Dear colleagues

The last few weeks have seen an upsurge of attacks against foreign nationals, particularly those from other African countries, in some of our cities.

We, the School of Public Health at UWC, wish to place the following on record:

The SOPH considers itself first and foremost an African institution. As staff, we come from all parts of the continent; more than half our students are based in countries other than South Africa, mostly studying at a distance but also attending our annual summer and winter school programmes in Cape Town; we regularly host research collaborators from other African institutions. In recent days some of these have expressed legitimate concerns about doing so in future because of the violence being perpetrated against foreign nationals in South Africa.

That anyone should feel unsafe participating in the everyday academic life of our School, or indeed in their homes, work places and in our streets, because of their nationality, is intolerable. It is an assault on our equality, dignity and the bonds of solidarity that bind us on the continent. We wish to express our solidarity with and support for our colleagues, students and neighbors from Africa and beyond. And we stand with the millions of South Africans in loudly condemning any expressions of xenophobia, and call for swift action on the part of all to put an end to the violence.

If any of our colleagues and students working at the SOPH at any point feel unsafe at home or on your way to and from work, please let Lynette, Marlene, Helen or Uta know, and we will make every effort to ensure your safety and wellbeing.

With best regards,

Helen

PROF HELEN SCHNEIDER
DIRECTOR, UWC SCHOOL OF PUBLIC HEALTH
Dear colleagues

Let me take this opportunity to congratulate the School on being recognised as one of the top ten departments for research output for the period 2011-2013. The SOPH is number 8 in the university.

Congratulations to all who contributed to this success and may we keep this up for the next three years as well.

Regards

Prof Frantz
DEAN FCHS
Cross-country Research on the Role of Multinational Corporations in Food Systems: the Case of South Africa, Mexico and Brazil

Multinational Corporations (MNCs) play a critical role in determining the level of food security and productivity for populations around the world. While appreciating this role, it is critical to examine the impact political capture and increasing economic influence by the MNCs has on food production and food security with a deliberate emphasis on how this impacts small-scale farmers.

Marginalised, small-scale producers often play an important role in the food production in emerging and developing countries. The implication of MNCs in political and economic decision making has consequences for economic inequality in food security. Inequality in food security has an adverse effect on marginalised groups within the food chain, like small-scale farmers, women & the younger generation.

Focusing on at least three countries (South Africa, Mexico and Brazil), this case study aims to analyse the impact of MNCs on food production and food security with a focus on how they operate in collaboration with national elites to capture political decision-making.

The cross country research on MNCs and food systems will highlight the negative impact MNCs have on food production and security, through corporate power in the political and economic spheres of developing countries, with emphasis on how this affects the poor and marginalised in these countries.
The aim is to contribute evidence and civil society perspectives to the debate on how government policies related to the regulation of MNCs in food production and security can reduce inequality.

By way of examining the role of MNCs on food production and food security and the impact of this role on marginalised groups, the aim is to postulate recommendations aimed at addressing and reducing MNCs determination on economic and political agenda setting in the food system of selected developing countries.

In particular the study will examine the following areas:

I. The role and influence of MNCs over food production, processing, distribution and sale, the impact of this on small scale producers and operators.
II. Public Policies related to the regulation and proper taxation of MNCs, and ways in which MNCs are able to influence decision-making in regard to these, in their own favour to monopolise food systems
III. The interaction between existing inequality (wealth, land and power) and the more recent domination by MNC’s of food systems and worsening this same inequality.

The study will answer the following questions:

I. Are MNCs regulated in the selected countries of research, and how effective is the regulation of MNCs in the food system in the selected countries?
II. Are MNCs paying their fair share of tax? In what ways do MNCs avoid tax, and what options are there for governments to ensure this does not happen?
III. To what extent are public policies limited by the power of MNCs to shape food systems to their own advantage?
IV. Can MNCs play a role in addressing inequality (wealth, land and power) and contribute towards an agricultural sector which promotes greater involvement of small-scale farmers?
A prevention approach which is designed to bridge the prevention ‘fault line’, enabling a multi-ontology conceptualisation of the challenge to be developed.

The article concludes that stepping outside of the ‘ordered’ epistemological parameters of the existing prevention ‘messaging’ mind-set towards a more systemic approach that emphasises agency, structure and social practices as a contribution to ‘ending AIDS by 2030’ is worthy of further attention if communities are to engage more adaptively with the dynamic HIV landscape in South Africa.

