



INDEPTH Training and Research  
Centres of Excellence (INTREC)



# South Africa Country Report

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**Mandy Maredza**<sup>1</sup>

**Karen Hofman**<sup>1</sup>

**Raman Preet**<sup>2</sup>

**Kathleen Kahn**<sup>1</sup>

**Martin Bangha**<sup>3</sup>

**John Kinsman**<sup>2</sup>

<sup>1</sup> MRC/Wits Rural Public Health and Health Transitions Unit, University of Witwatersrand School of Public Health, Johannesburg, South Africa

<sup>2</sup> Umeå Centre for Global Health Research, Epidemiology and Global Health Unit, Department of Public Health and Clinical Medicine, Umeå University, 901 85, Umeå, Sweden

<sup>3</sup> INDEPTH Network, Accra, Ghana

Correspondence to: [Mandy.Maredza@wits.ac.za](mailto:Mandy.Maredza@wits.ac.za) and [john.kinsman@epiph.umu.se](mailto:john.kinsman@epiph.umu.se)

*The INTREC South Africa Country Report*

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## 1. Executive Summary

Despite its well-established economy, South Africa is classified as one of the most unequal countries in the world. The legacy of apartheid, that was characterized by discrimination based on race and gender, created inequalities which the country is still grappling with to date. Indeed, social inequalities and health inequities have persisted even after independence, as indicated by the urban/rural disparities in health status and the unacceptable gaps that continue to exist between the rich and the poor.

The World Health Organization's landmark report by the Commission on Social Determinants of Health argues that addressing the social determinants of health (SDH) and their unequal distribution within populations throughout the world represents one of the next major frontiers for global health. To push the SDH agenda forward, INTREC (INDEPTH Training and Research Centres of Excellence) has been established in three African and four Asian countries. This report constitutes the South African national SDH needs assessment for INTREC, and it aims to identify issues within three major areas of concerns: (i) key research matters regarding SDH that may be relevant in the country; (ii) training needs for research on adult health and social determinants; and (iii) SDH-relevant policies, as well as opportunities for INTREC to contribute to upcoming policy reviews.

Using a combination of methods (including a curricula review, a literature review, and in-depth interviews with stakeholders from different sectors), several key messages emerged from the study:

- i) **Inequities in health status continue to exist in South Africa.** Research needs to be intensified with regards to measurement of health inequalities, including the extent, degree and gradient of these inequalities. Furthermore, monitoring impacts of SDH-relevant initiatives is critical in order to track progress.
- ii) **Training needs to be strengthened in order to prepare students for the practicalities of conducting research on SDH.** Teaching curricula need to incorporate training on methodology for conducting research on SDH. Students should be made aware of both the quantitative and qualitative tools of analysis that are available, and the challenges of measuring health inequalities.
- iii) **Increase awareness of the opportunities and challenges in inter-sectoral cooperation.** Inter-sectoral healthy public policy should be covered in training courses for people planning careers in civil service management.
- iv) **Highlight the economic burden of not addressing SDH.** Due to the scarcity of resources and competing health demands, highlighting the cost to the government of *not*

addressing SDH is essential as a means of creating a sense of urgency around the SDH. Thus, courses on SDH should include economic analysis as a core topic, to equip students with the basic skills necessary to carry out or interpret economic analysis related to SDH.

- v) **Increase human resource capacity to teach on SDH.** The INTREC initiative has the opportunity to address some of the human resource capacity challenges currently faced in South Africa. Collaboration with institutions that have not managed to offer SDH-related courses due to lack of human resources offers a good starting point.
- vi) **The need to communicate contextualized and actionable information.** To gain attention, research on SDH should be disseminated in a manner that can persuade, elicit interest, help engage, and initiate action amongst both the policy makers and the general population.
- vii) **Use of online media should be encouraged as a teaching platform for SDH.** Coverage of SDH-related training could be maximized through use of distance education platforms. While current broad band coverage in Sub Saharan Africa is relatively poor, and may hamper access as well as being expensive, internet penetration in the country continues to increase, and is likely to offer a viable option for wide-scale use in the future.
- viii) **Inter-sectoral health policy should be organized around concrete objectives.** All stakeholders should be involved in formulation of policy objectives, as the chances of success will be maximised when all parties support the objectives, and when they incorporate them into their own policy plans. Implementation of all components of an inter-sectoral policy should be enforced and monitored, including through the allocation of budgets. Critically, roles and responsibilities should also be carefully defined, particularly regarding the monitoring of key indicators.
- ix) **Support on-going inter-sectoral partnerships.** Efforts to integrate programmes that address social determinants of health should continue, for example the ‘health promotion fund’. This initiative provides a platform by which funders and other interest groups can contribute towards addressing social determinants of health in the country
- x) **Identify policy champions who can bridge the gap between research and policy.** Whilst engagement between policy-makers and researchers is often challenging, it is imperative that partnerships between people from different sectors, who share a vision to reduce health inequities, as well as having the skills, authority and power to bring about change, are developed and nurtured.

## 2. Introduction

The WHO's Commission on Social Determinants of Health was concerned with the dramatic differences in health status that exist between and within countries (1). It compared, for example, the lifetime risk of maternal death in Afghanistan (1 in 8), to the lifetime risk in Sweden (1 in 17,400) (2). It also highlighted the fact that maternal mortality is three to four times higher among the poor compared to the rich in Indonesia (3). The Commission argued that these disparities, and innumerable similar ones across the globe, are intimately linked with social disadvantage, and that they are both unjust and preventable.

Addressing health inequities is therefore a moral imperative, but it is also essential for reasons of global self-interest: a more inequitable society is inherently a less stable one. But the Commission recognised the challenges that face steps to strengthen health equity, and, critically, that it requires going beyond the current prevailing focus on the immediate causes of disease. Rather, it is necessary to identify and act upon the 'causes of the causes': *"the fundamental global and national structures of social hierarchy and the socially determined conditions that these create, and in which people grow, live, work, and age"* (CSDH, p42)(1).

To this end, three broad Principles of Action on these social determinants of health (SDH) were identified in the Commission Report, that together could, it was argued, 'close the gap' of health inequities within a generation (CSDH, p2)(1). These Principles of Action were:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

A wide range of actors is required if these Principles are to be effectively implemented. The Commission identified the core actors as the multi-lateral agencies (especially WHO), national and local governments, civil society, the private sector, and research institutions.

This report is concerned with the third of the three Principles of Action – the production of a strong SDH evidence base – and also with the people who are going to produce and then use that evidence base: those working in research institutions, and those with decision-making authority in governments. Current capacity to produce setting-specific, timely, and actionable

evidence on the relationship between SDH and health outcomes is limited, and especially so in low- and middle-income countries (LMICs). Likewise, with limited awareness of SDH among decision makers, and a general global culture that under-utilises evidence within the policy process, there is an urgent need for capacity-building activities to promote informed decision-making that aims at reducing health inequities. As the Report points out, *“Knowledge – of what the health situation is, globally, regionally, nationally, and locally; of what can be done about that situation; and of what works effectively to alter health inequity through the social determinants of health – is at the heart of the Commission and underpins all its recommendations”* (CSDH, p45)(1).

