight, people become easily susceptible to participate in the violence. This led to the deaths of thousands of people and hundreds of thousands who were displaced from family, home and neighbourhood. The human cost was enormous.

So we the doctors working the hospitals said: We have to do something about such a bad situation. If nothing else, let us try to do something positive in the health sector. Let us try to contribute something positive to narrow the disparities in health. One of the reasons why health professionals do not work in rural areas, like in your situations, is because trained personnel do not want to go and work there. Obviously there is no one single factor why this is so. There are policy issues, incentive issues, infrastructural issues, lack of adequate support and supervision, professionals feel isolated.

But our perspective was that when physicians and nurses are trained society has contributed so much in their training and they should give back in service to their country. But what we saw was that many leave for greener pastures in the US, Europe or Australia, and completely abandon the country that taught them the art and science of medicine. We said: This has got to change. We have to instill values of social accountability to give back to those from whom we gained so much.

With this in mind we created a new institution to train doctors, nurses and other categories of healthcare personnel who can contribute to society. We bring students from the rural areas, train them and then send them to function in rural areas. This is a very ambitious project for a very young institution and we are hoping to graduate our first batch of students in four years time.

We are also aware that the medical care provider – whilst necessary – can only function in health system. When the health of the national health system is sub-optimal the scope of these graduates to contribute will be limited. So we need to improve the health of the health system itself. This is one of the intentions of our School of Public Health, namely to create the potential public health leaders of tomorrow. In this regard I am so pleased to see what you are doing here at your School of Public Health under the wise leadership of Prof. Uta Lehmann, Prof Sanders and all your colleagues. Graduating over 10,000 healthcare professionals from the Winter School programme of your School is something that the whole African continent can take pride in.

In Nepal we say that a learning opportunity is a gift. Many others do not have such an opportunity. With the gift you received here comes the
responsibility, to apply the knowledge, the skills and the competence that you have acquired, as well as to share what you have learned with your colleagues in your workplace, in your community. In this way we can promote this culture of sharing and partnership. I am confident that you will consider this aspect of your learning.

UWC Centre for Research in HIV and AIDS
‘HIV in Context’ Seminar Series
Perceptions of HIV and AIDS-related Stigma among Employees in the Parliament of South Africa

Mr Buyile Bashe
Organisational Wellness Manager, Parliament of South Africa

The threat that HIV/AIDS poses to most institutions, including the Parliament of the Republic of South Africa, can potentially be decreased by reducing stigma and discrimination. Parliament’s Policy on HIV and AIDS provides protection for people living with HIV and AIDS (PLWHA) against stigma and discrimination.

This seminar, held 28 June 2012, reflected on a recent qualitative study of employee perceptions of HIV/AIDS stigma and of the effectiveness of existing programmes in the Parliament of the Republic of South Africa in order to inform improved anti-stigma strategies and interventions in Parliament as well as other workplace settings.

The threat that HIV/AIDS poses to most institutions, including the Parliament of the Republic of South Africa, can potentially be decreased by reducing stigma and discrimination. Parliament’s Policy on HIV and AIDS provides protection for people living with HIV and AIDS (PLWHA) against stigma and discrimination.

The purpose of this study was to explore employee perceptions of HIV/AIDS stigma in the Parliament of the Republic of South Africa in order to inform improved anti-stigma strategies and interventions. This exploratory qualitative cross-sectional study used individual interviews and focus group discussions among Parliamentary employees to examine perceptions of: HIV/AIDS related stigma in the workplace, the effectiveness of Parliament’s HIV/AIDS response strategy, and how HIV/AIDS-related stigma might be effectively addressed. A total of 49 respondents participated in:

a) 19 individual interviews across five employment grades (A-Band to E-Band).
b) 4 focus group discussions of 6-9 people each.

Data was analysed using thematic analysis. Five main themes were identified, as well as additional sub-themes. The main themes were: the actual acts of discrimination (enacted stigma), concerns related to disclosure, assumptions and preconceptions about causes and signs of HIV infection, concerns about psychological impact; and lack of knowledge and education. Discrimination was generally described as being treated differently, as well as prejudice and negative attitude to a person with HIV/AIDS. More specifically, it was understood as labeling those who are HIV positive negatively and ostracizing them. Gossip and lack of confidentiality were the main barriers to disclosure and testing while weight loss and long term sick leave were interpreted as classic signs of a person who is HIV positive in Parliament. Fear played a major role in these respondents’ accounts of HIV/AIDS related stigma, while the perceived widespread ignorance was attributed to lack of information, knowledge and education.