To link to this article: http://dx.doi.org/10.1080/17290376.2015.1034292

African Journal of AIDS Research

Reducing the overall HIV-Burden in South Africa: is ‘reviving ABC’ an Appropriate Fit for a Complex, Adaptive Epidemiological HIV Landscape?
Christopher J Burman, Marota Aphane and Peter Delobelle

Abstract
This article questions the recommendations to ‘revive ABC (abstain, be faithful, condomise)’ as a mechanism to ‘educate’ people in South Africa about HIV prevention as the South African National HIV Prevalence, Incidence and Behaviour Survey, 2012, suggests.

We argue that ABC was designed as a response to a particular context which has now radically changed. In South Africa the contemporary context reflects the mass roll-out of antiretroviral treatment; significant bio-medical knowledge gains; a generalised population affected by HIV that has made sense of and embodied those diverse experiences; and a government committed to confronting the epidemic.

We suggest that the situation can now be plausibly conceptualised as a complex, adaptive epidemiological landscape that could benefit from an expansion of the existing, ‘descriptive’ prevention paradigm towards strategies that focus on the dynamics of transmission. We argue for this shift by proposing a theoretical framework based on complexity theory and pattern management. We interrogate one educational prevention heuristic that emphasises the importance of risk-reduction through the lens of transmission, called A-3B-4C-T.

We argue that this type of approach provides expansive opportunities for people to engage with the epidemic in contextualised, innovative ways that supersede the opportunities afforded by ABC. We then suggest that framing the prevention imperative through the lens of ‘dynamic prevention’ at scale opens more immediate opportunities, as well as developing a future-oriented mind-set, than the ‘descriptive prevention’ parameters can facilitate. The parameters of the ‘descriptive prevention’ paradigm, that maintain — and partially reinforce — the presence of ABC, do not have the flexibility required to develop the armamentarium of tools required to contribute to the management of a complex epidemiological landscape.

Uncritically adhering to both the ‘descriptive paradigm’, and ABC, represents an historically dislocated form of prevention — with restrictive options for reducing the overall burden of HIV-related challenges in South Africa.

Men’s Moralising Discourses on Gender and HIV Risk in Rural KwaZulu-Natal, South Africa
Deborah L. Mindry, Lucia Knight and Heidi van Rooyen

Abstract

Various interventions have resulted in increased rates of HIV testing. However, encouraging men to acknowledge their risk for HIV, to test and link to treatment remains a challenge. In this study, we examine men’s perspectives on navigating HIV risk in rural KwaZulu-Natal, South Africa.

Qualitative interviews were conducted at four intervals over a three-year time period with a baseline cohort of 126 men and women. We found that men navigated HIV risk in their sexual relationships mainly by monitoring their partner's behaviour. Men expressed concerns about female respectability, invoking discourses on hlonipha rooted in Zulu cultural ideals and Christian ideals about women staying close to home. In the post-apartheid era, these concerns were inflected by anxieties over changing gender norms and the high rates and risks of infection in the region. HIV prevention discourses on behaviour intersected with men's efforts to assert their masculinity through the monitoring and controlling of women's behaviour. The potential negative impacts of this should be addressed. Prevention efforts need to focus on men's vulnerability to infection in terms of their own behaviour as well as the contexts in which they live.

Culture, Health & Sexuality, 2015
http://dx.doi.org/10.1080/13691058.2015.1027877

AIDS Care

Empowering patients to link to care and treatment: qualitative findings about the role of a home-based HIV counselling, testing and linkage intervention in South Africa
Lucia C. Knight, Heidi Van Rooyen, Hilton Humphries, Ruanne V. Barnabas and Connie Celum

Abstract

To explore the barriers and facilitators of linkage to and retention in care amongst persons who tested positive for HIV, qualitative research was conducted in a home-based HIV counselling and testing (HBCT) project with interventions to facilitate linkages to HIV care in rural KwaZulu-Natal, South Africa. The intervention tested 1272 adults for HIV in Vulindlela of whom 32% were HIV positive, received point-of-care (POC) CD4 testing and referral to local HIV clinics. Those testing positive also received follow-up visits from a counsellor to evaluate linkages to care. The study employed a qualitative methodology collecting data through in-depth semi-structured interviews. Respondents included 25 HIV positive persons who had tested as part of HBCT project, 4 intervention research counsellors who delivered the HBCT intervention and 9 government clinic staff who received referrals for care. The results show that HBCT helped to facilitate linkage to care through providing education and support to help overcome fears of stigma and discrimination.
The results show the perceived value of receiving a POC CD4 result during post-test counselling, both for those newly diagnosed and those previously diagnosed as HIV positive. The results also demonstrate that in-depth counselling creates an "educated consumer" facilitating engagement with clinical services. The study provides qualitative insights into the acceptability of confidential HBCT with same day POC CD4 testing and counselling as factors that influenced HIV-positive persons’ decisions to link to care. This model warrants further evaluation in non-research settings to determine impact and cost-effectiveness relative to other HIV testing and referral strategies.