INTREC (INDEPTH Training and Research Centres of Excellence) was established with precisely this concern in mind. INTREC’s two main aims are (i) providing SDH-related training for INDEPTH researchers in Africa and Asia, thereby allowing the production of evidence on associations between SDH and health outcomes; and (ii) enabling the sharing of this information through facilitating links between researchers and decision makers in these countries, and by ensuring that research findings are presented to decision makers in an actionable, policy-relevant manner.

The INTREC consortium consists of six institutions. The one around which most of the work revolves is INDEPTH – the International Network for the Demographic Evaluation of Populations and Their Health in Low- and Middle-Income Countries. With its secretariat in Accra, Ghana, INDEPTH is an expanding global network, currently with 44 Health and Demographic Surveillance Systems (HDSSs) from 20 countries in Africa, Asia and Oceania. Each HDSS conducts longitudinal health and demographic evaluation of rural and/or urban populations. INDEPTH aims to strengthen the capacity of HDSSs, and to mount multi-site research to guide health priorities and policies in LMICs, based on up-to-date evidence (4). The other five members of the INTREC consortium are all universities, which bring their own respective technical expertise to particular components of the work. These universities are Umeå University in Sweden; Gadjah Mada University in Indonesia; Heidelberg University in Germany; the University of Amsterdam in the Netherlands; and Harvard University in the USA.

The work of INTREC will build on the pre-existing INDEPTH network, and is primarily focused on seven countries. In Africa, these include Ghana, Tanzania, and South Africa; and in Asia, Indonesia, India, Vietnam, and Bangladesh are taking part. Starting in 2013, each continent will be served respectively by regional training centres in Ghana and Indonesia. These centres will act as focal points for research and training on SDH for the INTREC countries and, in due course, other low- and middle-income countries. See [www.intrec.info](http://www.intrec.info) for more details.



This report constitutes the very first step in the work of INTREC in South Africa, by providing a situation analysis, conducted by an in-country social scientist and with the support of members of the consortium, that addresses three areas of concern:

1. Current SDH-related training in South Africa, and gaps identified, as a baseline for INTREC to build on;
2. The core SDH issues of concern in the country;
3. Ongoing SDH-related work in South Africa, both in terms of government policies and programmes, and in terms of efforts made by non-governmental organizations.

The report ends with a series of recommendations for action, directed at decision makers, programme implementers, as well as at INTREC itself. Based on the comprehensive, empirical background material included in the report, these recommendations will prove to be an invaluable guide for the future development of INTREC, as the programme works towards reducing health inequities in South Africa, and also in other low- and middle-income countries.

### 3. Methods

#### a) South African context

Relevant databases pertaining to South Africa were identified via the internet. Criteria for selection included the likely reliability of a given database (e.g. WHO was considered as highly reliable), and the degree to which the information given was up to date. Databases such as Wikipedia, and unofficial or private websites were not referenced in this report.

The internet search for data and material included keywords or acronyms, such as “South Africa”, “fact sheet”, “country information”, “World Bank”, “WHO” (World Health Organization). More specific key words or acronyms were employed for different sub-sections, including “demography”, “geography”, “MDGs” (Millennium Development Goals), “NCDs” (non-communicable diseases), “HIV/AIDS”, “tobacco”, etc.

Cross-references were made where more than one database was available, to synthesize a comprehensive description of the situation. In some instances, WHO databases were the primary sources of information; in others, relevant journal articles were sought to give greater depth to an issue. The data were then presented along with a commentary on the statistical patterns and public health challenges that the country faces.

#### b) Curricular review

To search for courses that teach on social determinants of health at postgraduate level, we conducted a multi-stage search. We initially listed all Schools of Public Health in South Africa and visited the respective websites. Schools of Public Health were chosen as the first port of entry as ‘social determinants of health’ is primarily taught as a public health course in South Africa. An initial search using the phrase “social determinants of health” yield very few search results, confirming our initial assumptions that some of the relevant SDH courses would not explicitly mention the term. As such, we examined the course and module outlines that were freely accessible online, searching for courses that did refer at least indirectly to some determinants of health - for example by linking income inequality and health. We also searched for the following key terms; “health inequalities”, “health inequities”, “determinants of disease”, “socio-economic determinants of health”, “social aspects of health”, “health and society”. Where course outlines were not freely available online, we contacted course administrators and course conveners requesting details of the course and/or course outline.

The second stage involved identifying departments outside schools of public health that offered SDH relevant courses. To accomplish this, we examined all the courses enlisted on 2 University websites, specifically looking at the objectives of each course. Any course that had as one of its

main objectives a discussion around health impacts was enlisted as potentially SDH relevant. For example, a course that assessed the impact of social inequality, poverty and development on health was classified as SDH relevant. We noted the departments in which such courses were offered within the universities. The departments identified included: Sociology, Economics, Social Anthropology, Development and Social Sciences and Biostatistics. Nineteen South African University websites were subsequently visited; searching for SDH related courses in each of the departments listed above.

The last stage involved a basic internet search using Google search engine for any SDH related course offered in South Africa that might have been missed in the first 2 stages. Similar search terms outlined above were used and the country name “South Africa” included. We also added new search terms evolving out of the first 2 stages of search. These included: “chronic disease epidemiology”, “culture, health and illness”, “health and development”, “health and welfare”.

### *Limitations*

A few limitations should be noted. First, in spite of the follow-up schedule with course coordinators it was not possible to obtain comprehensive information on many of the courses offered. Researchers had to make value judgment as to whether a course was indeed SDH-related. Second, this study could not assess quality of the courses that were offered. This means that whilst we could determine what was intended to be taught, we cannot draw conclusions regarding what students actually got out of the courses. Student assessments are paper-based so it was not possible to easily get this information. In light of the latter, we contacted two conveners requesting their general assessment of student understanding based on assignment feedback. However, we still had not received any feedback at the time of writing this report. Thirdly, the finding that one of the modules enlisted in the MPH online handbook had not been taught presents a challenge to our analysis. Whilst highly unlikely, there is a chance that this could be the case with a few of the courses that we enlisted as currently offered in South Africa.

### **c) Literature review**

To search for existing papers on the social determinants of health, we reviewed papers that have been published by the Health and Socio-demographic Surveillance Sites (HDSS) of South Africa (including Agincourt in Mpumalanga; and the Africa Centre in kwaZulu Natal), examining those that were potentially SDH-related. We identified a paper as SDH-related if it directly/indirectly explored the relationship of some social and economic factors to health or if it examined impact of social and economic policies to health.

We also used Google search engine, Google scholar and PubMed to identify literature related to the social determinants of health. Search terms used included: “health inequalities”, “health inequities”, “determinants of disease”, “socio-economic determinants of health” and the country name “South Africa”.