Respondents perceived Parliament’s HIV/AIDS response strategy to be ineffective. They suggested more awareness and training, establishment of support groups, involvement of PLWHA and involvement of Senior Management in addressing HIV/AIDS related stigma in Parliament. HIV/AIDS-related stigma is serious; HIV is not yet “just another disease”. Parliament is not a particular problem, but is not exempt. People are ready and eager to “break the silence”, but policies and Wellness Programmes are not yet doing all they could to facilitate this. The revised HIV strategy must include targeted programmes and address gender, family and societal aspects.
The School of Public Health of the University of the Western Cape, South Africa equips health professionals with the knowledge and skills to contribute to transforming the health and welfare sectors in developing countries. Health professionals can study while they work, and gain credits incrementally towards a Master in Public Health or PG Diploma in Public Health. These flexible, modular Programmes use text-based learning modules and some e-learning opportunities as its learning media, with optional contact sessions in Cape Town in February/March and June/July every year.

**POSTGRADUATE DIPLOMA IN PUBLIC HEALTH**

The Postgraduate Diploma in Public Health is an Honours level qualification (at NQF level 8). This one or two year programme provides in-depth training for health and welfare managers, supervisors, educators and researchers, and is appropriate for local, district, provincial and national levels.

**Curriculum:** The curriculum is divided into dynamically interacting themes divided into six compulsory modules; these relate to critical competence areas in the practice of public health.

**Admission requirements:** Three or four year Diploma or Bachelors degree in a relevant discipline, e.g. health sciences, social work, and education, and three years relevant experience in the health or welfare sector.

**MASTER IN PUBLIC HEALTH (MPH)**

The MPH aims to equip health professionals to:

- Quantify and prioritise health needs;
- Design, implement and evaluate Comprehensive Primary Health Care Programmes;
- Manage District Health Systems.

The Programme is designed for a range of health and welfare professionals and managers from middle to senior level, at district, provincial or national levels, staff of NGO’s and academic research contexts. The Programme may be taken over two to three years.

**Curriculum:** The Programme is made up of eight coursework modules, six compulsory components (which includes two research methodology modules) and two electives and a mini-thesis.

**Admission requirements:** A four year degree (Honours Degree) or its equivalent in any discipline, or in exceptional cases, five years of relevant experience assessed by the university through a Recognition of Prior Learning (RPL) process. Preference will be given to candidates employed in the health, welfare and education sectors with three years of relevant experience.

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or contact

Mrs Janine Kader [jkader@uwc.ac.za](mailto:jkader@uwc.ac.za) or soph-comm@uwc.ac.za
Addressing the South African Medical Association (SAMA) conference on Thursday, Health Minister Dr Aaron Motsoaledi said both the private and public healthcare sectors needed an overhaul in order to effectively respond to the healthcare challenges present in the country.

He conceded that the public sector needed drastic change, which government was trying to do through the implementation of the National Health Insurance (NHI). For the private sector, Motsoaledi told delegates at the conference of the biggest doctors' organisation, measures had to be put in place to deal with the high costs, which he labelled as "uncontrolled commercialism".

The 2010 medical scheme expenditure showed that the total spent was R84.7 billion, with R31.1 billion being spent on hospitals (R30.8 billion on private and R281 million on public hospitals); R19 billion on specialists; R6.2 billion on general practitioners; R2.5 billion on dentists, R6.7 billion on allied services and R11.6 billion on total non-health care.

Motsoaledi said it was for this reason that his department was planning on introducing a pricing commission that would regulate pricing in the private health sector.

These figures, he said, undermined the basic principles of healthcare. Motsoaledi said the situation in the entire healthcare system had to be rectified in order for NHI to exist successfully.

"We cannot continue to have a healthcare system where only a few have access to proper healthcare... We cannot be controlled by commercialism," Motsoaledi said. The minister added that the country needed a universal healthcare system if it wanted to address the challenges faced by the country, which he said included infrastructure; human resources; improved life expectancy of South Africans; reduced child/maternal mortality; addressing the scourge of HIV and Aids, while improving efficiency in the healthcare system.

Some basics to address these challenges, he said, were already underway through the piloting of the NHI. They were training personnel with the view of making them inspectors.

Others include the accreditation of hospitals for piloting the NHI, which Motsoaledi was visiting across the country, while there were plans to establish an ombudsman that would act as a "public protector", where people can report misconduct in the health sector.

The minister also mentioned that there were plans to tackle infrastructure underspending in the department by refurbishing several hospitals in the country, and increasing the number of doctors produced to about 2 600 per annum. Already, Motsoaledi said, the department would be sending 1 000 matriculants to study medicine in Cuba.

Other plans included a policy where all learners coming to school for the first time will do eye, ear and oral hygiene tests followed by vaccinations through the School Health Programme. The department was also planning to bring the issue of reproductive health
under the spotlight to deal with the problem of teenage pregnancy. The number of pregnant learners in schools jumped to 95 000 last year alone.