AIDS Care, 2015
http://dx.doi.org/10.1080/09540121.2015.1035633

"Without a Mother": Caregivers and Community Members’ Views about the Impacts of Maternal Mortality on Families in KwaZulu-Natal, South Africa

Lucia Knight, Alicia Ely Yamin

Abstract
Background:
Maternal mortality in South Africa is high and a cause for concern especially because the bulk of deaths from maternal causes are preventable. One of the proposed reasons for persistently high maternal mortality is HIV which causes death both indirectly and directly. While there is some evidence for the impact of maternal death on children and families in South Africa, few studies have explored the impacts of maternal mortality on the well-being of the surviving infants, older children and family.

This study provides qualitative insight into the consequences of maternal mortality for child and family well-being throughout the life-course.

Methods:
This qualitative study was conducted in rural and peri-urban communities in Vulindlela, KwaZulu-Natal. The sample included 22 families directly affected by maternal mortality, 15 community stakeholders and 7 community focus group discussions. These provided unique and diverse perspectives about the causes, experiences and impacts of maternal mortality.

Results and Discussion:
Children left behind were primarily cared for by female family members, even where a father was alive and involved. The financial burden for care and children’s basic needs were largely met through government grants (direct and indirectly targeted at children) and/or through an obligation for the father or his family to assist. The repercussions of losing a mother were felt more by older children for whom it was harder for caregivers to provide educational supervision and emotional or psychological support. Respondents expressed concerns about adolescent’s educational attainment, general behaviour and particularly girl’s sexual risk.

Conclusion:
These results illuminate the high costs to surviving children and their families of failing to reduce maternal mortality in South Africa. Ensuring social protection and community support is important for remaining children and families. Additional qualitative evidence is needed to explore differential effects for children by gender and to guide future research and inform policies and programs aimed at supporting maternal orphans and other vulnerable children throughout their development.

Knight and Yamin Reproductive Health 2015, 12(Suppl 1):S5
http://www.reproductive-health-journal.com/content/12/S1/S2
Dr Hazel Bradley recently contributed a chapter on Participatory Action Research in Pharmacy Practice in a newly published text book for pharmacy students and practitioners. The book is titled: Pharmacy Practice Research Methods and is edited by Zaheer-Ud-Din Babar and published by Springer.

It has thirteen chapters covering the range of quantitative, qualitative, action research and mixed methods as well as management theories underpinning change in pharmacy practice. The chapter was largely based on Hazel’s PhD research where she used a participatory action research approach to identify district and sub-district pharmacists’ roles and competencies, and their transitions into these new positions, in the emerging district health system in Cape Town.

Chapter 6: Participatory Action Research in Pharmacy Practice - Abstract

Participatory action research is part of a broad family of approaches and includes as its distinctive features action, reflection and partnership. In participatory action research knowledge is created in the interplay between research and practice, thus requiring researchers to work with practitioners as active researchers and agents of change through iterative cycles of action and reflection. The purpose of Participatory Action Research is to understand and effect change through generating new learning and knowledge whilst empowering participants. The approach facilitates in-depth understanding of issues in complex settings, which is perhaps not possible with narrower traditional research approaches. Participatory Action Research’s emergent nature is particularly suited to research in changing circumstances, such as professional development of pharmacists or developing pharmacy services in new settings.

This chapter describes the key features of the participatory action research approach, describes innovative participatory processes and methods and discusses critical issues of the approach including ethical concerns, quality and generalisability. The benefits and challenges and application of participatory action research are highlighted. Finally I illustrate the application of the participatory action research approach through my own experience of conducting a case study to identify roles and competencies of district and sub-district pharmacists in Cape Town.