#### d) Stakeholder interviews

A purposive sample of eighteen key informants in South Africa was selected for the individual interviews. These people represented policy makers in the national and provincial departments of health, representatives of the World Health Organization, academics, representative of NGOs, and policy makers outside the health sector. Letters requesting participation were sent to the informants, detailing the purpose of the study and informing them that participation was voluntary and information obtained would be confidential. In many instances, a draft interview guide was attached for the key informants’ perusal prior to interviews being set up.

One-on-one interviews were conducted with the interviewees. Most of these were telephonic as time and budgetary constraints restricted travel. The interviews commenced in the middle of April 2012, and were conducted over a 10 week period. Initially, we received 13 positive confirmations to interview. However, after several unsuccessful follow-ups to confirm dates for six of the interviewees we decided not to pursue these individuals further. In total, we managed to interview seven people. Table 1 shows the list of respondents interviewed and their respective sectors.

<b>Respondent</b>	<b>Sector/Institution</b>	<b>Number Interviewed</b>
Decision makers (national)	Department of Health	2
	Water and Sanitation	1
Decision makers (provincial/ district level)	Provincial Department of Health	1
	Ekurheleni District (Water and Sanitation)	1
NGOs	NGO	1
Academic	University	1
<b>Total</b>		<b>7</b>

**Table 1: Type of respondents for in-depth interviews, and their respective sectors**

In the present study, semi-structured interview guides were used to collect data and these were individualized for each category of respondents. The questionnaires consist of 12 questions for decision-makers in health sector and academics, 8 questions for NGOs, and 3 questions for decision-makers outside the health sector. Overall the questionnaires covered the following topics:

- a) General understanding and opinions on social determinants of health
- b) Policy-making institutions on health
- c) Policy responses to social determinants of health
- d) Social determinants of health interventions and their impact
- e) Perceptions and attitudes towards mainstreaming health within non-health sector
- f) Translation of research into policy
- g) Recommendations for addressing the social determinants of health

Since five of the seven interviews were conducted by telephone, notes were taken and written up soon after each interview. A file of the interview notes was kept on a Flash Drive, which was kept secure in a locked cabinet.

#### *Thematic analysis*

The thematic analysis was carried out according to the 6 stage approach by Braun and Clarke (5). The initial stage involved familiarization with the interview material through repeated reading of interview notes, noting some patterns in the data collected and highlighting key and “interesting ideas” within the data. Because only seven interviews were successfully completed, it was possible to write up notes after each interview and actively engage with the data set throughout the data collection phase.

The second stage involved manually assigning initial codes to the data. Most of the coding during this stage was data-driven and produced using the initial list of ideas highlighted in the first phase. Notes were written next to each text segment of the interview being analysed and the process repeated for the entire data set (all seven interview notes). Following this, we collated all data extracts within each code.

After initial coding and collation we sorted different codes into potential themes and collated all relevant data extracts within the identified themes. It is important to note that we were not particularly interested in the number of times a particular theme appeared across the entire data set. Provided that the theme captured something that was perceived to be important in understanding social determinants of health (alone and alongside other themes), it was perceived as key even if it only appeared in one data item.

The fourth stage involved reviewing the themes identified. The goal at this stage was to determine if candidate themes identified in the third stage were strictly key themes and refine them. To accomplish this we re-examined the interview extracts within a particular theme and assessed whether these “told” a coherent and meaningful story. The fifth stage, involved defining and naming themes. Defining themes entailed re-reading the interview extracts and

deciding the “story within a particular theme”. We also identified potential sub-themes. Because assigning thematic names that are concise and punchy can be a challenge, we engaged with published literature on social determinants of health, and identified some thematic names that could best describe some of the themes we had already identified. Through this process we aimed to identify some key differences between the current study and past studies. The last stage involved a final analysis and write-up; the results are presented in Chapter 7.

### *Limitations*

It was difficult to schedule the interview appointments within the 6-week time frame that was originally planned. As a result, we failed to reach our target number of between 10 - 20 informants even after extending the interview deadline by a further 4 weeks. Thus views and opinions from the interviews are based on a small sample of respondents.

#### 4. The South African context

South Africa has a well-established economy and is classified as a middle income country. However, the legacy of apartheid that was characterized by discrimination based on race and gender, created inequalities which the country is still grappling with to date (6). In fact, South Africa has one of the highest income inequalities with a Gini coefficient that has remained at 0.68, showing little overall change since 1994 (7). In addition to income inequalities, the history of South Africa had a pronounced effect on the health of its people. Extensive health inequalities exist within and between population groups, and by geographical locations. The disease profile characterized by poverty-related illnesses such as infectious disease, maternal deaths, malnutrition, and the emerging epidemic of non-communicable diseases is critical evidence of this inequality (6).

##### Geography

South Africa is located at the southern tip of Africa with 2,798 kilometres of coastline on the Atlantic and Indian oceans. It shares its borders with Namibia, Botswana and Zimbabwe in the north; and Mozambique and Swaziland in the east. South Africa also completely surrounds Lesotho, while nearly enveloping Swaziland (8). See Figure 1.



**Figure 1 – Map of South Africa; and South Africa in relation to the rest of the continent**  
 [Source: [www.map-zone.net/map/south-africa](http://www.map-zone.net/map/south-africa)]

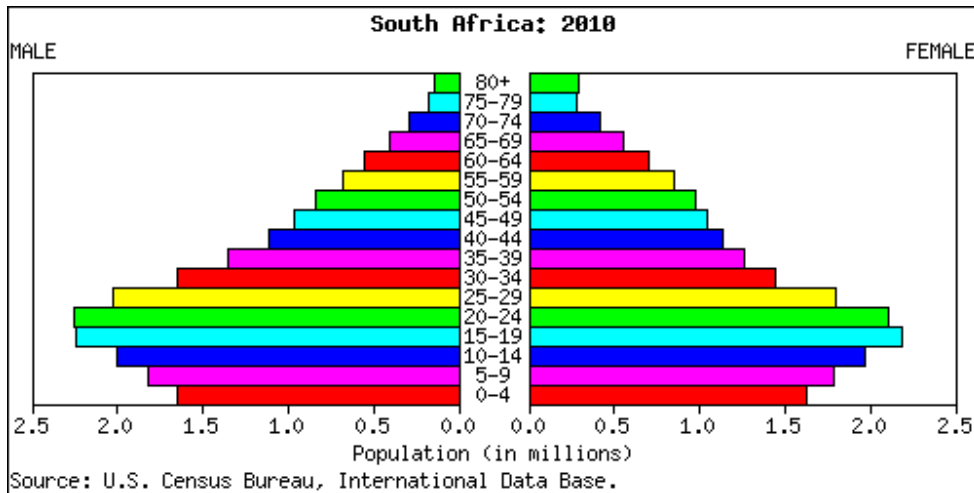
The country has three capital cities: (i) Cape Town is the legislative capital; (ii) Pretoria is the administrative capital; and (iii) Bloemfontein is the judicial capital. The World Bank now ranks South Africa as a middle-income country (9).