"About 750 000 pregnancies were reported in public hospitals back in 2007/08, with some girls having abortions three times within a period of six months. Family planning has disappeared and the only thing left is abortion," Motsoaledi said, stressing that this had to change.

The plan would also deal with alcohol and drug abuse in schools, he said, mentioning that they had already started with piloting these programmes.

Acting chairman of SAMA, Mark Sonderup, admitted that the success of NHI would need commitment from all parties. He said several issues would need to be ironed out first, including attracting back the large number of doctors who left the country; and the lack of equipment and infrastructure, if NHI is to be a success.


“Big Food,” the Consumer Food Environment, Health, and the Policy Response in South Africa

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In South Africa, as in other jurisdictions, “Big Food” (large commercial entities that dominate the food and beverage environment) is becoming more widespread and is implicated in unhealthy eating. “Small food” remains significant in the food environment in South Africa, and it is both linked with, and threatened by, Big Food.

Summary Points
Big Food in South Africa involves South African companies, some of which have invested in other (mainly, but not only, African) nations, as well as companies headquartered in North America and Europe. These companies have developed strategies to increase the availability, affordability, and acceptability of their foods in South Africa; they have also developed a range of “health and wellness” initiatives. Whether these initiatives have had a net positive or net negative impact is not clear.

The South African government should act urgently to mitigate the adverse health effects in the food environment in South Africa through education about the health risks of unhealthy diets, regulation of Big Food, and support for healthy foods.

Introduction
Despite continuing high levels of underweight and nutritional deficiencies, overweight and obesity among both adults and children is a rapidly growing public health problem in South Africa. In 2000, an estimated 36,504 deaths (7% of all deaths) in South Africa were attributed to excess body weight, and in 2004 non-communicable diseases (NCDs) linked to dietary intake—cardiovascular diseases, diabetes mellitus, cancers—together with respiratory diseases contributed 12% of the overall disease burden.
Paralleling this increase in overweight/obesity, there has been a steady increase in the per capita food supply of fat, protein, and total calories in South Africa and salt intake appears to also be in excess of recommended levels. These changes of nutrient intake appear to be associated with changes in dietary patterns. So, for example, a study of adults in the North West Province showed a shift with increasing wealth from a traditional high carbohydrate—low fat diet (in which maize made the largest contribution to energy intake) to a higher-fat diet in which maize was replaced by red meat and other cereal foods.

In recent years, there has also been an increase in the sales of almost all categories of packaged foods in South Africa. For example, sales of snack bars, ready meals, and noodles all rose by more than 40% between 2005 and 2010. In addition, a recent assessment of the consumption of street food (sold by vendors) and fast food (from formal fast food outlets) revealed that, nationally, 11.3% of the population bought food from street vendors and 6.8% bought food from fast food outlets at least two times a week. South Africans are also increasing their consumption of soft drinks. Compared with a worldwide average of 89 Coca-Cola products per person per year, in 2010 South Africans consumed 254 Coca-Cola products per person per year, an increase from around 130 in 1992 and 175 in 1997. In 2010, up to half of young people were reported to consume fast foods, cakes and biscuits, cold drinks, and sweets at least four days a week. Carbonated drinks are now the third most commonly consumed food/drink item among very young urban South African children (aged 12–24 months)—less than maize meal and brewed tea, but more than milk.

It can be hypothesised that various strategies adopted by “Big Food” to increase the availability, affordability, and acceptability of their products have contributed to these dietary changes in South Africa and to the increased burden of obesity and NCDs (Figure 1). In this context, in this article we provide an overview of “Big Food” in South Africa. We use the term “Big Food” as shorthand for large commercial entities—both multinational and national—that increasingly dominate key components of the food and beverage environment. We include companies that have an identity with consumers—manufacturers, retailers, and food outlets—rather than agribusiness and primary processors. Although many authors have written on Big Food in the US, the UK, and other developed nations, much less has been written about their operations and practices in developing countries experiencing significant transitions. As such, this article contributes to filling a gap in the literature and provides similar nations with a process for examining the role of Big Food in health and nutrition. Our article draws on information published in the academic literature, reviews of food industry documents, data compiled by market research agencies, and data from pilot studies conducted by researchers at the University of the Western Cape, South Africa.

![Figure 1](https://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001253.g001)

We first present data on the presence of Big Food in South Africa, then examine some of the strategies used by large food corporations to change the consumer food environment in South Africa. We argue that these strategies aim to alter the availability, affordability, and acceptability of foods produced and sold by Big Food (Figure 1). Finally, we discuss the responses to health concerns made by both Big Food and the South African government, and briefly explore the policy implications.

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