Further information on this book click on link below: http://www.springer.com/gp/book/9783319146713?wt_mc=email.event.1.SEM.ChapterAuthorCongrat
Kindly join me in welcoming Mr Percival Daames who joins the School of Public Health as extraordinary lecturer in the School of Public Health. Percival is a Senior Technical Advisor, Pharmaceutical Therapeutics and Medicine Use Evaluations and has more than thirteen years cumulative work experience across the pharmaceutical and health sector. Percival is assisting the School of Public Health in the development of learning materials and delivery of courses in our new area of Pharmaceutical Public Health, and is involved specifically in the Rational Medicines Use Winter School short course and online module.

Percival worked for a variety of local public, private sector and international institutions. He previously worked for the Commonwealth Secretariat as Health Advisor, where he was responsible for assisting Commonwealth countries in strengthening healthcare delivery, specifically in areas of HIV and AIDS and E-Health. Prior to this, Percival worked for the National Department of Health as Pharmaceutical Policy Specialist, as well as the medical insurance industry, retail and hospital pharmacy.

Percival holds a Bachelor of Pharmacy form the University of the Western Cape, as well as a Master of Science in Health Economics and Health Policy from the University of Birmingham, United Kingdom. His interest is health technology assessment, infectious disease and health economics.

Dr Hazel Bradley

New Arrival into the SOPH Family...

It’s with a grateful heart that we would like to thank you for all the love and support provided during my pregnancy till the arrival of our little princess Joy Zoe Nicol who was born on the 28th April weighing 4.47 kg

Dr Jeanine Uwimana

Joy Zoe Nicol
It is my honour and pleasure to present to this Honourable House the 2015/16 Budget Policy Statement of the Department of Health, for your consideration and approval. Honourable Members, in the previous financial year a sum of R33.95 billion was voted by this Parliament for the Department of Health. In using this appropriation, we did have our achievements but also challenges which I hope to reflect on during this budget vote.

Let me start by reminding Honourable Members that South Africa now has a plan. The first ever South African plan, pre- and post Apartheid. The National Development Plan or the NDP. We are aware that there are some individuals or even organisations that have some reservations with the NDP or Vision 2030. In some instances, maybe rightly so. However, I wish to take this opportunity to reassure this House that in as far as health is concerned, we have no reservations at all. There is no reason for anybody to have. What I am saying is borne out of hard facts which are available for those who may be interested.

The health demands of the African Claims of 1943, the health ideals of the Freedom Charter of 1955, the National Strategic Plan for HIV and AIDS 2012-2016, the Plan to end HIV and AIDS by 2030 as agreed to in the International AIDS Conference in Melbourne, Australia last year, the Global Plan on TB, the three health goals of the United Nations Millennium Development Goals of 2000, and the envisaged United Nations Post- 2015 Social Development Goals, the World Health Organisation’s 1998 Alma Ata Declaration on health, the six building blocks of health care system as declared by the World Health Organisation - all these can be easily identified and recognised in the health chapters of the National Development Plan.

Hence Honourable Members, I wish to reiterate that every single vision in health, every single policy, plan, programme, decision or campaign will from now henceforth be based on and be directed by the dictates of the National Development Plan without any reservations whatsoever. This budget policy statement shall not be an exception to that rule. It will be fully informed by the National Development Plan.

For those who might not be informed, here is what the NDP envisages for health by 2030:

“We envisage that in 2030, South Africa has a life expectancy rate of at least 70 years for men and women. The generation of under-20s is largely free of HIV. The quadruple burden of disease has been radically reduced compared to the two previous decades, with an infant mortality rate of less than 20 deaths per thousand live births and an under-five mortality rate of less than 30 per thousand. There has been a significant shift in equity, efficiency, effectiveness and quality of health care provision. Universal coverage is available. The risks by the social determinants of disease and adverse ecological factors have been reduced significantly.

However Honourable Speaker, I wish to warn that there are three (3) issues which will finally determine or even dictate whether these noble goals are achieved or not. These are:

(1) The successful implementation of the NHI;
(2) The Outcomes of the Competition Commission’s Public Market Inquiry into the cost of Private Health care, led by former Chief Justice Sandle Ngcobo; and
(3) Issues pertaining to the explosion of medico-legal litigation whose full facts I am intending to bring to this Parliament – these will be full facts and not the half-truths that have been bandied around.

These three issues Honourable Speaker are to determine whether the country goes forward or backwards in the provision of proper health care and in the implementation of the National Development Plan.