The total population for South Africa was estimated at 50,586,757 in 2011 (10). It is the 26<sup>th</sup> most populous country in the world with an estimated age group structure in 2011 as follows: 0-14 years: 28.5%; 15-64 years: 65.8%; 65 years and over: 5.7% (11). The annual population growth rate for the period 2002-2008 is reported as 1.2%, with the total fertility rate (births per woman) as 2.7 (8).

**Demography**

According to 2009 estimates (9), life expectancy at birth for males and females is estimated as 49 years and 52 years respectively. As a result of the very heavy burden of HIV, the nation has seen a continuous fall in life expectancy since the 1990s, when these were estimated at 57 years for males and 65 for females. The infant mortality rate (per 1000 live births) is 46; Under 5 mortality (per 1,000) is 59; and the maternal mortality ratio (per 100,000 live births) is 400. AIDS also impacts severely on these parameters (8, 9).

South Africa’s age and sex distribution is presented in the population pyramid below; the shorter bars at the base of the pyramid are primarily the result of falling fertility rates.



**Figure 2 – Population pyramid, South Africa, 2010 [Source: US Census Bureau]**

The population living in urban areas has increased from 49.4% in the 1980s to 60.7% by 2009. Almost 100% of the urban population and 82% of the rural populations is reported to have access to improved water sources. About a quarter of the population of South Africa is unemployed and lives on less than US \$1.25 a day (9).



### **Socio-economic and political context**

South Africa became a republic on 31<sup>st</sup> May 1961, and on 27 April 1994 majority rule was achieved. The constitution of South Africa was signed by the then President Nelson Mandela on February 4, 1997. South Africa's relatively smooth and peaceful political transition to constitutional democracy along a negotiated path of reconciliation is one of the most remarkable political achievements of recent times. The vision to build a non-racial, diverse and economically strong nation has produced results, but many challenges still remain (9).

Gross Domestic Product (GDP) growth of the country rose from 2.7% during 1994-98, to an average growth of 4.1% during the period 1999-2008. Overall, this rise resulted in a 50% increase in GDP by the end of 2008. Over this period and until today South Africa has consolidated its position in the ranks of upper middle-income countries (8, 9).

Today, South Africa has the largest economy in Africa. However, the legacy of apartheid – an outdated infrastructure, high unemployment rates, lack of economic empowerment amongst disadvantaged groups, and a shortage of public transportation – are all hindrances to overall economic growth in the country. The need to deliver basic services to low-income areas and to increase job growth is an increasing pressure being faced by the present government (9).

### **Health and Development**

South Africa is making efforts at addressing the health needs of the population. The stable political leadership and well-developed health policies have all helped in the growth of the country. To dismantle the apartheid system and to create a democratic society, South Africa as a nation since 1994 has worked on the principles of equity, non-racialism and non-sexism. To achieve these principles the Government has been undertaking efforts in building a new nation in the post-apartheid era. It is committed to fulfilling its constitutional obligations and deliver socio-economic rights as envisioned in its national plan of action, 'Vision 2014'.

However, the rise and spread of HIV/AIDS has had a huge impact on the health of the South African population. Also, the migrant labour system has contributed to many health and social problems, including the destruction of family life, alcohol abuse, and particularly gender-based violence.

### **Millennium Development Goals**

One of the indicators of MDGs that has progressed is the effective and equitable delivery of public services such as basic water supply. Significant efforts are being taken to ensure that children are able to complete primary schooling; youth literacy rates (% of people age 15-24)

has risen from 88% (1990) to 95% according to 2008 estimates. To promote equality and eradicate poverty are other factors that the Government is seriously working with.

Despite overall economic progress South Africa has been hit hard by HIV/AIDS (12). Because of this rise, other MDGs like maternal and child health (goals 4 and 5) have seen upward trajectories since 1990. After a fall and then rise, the Under-5 mortality (at 59 per 1,000) and infant mortality rate (at 46 per 1,000 live births) had more or less stabilized by 2007. Whereas, non-pregnancy related infections, most of them due to AIDS, accounted for nearly 44% of maternal mortality between 2005 and 2007. Moreover, maternal mortality ratio is estimated to have doubled from 230 in 1990 to 410 per 100,000 live births in 2009 (13).

### **Disease Burden**

South Africa has 0.7% of world's population however houses 17% of the global HIV/AIDS burden. It has the largest number of people living with HIV/AIDS in the world (5.5 million) and continues to battle a dual epidemic of TB and HIV/AIDS, while bearing 24% of the global burden of HIV-related TB (13). For estimated proportional mortality (% of total deaths, all ages) communicable diseases account for 67% of total deaths in all ages, and non-communicable diseases are estimated to account for 29% of all deaths (14).

### **HIV/AIDS**

The spread of HIV/AIDS is affecting the country in a harsh way. According to 2007 estimates, produced and compiled by the UNAIDS/WHO, an estimated 5,700,000 adults (15-49 years) are currently living with HIV, with national HIV prevalence estimated at around 21% (15). Around 460,000 people were receiving antiretroviral therapy in 2006-2007, of an estimated 1,700,000 in need.

### **Tuberculosis**

WHO categorizes South Africa as High TB burden, High HIV burden and High MDR-TB (Multiple Drug Resistant-TB) burdened country (16). In 2010, a total of 396,554 TB cases were notified, of which 335,974 were new cases and 60,580 were retreatment cases. TB treatment success rate (for new smear-positive) was 73% in 2009. While most of the world is celebrating a decline in TB rates, the disease continues to strike hard in South Africa, with the result that it is considered by WHO to be one of 22 'High Burden' countries (16).

### **Malaria**

South Africa is one of the 8 countries in Africa that has reported > 50% reduction in either confirmed malaria cases or malaria admissions and deaths in recent years (17). Out of the total population, 10% is considered to be at some risk for Malaria infection. As a preventive strategy,

the country largely follows Indoor Residual Spraying (IRS) as the main WHO recommended intervention for Malaria control. It is reported that in 2010, IRS was sufficient to protect >50% of the population at risk (18).

### **Non-communicable diseases overview**

NCDs account for approximately 29% of all deaths in the country, with an estimated 92,400 deaths among males, and 98,100 deaths among females in 2008 (10). Forty per cent of the male NCD-related deaths occurred in those aged under 60, with 29% of the female NCD-related deaths occurred in the same age group. The disease specific age-standardized death rates per 100, 000 for four main NCDs are given in Table 2.

<i>Age-standardized death rate per 100 000</i>	<i>males</i>	<i>females</i>
All NCDs	733.7	555.2
Cancers	207.2	123.9
Chronic respiratory diseases	86.6	44.5
Cardiovascular diseases and diabetes	327.9	315.2

**Table 2 – Age standardised death rates for NCDs in South Africa [(14)]**

Evidence suggests that the prevalence of certain non-communicable diseases, such as diabetes and hypertension, is increasing rapidly in parts of sub-Saharan Africa (18).