I also want to plead to this House not to regard health in isolation or regard it just as a component of the social imperatives of Government. There is general agreement now around the globe that good health is a key ingredient for development. There is general consensus about this even among organisations as diverse as the World Bank and the World Health Organisation. Let me quote the President of the World Bank, Dr Jim Yong Kim on this relationship:

“There is a evidence that investment in people – like health care, education and social protection, are not just good for the individuals who directly benefit, they are also good for their countries’ growth and political stability. Likewise, I believe not providing health, education and social protection is fundamentally unjust, in addition to being a bad economic and political strategy”.

Dr Kim said this while speaking on the topical issue of Universal Health Coverage (which we in South Africa call NHI) in Emerging Economies, on January 14, 2014. This relationship between health and the economy, as well as social and political stability, has been seen recently with the Ebola outbreak in the three most affected countries in West Africa: Liberia, Guinea and Sierra Leone.

As you all know by now, South Africa thus far has had no case of Ebola. We took the necessary precautions and put up the necessary contingency plans. We however still need to ensure that we continue with our vigilance as well as our surveillance. This outbreak has also forced us to redouble our efforts to get everyone to wash their hands. I
launched the national hand-washing campaign last year to advise the Nation about the importance of hand-washing, because it is not only good to prevent the spread of Ebola, it is also good to prevent the spread of influenza and all forms of gastroenteritis or diarrhoea too!

Yesterday health workers washed their hands and thousands more are doing so today, in recognition of Hand Hygiene Day for Health Professionals declared by the World Health Organisation. I wish to thank our partners at home, both public and private, for their support and cooperation in the fight against Ebola in West Africa, and for prevention measures at home. Africa has learnt extremely important lessons with Ebola.

The first and the biggest lesson learnt is that weak health systems make it virtually impossible to prevent and manage disease outbreaks. Whether it is Ebola, Meningitis, TB, HIV and AIDS, Polio, Malaria or whichever outbreak it is, if the overall health system is weak, such an outbreak will be unmanageable!!

What do weak health systems mean? It simply means systemic and perennial inadequacies in the following areas:

- information systems;
- health facilities;
- infrastructure and equipment;
- number of health professionals;
- supply chain processes;
- financial management; and
- ability to coordinate development partners and assistance from international organisations.

It is for this reason Honourable Members of the House, that in the World Health Organisation’s Africa Regional Conference held in Cotonou, Benin in November last year, we as Ministers of Health have had to decide to break with the past. Ordinarily, the budget of the World Health Organisation on the Continent of Africa is based on vertical programmes, i.e a budget to fight Malaria, Polio, HIV/AIDS and TB programmes, etc. We argued as Ministers of Health that these vertical programmes are by themselves not going to propel the Continent forward. We believe that what will help Africa are strong health systems which in turn will withstand whichever outbreak emerges because Honourable Speaker, we actually do not know what will follow next.

Yesterday it was HIV and AIDS, today is Ebola and TB and tomorrow is what?? We do not know but we believe that some other outbreak is unfortunately in the pipeline due to three reasons:

- Reason number one is climate change. We do not know what disease climate change is going to bring along;
- The increasing encroachment of humankind in the habitat of other species in search of food, water and shelter;
- The ever increasing emergence of the post antibiotic era.

This Honourable Members is precisely why the NDP as well as the World Health Organisation believe that strengthening health systems is key to any country’s development! Hence in Benin, we took a resolution that the WHO must change its budget and strategy, and put as its flagship, strengthening of health systems and rearrange the budget such that the biggest chunk of money is allocated for this purpose rather than for vertical health programmes.

Honourable Speaker, during the 2014/15 financial year the Department of Health has been busy putting up plans to strengthen the public health system. This will include preventing disease, promoting health and making sure that our people get good quality health care. This is our mandate and this we shall pursue with vigour. This does not mean that vertical programmes are to be abandoned. It simply means that strengthening health care systems will be our flagship while the vertical programmes will be supportive.

In our country up to so far, our vertical programmes have actually achieved a lot and we have announced that many times in the past like increasing life expectancy and the dropping mortality figures, i.e overall mortality as well as neonatal, infant, child and maternal mortalities, markedly reducing mother-to-child transmission of HIV, on the verge of eradicating Malaria, big progress on vaccine – preventable diseases, etc.

One area of health care which is commonly undermined by public utterances from politicians, the media and sometimes even members of the public is the area of prevention of diseases and promotion of health. Curing diseases is always regarded as a nobler scientific feat and preventing them is never regarded as a scientific achievement. Hence the most sustained focus in the public arena is always on what is, or what is not happening inside the hospital or clinic. In fact the performance of the health care system is usually based on the goings on inside the hospital and clinic.