### **Risk factors**

The WHO resources present risk factors for NCDs in two parts as the behavioural and metabolic risk factors. The figures for those estimates (14) are provided in Table 3. The Table shows that 51% of the total population is reportedly physically inactive, with rates of 46% for men and 56% for women. This has significant implications for a country already heavily burdened by communicable diseases.

<b>Behavioural risk factors</b>			
<i>2008 estimated prevalence %</i>	<i>males</i>	<i>females</i>	<i>total</i>
Current daily tobacco smoking	21.2	7.0	14.0
Physical inactivity	46.4	55.7	51.1
<b>Metabolic risk factors</b>			
<i>2008 estimated prevalence %</i>	<i>males</i>	<i>females</i>	<i>total</i>
Raised blood pressure	43.1	41.4	42.2
Raised blood glucose	10.3	11.0	10.6
Overweight	58.5	71.8	65.4
Obesity	21.0	41.0	31.3
Raised Cholesterol	31.3	36.5	34.0

**Table 3 – NCD risk factors in South Africa, 2008 (14)**

In metabolic risk factors estimations for females is higher for all factors. These numbers clearly present a gender dimension to the NCDs risk factors in South Africa. It can be interpreted that due to behavioural factors females are more inactive physically, and that extends to their being vulnerable to metabolic risk factors. They have higher raised blood glucose levels, are more overweight and obese, and also have higher raised cholesterol levels compared to males.

### **Tobacco**

In the WHO Global Tobacco Epidemic Report 2011, tobacco use data (age 15+) as provided by the country from the latest survey result as of 1 November 2010, accounts the adult prevalence, males, for any smoked tobacco current user at 35.1% and 31.7% for daily user. For females, the prevalence is reported as 10.2% for current and 9.0% for daily users respectively.

However, the prevalence drops if WHO age-standardized estimated prevalence of smoking among those aged 15 years or more for Year 2009 is considered. These are given in Table 4.

South Africa signed the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2003 and ratified in 2005. The smoke-free environment law has been enforced in health facilities, university and educational facilities but not in public places like restaurants, pubs, bars, public transport or even government facilities. Bans on tobacco promotion, advertising and publicity are enforced and are reported to be working, with WHO giving the country's compliance on advertising bans a score of 7 out of 10 (19).

<i>Adult prevalence, smoking (%)</i>	<i>Any smoked tobacco</i>		<i>Cigarettes</i>	
	Current	Daily	Current	Daily
Male	24	19	21	17
Female	8	7	7	5
Total	16	13	14	11

**Table 4 – Smoking prevalence rates in 2009, by sex, South Africa [15]**

In its national tobacco control programme, there are specific national government objectives that are handled with considerable Government expenditure on tobacco control by a technical unit, though there is just one full-time equivalent staff working with tobacco control (14).

### **Alcohol**

According to the 2003 data (20), many different forms of alcohol beverages are consumed in South Africa. Beer accounts for 56%, 17% wine, 16% spirits and the remaining 11% belongs to other (such as fermented beverages made from sorghum, maize, millet, rice or cider, fruit wine, fortified wine etc.). Around 65.2% of the population aged 15+ is reported as life abstainers for both sexes.

While taking the lifetime abstainers figures for males, 51.0%, into account it can be interesting to consider that almost half of the population above 15+ drinks alcohol.

Alcohol policy is established with excise tax on beer/wine/spirits. 18 years is national legal minimum age for off-premise sales of alcoholic beverages, selling or serving including restrictions on time of the days when such sales can be undertaken. However, legally binding regulations on alcohol advertising and sponsorship are not in place yet (20).

### **Physical activity and nutrition**

In the resources used to write this review, not much information is available to present for the risk factors, physical activity and nutrition. It is now an established fact that physical inactivity is identified as the fourth leading risk factor for global mortality. Physical inactivity levels are rising in many countries with major implications for the prevalence of NCDs and the general health of the population worldwide. It is also reported that in all WHO Regions, men were more active than women (21).

From the limited information known and as presented in the Table 3 earlier, 51.1% of population (46.4 % males and 55.7% females) is reported to be physically inactive. Females are

physically more inactive than males, which is closely related to the proportion of females being overweight (71%) and obese at (41%) (14).

### **Country capacity to address NCDs**

The prevention and control of chronic disease in South Africa is under constant reappraisal. With rising burden of these diseases the Government is making efforts to deal with these health issues. The resources used suggest that a unit responsible for NCDs exists at Ministry of Health. There is funding available for treatment and control; prevention and health promotion; and surveillance, monitoring and evaluation. A national health reporting system that includes NCD cause-specific mortality and morbidity and NCD risk factors reporting is also functional.

South Africa is also reported to have an integrated or topic-specific policy/programme/action plan which is currently operational for all four NCDs (CVDs, cancer, chronic respiratory diseases and diabetes) and their four main risk factors (alcohol, unhealthy diet, physical inactivity and tobacco).

### **Summary**

Over the last two decades, South Africa has developed at a fast pace. It established itself into a democracy and gradually achieved the status of having the largest economy of Africa. However, the health of its population has not developed along similar tracks. Being the largest carrier of HIV/AIDS population in the world and with rising burden of NCDs, the country needs to develop its health agenda appropriately. It is also apparent that being born as a woman or a girl in South Africa may be a health determinant in itself: prevalence of both HIV and many NCDs is higher among women than men. A gender-sensitive approach to national health policy and planning will therefore be an essential component of efforts to addressing this core social determinant.

## 5. Review of teaching curricula

### a) Aims

This section of the report has two aims:

1. To identify on-going ‘SDH-relevant’ training courses in South Africa; and
2. To establish gaps in SDH training in the country that INTREC can fill

### b) Summary of available courses

Based on course names, we identified 28 courses that were potentially relevant to our study. To confirm relevance, we examined the course outlines, specifically looking at the type of topics covered in the course and the prescribed core course literature (Annex 1). Complete course outlines (with prescribed core course literature) were freely accessible online on 6 out of the 21 university websites visited. Response rate from course administrators and course conveners was poor, with 5 out of the 15 people contacted responding positively and offering course outlines. Due to the challenges in accessing prescribed readings, we included all courses found through our basic search, provided a brief description of the course was available. In total, we included 24 courses from 12 academic institutions. Thirteen of the courses were offered within the Schools of Public Health, 10 were offered in university departments outside schools of public health and 1 course was taught through a non-governmental organization initiative.

Annex 1 shows the summary of SDH related courses that were included in this study. The courses are split into 3 categories: (i) courses offered within schools of public health, (ii) courses offered outside schools of public health, (iii) short courses offered within University institutions but targeting health professionals who are not registered for full time study and full-time registered students. In summarizing the nature of SDH-related courses offered in South Africa, we first give a general overview of the course structures by category, specifically focusing on the course content. We then draw attention to the teaching strategies employed, highlighting the extent to which courses are offered as face-to-face versus online and elective versus core courses.

Examining the courses offered in the different categories revealed that the focus of the SDH-related courses tend to be similar in each category. SDH-related courses offered within the schools of public health primarily focused on identifying major social determinants of health through a review of published literature. A specific and common objective of the courses was to equip students with the necessary knowledge to identify key social determinants of health that are relevant to South Africa. To accomplish this, a few of the courses, used a case-study based approach where students critically review a study setting/ or hypothetical community and identify the factors influencing “observed” health problems (see “Health and social change”

course offered at the University of Western Cape). An alternative approach examined health and demographic transitions that have occurred in society and linked these to social and economic transitions.

Reviewing health-seeking behaviour models was another common feature of SDH-related courses offered within schools of public health, and explicitly mentioned in 2 out of the 9 courses reviewed: “Society and Health” course offered at the University of Pretoria, and the “Social and behaviour change communication” course offered at the University of the Witwatersrand. These models are seen as key to understanding how people utilize health care systems in their respective socio-cultural, economic and demographic circumstances. The intent was to use health care utilization models to explain the findings of empirical studies. In addition to the latter, one course took a more interventional approach and explored the role that communication programmes could play in influencing social and behaviour change, and ultimately social determinants of health.

A review of methods related to the study of social factors and health was not common amongst SDH-related courses taught within public health schools. However, the social epidemiology course offered at the University of KwaZulu Natal included a discussion of methods but emphasized that the course was not a methodological course. Hence, the discussion was mostly probably an overview of methods rather than an in-depth discussion.

With regards to SDH courses taught outside public health, the course content was structured to fit the degree/ programme in which the course was offered. Within economics departments/ divisions, a social determinant framework was used to illustrate one of several policy frameworks necessary to understanding economic development. A social determinant approach was seen as key to addressing developmental challenges both at a global and national level. The other academic division that offered a significant number of SDH-related courses was sociology. As can be expected, these courses focused on the sociological perspective of health and social care. Topics covered included an in-depth discussion of the theoretical origins of health and illness, and the discussion around health and illness as social constructs. The role of culture in influencing medical pluralism<sup>1</sup>(22), health seeking behaviour and ultimately health status was explored.

Due to the widespread HIV/AIDS epidemic in South Africa and in Sub-Saharan Africa, most of the SDH-relevant courses offered within sociology examined the role of social and economic factors using HIV/AIDS as an example. Nonetheless, other courses focused solely on this

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<sup>1</sup> Medical pluralism (MP) can be defined as the employment of more than one medical system, or the use of both conventional and complementary and alternative medicine (CAM) for health and illness



epidemic and examined the link between societal aspects and HIV/AIDS including the origins of the disease. With the exception of one course that discussed methods used in sociology that have special relevance in public health, methodological issues were not fully explored/emphasized.

Two short courses targeting a broader target population were enlisted. In one course that has recently been offered at the University of the Western Cape, the emphasis was on global factors that contribute to inequalities and inequities. Since the course was offered within a school of public health it is likely that a similar approach to that taken for SDH-related courses offered within schools of public health was taken. The other course offered by the Global Equity Gauge Alliance in partnership with the School of Public Health (University of Western Cape) was methodological in nature. The focus of the course was primarily to raise awareness and understanding of equity issues with an emphasis on health systems. The Equity Gauge approach is represented as three pillars supporting equity. The pillars represent:

- i) Assessment and monitoring: to analyse, understand, measure and document inequities
- ii) Advocacy: to promote changes in policy, programmes and planning
- iii) Community empowerment and participation: to support the role of poor and marginalized people as active participants in change, rather than passive recipients of aid/help

It is critical to highlight that both the courses above target professionals within and outside health and also international applicants.

### **c) Training gaps**

Identifying training gaps within a curriculum requires comparing curriculum elements to an existing 'standard'. The latter would ideally comprise all essential aspects relevant to a topic being taught. In teaching on SDH and other interdisciplinary courses, the challenge is in finding that existing standard, as courses are tailored for a specific target audience, for example, economics courses would tend to focus more on SDH as a framework to economic development, whilst public health courses would view SDH within a public health lens. Thus, for this study, we ascertained gaps in the curriculum using a variety of approaches: (i) solicited views from academics teaching on SDH through informal discussions (ii) a review of mission statements of academic divisions with a major focus on SDH, and assessing whether teaching curriculum would permit the accomplishment of these stated objectives. Furthermore, we reviewed recommendations of the WHO Commission on Social Determinants of Health and assessed whether the courses offered within the different academic divisions would assist in meeting those objectives. The results of our assessment are presented below.

*i. Teaching strategy limits coverage*

Addressing health problems through a social determinants approach requires a multidisciplinary approach involving trained professionals both within and outside health. Thus, multidisciplinary training is critical for postgraduate students within public health, education sectors, development and finance, public works and so on. To ensure that demands for training are aligned with supply, teaching strategies that combine traditional classroom based and online distance education programmes are vital in meeting this need. However our assessment showed that most of the courses are taught as face-to-face courses. Such a strategy is unlikely to meet demand as certain groups of people such as the working population could be excluded due to inability to take time off work to pursue these courses. Furthermore, 50% of SDH-related courses are offered as electives within the schools of public health. Whilst offering a course as an elective rather than a core course has its advantages, it could reduce the potential to reach broader target population especially aspiring public health professionals

*ii. Limited focus on methodology*

The WHO Commission on Social Determinants of Health suggests that, *“Evidence-based policy-making on the social determinants of health offers the best hope of tackling health inequities...[and] requires an understanding of the evidence, among policy-makers and practitioners, such that social determinants of health are acted on”* [Final Report of the Commission on Social Determinants of Health (1), page 178]. This would demand that institutional capacity to collect, analyse and utilise data on SDH is strengthened. Results of this review indicate that the majority of the teaching curricula on SDH have very limited and/or a narrow focus on methods training, both quantitative and qualitative. This includes both the collection and synthesis of epidemiological data and the use of qualitative research techniques in SDH-related research. With the exception of the short course offered by the Global Equity Gauge Alliance (GEGA), none of the courses displayed a strong focus on measurement of health inequities. Thus, in their current form, SDH courses offered in South Africa are unlikely to adequately equip one to understand and/or carry out research that answers pertinent questions on social determinants of health.

*iii. Limited training in departments outside health*

Whilst social determinants of health include factors influencing health that fall outside the health system, there is limited training on SDH in other departments outside schools of public health. For example, in South Africa, education is highlighted as a critical social determinant of health but few courses seemed to cover SDH within the Universities’ departments of education. Because we had limited access to course outlines it is possible that we may have missed a few relevant courses. Nonetheless, we attempted as much as possible to diversify our search criterion.

*iv. Human resource constraints limit capacity building efforts*

Human resource constraints tend to limit capacity strengthening initiatives in South Africa and could be a key factor challenging delivery of SDH-related courses. An interesting finding from this review was that not all the courses that are listed in online degree handbooks have actually been taught or offered to the intended audience. We specifically identified a module that had been developed as part of the Master of Public Health (MPH) programme at the University of KwaZulu Natal that had to date never been taught to the MPH students. Upon inquiry, lack of academic staff resources to offer the course was cited as the key reason why this was so.