That is why any one negative event that takes place there is almost immediately regarded as the collapse of the health system. This of course is a knee-jerk response. No matter what detractors will say, we shall not abandon or weaken the preventative aspect of the health system, on the contrary it is going to be the foundation of our programme of health system strengthening.

Honourable Speaker, in pursuance of these goals, in 2009 we introduced two new vaccines in our routine immunisation programme, namely the Pneumococcal conjugate vaccine and the rotavirus vaccine. To avoid reliance on anecdotes and arrive at wrong conclusions, at the time of the introduction of these two vaccines, we requested the
National Institute of Communicable Diseases (NICD) to monitor the impact of these new vaccines on the population. I am very pleased to report that the results are overwhelming.

The NICD found a 70% decline in invasive pneumococcal disease in children under the age of five. Pneumococcal diseases include very dangerous diseases like meningitis and severe pneumonia. These are the leading causes of death of children 5 years and under globally. In South Africa, pneumococcal disease comes only second to HIV and AIDS in causing death of under fives. That we decreased these by 70% is something we cherish immensely. Sadly in today’s public narrative, it may count for nothing. What would have counted is if I were to announce that we allowed children to have pneumonia and meningitis and successfully treated all of them. That type of announcement would have found resonance with major sections of the media and some politicians. I read with trepidation one media report bemoaning the fact that South Africa did not get Ebola, and that this deprived the country to test whether the health system can hold.

That I am announcing today that we actually prevented 70% of children from ever catching the deadly pneumococcal disease may mean nothing to people with this perverse narrative of “cure is better than prevention” rather than the age old adage of “prevention is better than cure”. In addition, the NICD also found a decline in unvaccinated adults, including HIV-infected individuals in whom pneumococcus is a leading bacterial cause of sepsis. This demonstrates the indirect protection conferred by what is called herd immunity. I am also very happy to announce that the NICD further documented a 66% reduction in rotavirus diarrhoea hospitalisation in the first 2 years after we introduced rotavirus vaccine we introduced in 2009.

These reductions may not ring a bell to some people. Before we embarked on these two new vaccines, the NICD did a cost-benefit analysis and arrived at staggering figures:

- One shot of vaccine for pneumococcus is R600.00 but to treat pneumonia will cost R6 930.00 and to treat meningitis will cost R17 903.00. These are 2009 figures;
- The massive benefits to be derived from investing R400 million per annum for HPV vaccine for young girls which we introduced last year will be realised in the next two to three decades.

Unfortunately when those benefits start manifesting themselves in the health services, people would have forgotten that it is because of this wise investment we are doing today.

Honourable Speaker we are spending R450 million per annum on pneumococcal vaccine and R200 million per annum on rotavirus vaccine. But as I said, the most important gain here is that mortality among children under 5 years has gone down with a major contribution by the combination of ART programme and these two new vaccines. The Road to Health Booklet is our children’s passport to health. We need to use it to ensure that our children are fully immunized and protected against vaccine preventable diseases. It is also used to monitor the child’s growth and to ensure that a child that falters can receive the attention that they need without delay. It contains message that can alert the caregiver to danger signs that require urgent medical attention. I therefore call on all caregivers and health professionals to check the Road to Health Booklet and ensure that all children get all their vaccinations – from birth to age twelve.

Let me move to the mothers of this country – the source of life and sustenance in the whole universe. In August last year, we launched the MomConnect project at Motubatse clinic in Soshanguve, Tshwane Metro. This project uses cellphone technology to register pregnant women – all pregnant women in both public and private health care. This empowers them to get all the information and instructions necessary for them to ensure a healthy pregnancy and deliver a healthy vibrant baby. After delivery, the messages switch over to focus on information on the health needs of a newborn and will continue for up to one year after birth.

Honourable Speaker, I am very happy to announce that in a short space of only 8 months we have been able to register 383 354 pregnant women on the system. It is regarded as the largest number in the world. Before we started, Bangladesh was regarded as a world leader after registering 100 000 women in 18 months, while other countries are having only small pilot projects – nothing yet on a massive scale like we have. The system does not only dish out information and instructions, it also enables pregnant women to ask questions and send to us unsolicited complaints and unsolicited compliments about our services.