## 6. Literature review on Social Determinants of Health in South Africa

### a) Aims

Following the publication of the WHO Commission on Social Determinants of Health (CSDH) report, research focus has shifted towards health inequalities that are induced by socio-economic circumstances, as these are considered unjust and unnecessary. The intent is to facilitate evidence-based decision making on policies that will address the underlying socio-economic disparities (23). Nonetheless, to design evidence-based policies, it is crucial to identify the appropriate social determinants of health using local level and country-specific data.

With this context, this section reviews the existing literature on socio-economic determinants of health in South Africa, exploring three broad issues:

- i) What is already known about SDH and health inequalities in South Africa?
- ii) On-going work on SDH and health inequalities in South Africa
- iii) What SDH-relevant policies currently exist in South Africa, and what policy reviews – to which INTREC may contribute – may be forthcoming?

### b) SDH and health inequalities in South Africa: the current context

Published research in South Africa has examined social determinants of health with a specific focus on: progress made since the end of the apartheid era in 1994, impact of SDH-related policies, impact of multi-sectoral interventions and population/ geographical disparities in health. Bradshaw et al (7) review progress made in South Africa (14 years after democracy) in terms of the broader determinants of health, and reflect on changes in health status in post-apartheid South Africa. The analysis is based on data from Statistics South Africa (StatsSA), the South Africa Demographic and Health Surveys (SADHS), development reviews, such as the mid-term review of development indicators, and the macro-social review conducted by government. The study finds that: (i) national economic and social policies have resulted in economic growth, and there has been some improvement in living conditions, through access to basic services such as water, sanitation and electricity remains patchy in some parts of the country, (ii) despite the increase in social grants, extreme wealth inequalities and high levels of unemployment seem to play an important role in the poor health outcomes. Table 5 shows some trends in key SDH in South Africa.

#### Trends in social determinants of health (1996- 2008)

- An improvement in living conditions, namely housing, water, sanitation and electricity:
  - Proportion of households with formal housing<sup>2</sup> increased from 64.4% to 70.5%, whilst those with informal housing decreased from 16% to 14.5%
  - Proportion of households with piped water increased from 81.2% to 88.6%
  - Proportion of households with a flush toilet (includes chemical toilet) increased from 50.5% to 57.9% whilst those with no toilet reduced from 12.4% to 8.2%
  - Access to electricity increased rapidly with proportion of households with access to electricity increasing from 57.6% to 80%
- Unemployment increased between 1994 and 2003 (from 20% to approximately 30%), then decreased to 23% in 2008
- Unemployment remains high amongst the African group and was estimated to be 23% amongst men and 31% amongst women in 2008
- Proportion of the population without any schooling decreased from 19.1% to 10.3%. The greatest improvement is amongst those with some secondary education where proportion has increased from 33.6% to 40.1%.
- Higher level education has not improved much with a 2% increase in the proportion of population with higher education between 1996 and 2008

**Table 5: Trends in social determinants of health (1996 - 2008), South Africa [Source: Statistics South Africa 1996 & 2007 (12, 13)]**

Other important findings of this report include the fact that relatively little research has been done on trends in violence in South Africa, even though violence-related injury is a significant contributor to the burden of injuries in the country. Key recommendations emanating from this study include:

- (i) The need for South African government and society to take action to build social cohesion. Whilst the report does not explicitly define social cohesion, reference is

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<sup>2</sup> Formal housing is used as a proxy for 'adequate' housing and includes: dwelling or brick structure on separate stand; flat or apartment; town/cluster/semi-detached house; unit in retirement village; room or flatlet on a larger property. 'Informal' housing consists of the following dwelling types: informal dwelling or shack in backyard; informal dwelling or shack in informal settlement; dwelling or house/flat/room in backyard; caravan or tent.

- made to proportion of population who belong to voluntary organizations such as churches, political parties and labor unions as one of the indicators of social networking. In addition, the crime rate (murder, rape and robbery rates) are also reported as indicative of the extent of social cohesion. Nonetheless, the report does not specify strategies to build social cohesion;
- (ii) The importance of establishing robust methods of social insurance as a longer-term goal to maintain a redistributive element of the economy and to ensure sustainability;
  - (iii) The need to continue improving the health information system and population health data so as to facilitate monitoring of progress and inequities.

In another study on health inequalities, the authors investigate: (i) the various constructs of social exclusion and the impacts this has on health and well-being; and (ii) policies that have the potential to address exclusionary processes and ultimately reduce their impact of health inequalities (24). Based on key informant interviews the authors find that the impact of social exclusion on health is linked to social stratification, differential exposure and differential vulnerability to health risks. With regards to social inclusion policies, the authors conclude that whilst most of the policies in South Africa have to date focused on addressing the legacy of apartheid, many of the historical and intractable inequalities remain at both macro and micro levels. Key recommendations included measurement of health inequalities, including the extent, degree and gradient of these inequalities.

A more recent study investigates socio-economic related health inequality in South Africa and examines how the burden of self-reported illness and disability is distributed and whether this has changed since the early 2000s (25). The study is a trend analysis of data from the South African General Household Surveys (GHS) of 2002, 2004, 2006 and 2008. Based on this analysis, the study finds that socio-economic gradients exist in self-reported ill health in South Africa. The burden of the majority of categories of ill health and disability is greater among the lower than higher socio-economic groups and this includes non-communicable diseases. Key recommendations include the need to improve access to and use of health services, particularly amongst the poor. Inter-sectoral action is seen as key in addressing the health inequalities in South Africa.

Going beyond assessing risk factors, two studies examined the impact of the IMAGE intervention (26, 27). IMAGE was a structural intervention that aimed to address the social determinants of HIV and interpersonal violence through; (i) economic empowerment (group-based financing) and (ii) social empowerment (community mobilization and gender and HIV training). IMAGE is one example of a multi-sectoral initiative for addressing SDH in South Africa.

The authors find that social and economic development interventions have the potential to alter risk environments for HIV and intimate-partner violence in Southern Africa. However critical challenges are also raised. These include the difficulty of managing inter-sectoral partnership as management structure emerging between health partners and the microfinance partners was complex and partially integrated. In addition, lack of ownership of the IMAGE programme by the microfinance partner created problems with timely decision making as financial and administrative roles fell outside the implementing body. To ensure success of inter-sectoral programmes, the authors recommend a shared vision and ownership of the programme. Other suggestions include the need to define roles and responsibilities of various actors, sensitizing staff to the perspectives of new partners and harmonizing conditions for staff between sectors.

In a more policy-oriented paper, Rispel and colleagues review social inclusion policies in six different countries (including South Africa) that could influence health inequalities (28). In South Africa the child support grant (CSG), free health care policies and Bana Pele policies were reviewed. Bana Pele, meaning 'children first', was conceptualized as a pro-poor, comprehensive and integrated package of free services (e.g. free school uniforms, school feeding programme, scholar transport, free health care) aimed at vulnerable children in Gauteng province, South Africa and commenced in 2005.