Unsolicited means that the woman sends in a complaint or a compliment without being asked, requested, provoked or prompted as is often done by researchers. This means we get to know about our services from the horse’s mouth unprovoked. The compliments and the complaints constitute the good and the bad. Much against conventional wisdom Honourable Speaker, let me start with the good. The good is that we received 1 553 compliments in these eight months. While these compliments are diverse, there are 3 main categories worth noting:

- Thanking us that the messages are very useful in guiding them about their wellbeing;
- The service they received has been good;
- Individual nurses who exert themselves and perform above the call of duty and are real angels to the pregnant women.

These 1 553 compliments constitutes what you will never read about in the print media or hear about in the electronic media.
What you will always hear and read about will be the bad, which I am now coming to. The bad consists of 290 complaints which we have received. Just like the compliments, they are also many and varied but again, three came out prominent:

First and the commonest of them all, are the long queues and long waiting times in our public health facilities.

Long before MomConnect, we have come across this phenomenon of long waiting times as far back as 2010 when we did our own audit of health facilities. It is important to explain why this is so lest, some people blame us for doing nothing. We are trying day and night but it is a huge problem and hence the pregnant women on MomConnect have come across it.

Honourable Speaker, these unbearable waiting times are caused mostly by the fact that in 2004, we only had 400 000 people on ARVs. By 2009 the figure more than doubled to 923 000 and today Honourable Speaker we have 3 million people on ARVs. This figure is more than 30% of the World’s programme. There is no way clinics and hospitals will not be congested. Add to these the explosion of noncommunicable diseases like Diabetes and High blood pressure, then you have very long queues in the making.

The solutions lie in making sure that very few people are forced to or have to visit a hospital and clinic and also by introducing new efficient technology systems in our health facilities. I shall visit these issues later on in the speech.

The second major complaint which pregnant women have raised Honourable Speaker are the rude and unfriendly health workers who do not even respect the state of pregnancy. We also picked this up in our 2010 audit.

The third is of course the non-availability of some drugs, leading to drug stock-outs – also due to the large volumes of people and difficulty in logistics which we are busy trying to resolve.

Honourable Speaker, we investigate and try to respond to each and every complaint that we pick up on MomConnect. I wish to thank our partners who have helped us to develop and scale up this service. The main partners were the United States Government, through its OGAC (Office of the Global AIDS Coordinator) programme and Johnson and Johnson. MTN, Cell C and Telkom all contributed by giving 50% discount to the sms’s. Vodacom contributed by giving a 30% discount and we are happy that they are prepared to increase this very soon.

Our intention Honourable Speaker is to ensure that everyone of the 1,2 million women who get pregnant annually register on MomConnect. I wish to take this opportunity to acknowledge the presence in the gallery, of Ms Tshepiso Makwetla, the SAfm journalist who volunteered to be our MomConnect Ambassador. She has travelled the length and breadth of the country and encouraged pregnant women to register. We thank her for the job well done!

Honourable Speaker, we are aware that this is going to be a hard and long road but there is no alternative if we are to achieve our goal of Health System strengthening, and make NHI worthwhile. While the Ideal Clinic model as implemented through Operation Phakisa is aimed at strengthening health care systems at our primary health facilities, this similar approach will eventually also be extending to our hospitals in the near future. But as I said, I wish to reiterate that we are not labouring under any illusion that this is going to be a short and smooth road. Earlier...
on in this speech, I promised to revisit the issue of waiting times, which featured prominently on the complaints in MomConnect and on the results of our own health facility audits done in 2010.

I told you that it is because of huge volumes of patients which South Africa is experiencing and I also suggested that one of the solutions will be to make sure that as many patients as possible do not have to visit our health facilities. This may make some of you to believe that we are going to chase patients away. NO!! We are doing it by asking those patients who are stable, who do not really have to see a doctor or a nurse but who have to visit a health facility for their monthly supply, to register a collection point where they may collect their medicines, without having to queue or wait. Collection points may be a clinic or hospital dispensary, private GP, private pharmacy or even treatment adherence clubs.

Such patients do not even have to queue for a file – they just march straight to the collection point and produce a card which they would have found in the pack they collected in the previous visit, or they produce an sms which would have been sent to them by us. Presently we have 383 989 patients on this system and we are targeting 0,5 million people.

Honourable Speaker, another project to strengthen the health care system is to deal with drug stockouts. Having 3 million people just for collecting ARVs only, the logistics of supplying drugs have become problematic. Demands may always exceed supply, not because of shortage in one country but due to logistical problems. We have instituted a cellphone-based technology to deal with this. Presently this project is being conducted in 1 160 health facilities in the country, i.e it is still in 25% of our health facilities. A nurse has to read a barcode on every package of medicines every week, using the cellphone that we would have supplied. She or he would then send this information to a central database where it is fed into a geomap. The facility that has a stock-out will blink a red light in the geomap and we will phone the District Pharmacist in that District to warn them.

Honourable Speaker I cannot finish this budget vote without dealing with the issue the President mentioned in the State of the Nation Address earlier this year. I quote him, “Over the past five years, Government has scored significant gains in health care. This year, we are going to launch a massive programme to turn the tide against Tuberculosis (TB) with a special focus on three vulnerable communities, offenders at Correctional Services facilities, mineworkers and communities in mining towns”. While the huge and successful ART programme has helped us to deal with TB, the epidemic is still very high as indicated in the President’s State of the Nation Address.

We have identified areas of the population which are very vulnerable to TB, and as the President alluded to, they are:

- Correctional Service facilities;
- The mines, especially Gold mines; and
- Peri-mining communities or communities where there is intense mining, especially Gold mining activities.

We also used this concept of vulnerable communities to determine which districts are more affected:

- District number one by far is Lejweleputswa in the Free State;
- Number two is Dr Kenneth Kaunda District in North West;
- Number three is Waterberg in Limpopo;
- Number four is West Rand in Gauteng – especially around Carletonville;
- Number five is the Bojanala District in North West;
- Number six is Sekhukhune District in Limpopo.

On World TB Day, March 24, the Deputy President of the country, Mr Cyril Ramaphosa, launched the biggest TB screening programme that has ever been. The launch took place in Orkney, for obvious reasons. Hence screening is going on in the six Districts in Correctional Service facilities, mines, schools, crèches and indeed when you visit a health facility in these Districts for any ailment or any service you may be asked to subject yourself to TB screening. The screening may be by five oral questions and depending on your answer, it may proceed to XR via a digital XR equipment on mobile vehicles bought for this purpose through funding from the Global Fund, to sputum examination using the GeneXpert technology which every district in South Africa is now having after we started the rollout in 2011.

From the six districts, we shall move over to the big Metros, especially the Ethekwini Metro and the Cape Metro which are the most affected in terms of the TB case loads. From the Metros, we shall move over to the four provinces which are most affected. These are:

- Eastern Cape;
- Gauteng;
- KwaZulu Natal and
- Western Cape

I would like every Member of Parliament to join me in spreading the message about TB. The three simple messages are: Get screened, get treated if you are diagnosed to be having TB, and complete your treatment. I would like all Members of Parliament to undergo screening for TB. It is important.

Let me just give you a glimpse of what the screening programme is revealing.
In the Correctional Service facilities, there are 160,000 inmates. The screening so far revealed 468 with ordinary TB and 17 with Drug Resistant TB. They have all been initiated on treatment and the screening process is continuing. In the six districts I have mentioned, 36,415 community members were screened so far using the GeneXpert technology. A total of 3,256 were found to have ordinary TB and 57 were found to have Drug Resistant TB. All those did not know about their TB status before the screening. They are now all on treatment.

Honourable Speaker, just to summarise the extent of the TB epidemic in our country, when Ebola struck and you were all dying of worry and anxiety about it, the Executive Director of NICD, Prof Shabir Madhi shared a platform with me on TV in July last year to speak about Ebola. He advised South Africans not to worry a lot about Ebola as the chances of contracting if are very slim. He said that what South Africans should worry about is TB rather than Ebola. People phoned in and attacked the Professor and accused him for misleading them or for taking them for fools.

I am not here today to defend Prof Madhi. Facts and figures speak for themselves. Since he uttered those words, nobody in South Africa died of Ebola, but 40,542 people died of TB – but South Africans will still believe that the Professor was taking them for fools.

In conclusion, Madam Speaker, let me briefly summarise the budget request from the National Department of Health. For the 2015/16 financial year, the proposed budget that we are requesting your approval for is R36.46 billion. This is broken down into four components as follows: R772 million is for compensation of employees; R1.579 billion is for goods and services; R33.448 billion is for transfers – these are the conditional grants that we provide to provinces; and R668 million is for capital expenditure. The total budget represents a 7.4% increase when compared to the 2014/15 budget.

I request this House to approve the budget of the National Department of Health for the 2015/16 financial year.

I thank you!

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