Benefits were assessed by reviewing impact on poverty alleviation, economic opportunities, and access to health services whilst impact on the health inequalities was inferred. Based on their review, free health care policy reduced access barriers to health care. However, the impact on health inequalities was not assessed/ is unknown. The other two policies target children and impacts of health inequalities to adults are not assessed. Based on the policy reviews, the authors recommended the following key actions: measuring health inequalities, carefully designing and effectively implementing social policies, monitoring and evaluation and strong movement by civil society to address health inequalities

Other studies have focused on social determinants of health in rural areas, particularly in Health and Socio-Demographic Surveillance Sites (HDSS). In one study which investigated underlying risk factors for disease, social exclusion was found to be a major determinant of health (29). In this study, Mozambican households (immigrants) settled in the Eastern side of the Agincourt HDSS showed significantly higher all-cause mortality, adult and child mortality compared to South African settlements. Mozambicans generally live further away from labour markets, have lower standard of living, live further away from health facilities with poor sanitation and electricity. The latter factors are probably the causal pathway by which immigration results in poorer health outcomes.

A similar study conducted in the Africa Centre HDSS also concludes that migration is a key determinant of adult mortality (30). In this study, it was found that individuals who move from places outside the demographic surveillance area to seek residency in surveillance area (external migrants) are at an increased risk of death compared to those always resident in the HDSS. Furthermore, external migrants are twice as likely to die from HIV related death compared to residents. Another study in Agincourt corroborates these findings and concludes that short term migrants up to twice as likely to die compared to long term migrants and residents<sup>3</sup> (31).

Disease specific studies have also been conducted that examined the socio-economic determinants of specific disorders. One such study assessed the prevalence and associated risk factors of common mental health problems in the Agincourt sub-district and Khayelitsha peri-urban town of South Africa using cross-sectional data (32). The study showed that lower educational achievement and poverty are the key risk factors of mental disorders in rural Agincourt whilst unemployment and female gender is a key determinant in Khayelitsha urban area.

A significant proportion of research has focused on the risk factors of HIV/AIDS. One such study investigated the effect of three measures of socio-economic status – educational attainment, household wealth categories (based on a ranking of households on an assets index scale) and per capita household expenditure on HIV incidence (33). The findings of this study show that education is the key determinant of HIV incidence with one additional year of education reducing the hazard of acquiring HIV by 7%. Unexpectedly, wealth status and household expenditure did not have major influence on HIV incidence or sero-conversion. In a separate study, distance of household from nearest primary road (<5km) was found to be a critical determinant of HIV prevalence amongst individuals over the age of 50 years in a predominantly rural population of South Africa (34).

Injury is one of four major causes of disease burden in South Africa and few studies have examined the underlying risk factors of injury-related mortality. One such study identified socio-demographic risk factors associated with adult injury-related deaths in a rural population in KwaZulu Natal province. The study was based on an analysis of population-based mortality data from Africa Centre's HDSS for the period 2000-07. The study found that social inequality, lack of social cohesion, lack of education, poverty and male youth unemployment are key factors influencing injury related mortality and/or assault (35).

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<sup>3</sup> Short-term returning migrants are migrants who have been back for less than 5 years, whilst long-term returning migrants have been back for ≥5 years



Other key determinants of health that have consistently been reported in literatures and are a result of longitudinal studies include: household socio-economic status, living arrangements, education, poverty and unemployment (36-38).

See Annex 2 for details of studies focused on specific SDH areas of concern.

### **c) On-going work on social determinants of health**

Because many initiatives that impact on livelihood, education, and employment opportunities also have the potential to influence SDH, it is challenging to identify, from the long list of on-going initiatives, those that would significantly impact on health inequality. In this section, we provide a snapshot of programmes that could assist in: eradication of extreme poverty, promoting gender equality and women empowerment and improving maternal health. We chose to use these programmes as examples as they are comprehensively described online, but we also acknowledge that other small- and large-scale initiatives exist that could impact upon SDH in South Africa. As the programmes are enlisted on the South African Social Investment Exchange (SASIX) website, and attract some of the funding through this initiative, we describe this initiative first.

#### *i. SASIX: Initiative of the Greater Good South Africa Trust*

The South African Social Investment Exchange (SASIX) is South Africa's first online social investment stock exchange that facilitates investment in social development projects. Basically, organizations that are achieving a measurable social impact are selected to list on the exchange and offer anybody the opportunity to make a contribution to them for as little as R50 (approx. USD\$7) per share. This is seen as social investments because, while the investments do not offer a financial return, they are expected to result in measurable social change. As a SASIX investor, one can monitor the level of investment in the project on the website and once a project is fully funded, regular progress reports and a final project performance report are sent to investors. SASIX is estimated to have raised approximately R2.4-million for selected projects since its launch in June 2006.

Examples of projects that have benefited from SASIX investor funds include the South Coast Hospice Association (SCHA) project. SCHA delivers care to 1600 HIV/AIDS patients in their own homes and care and support includes: pain and symptom control, HIV/AIDS counselling and education, education in sexually transmitted diseases (STDs), psychosocial support services, poverty relief (through the distribution of food and care packages), education in nutrition, and early identification of orphaned and vulnerable children. Through SASIX funding SCHA bought two new vehicles and this has strengthened capacity of mobile home care teams to carry out

their activities. The Ugu District in KwaZulu Natal, where SCHA operates, is characterized by rugged terrain and a lack of infrastructure and hence transport was a much needed investment. Other initiatives that have benefited from SASIX funds include the Black Umbrellas initiative which supports skilled artisans to develop new enterprises.

Below we provide brief descriptions of initiatives that have the potential to influence SDH and listed on the SASIX website. For full description the reader is referred to: <http://www.sasix.co.za/reports/>.

Sector	Project	Description	Province
Health	Tapologo HIV/AIDS Programme: New satellite clinic to deliver life-saving medicine	A satellite clinic at Photsaneng will enable Tapologo to render much needed comprehensive health care services, including Antiretroviral treatment, in under-served communities near Rustenburg	North West
Health	New loveLife Trust: Empowering goGo's to Strengthen their Communities	loveLife's goGogetter Programme allows communities to take better care of their orphaned and vulnerable teenagers, and in so doing, reduce their risk of HIV/AIDS and other diseases. Through this project, loveLife will encourage 500 grandparents to provide the kind of guidance and support needed by young people especially in cases where there are no longer parents to fulfil this function	National
Vulnerable People	Employment Solutions for People with Disabilities: Setting up a crafts enterprise for people with disabilities	A crafts project producing high-quality products will provide employment to 30 disabled people in Pretoria	Gauteng
Health	Mamelani Projects: Building healthier communities in the Western Cape	The purpose of Mamelani Projects is to empower and strengthen marginalised communities by listening to the particular needs of women, youth and children. Mamelani's primary focus is on developing people through health education, skills training	Western Cape

Sector	Project	Description	Province
Small Business Development	The Clothing Bank: Business skills for 100 women	and personal development programmes Previously disadvantaged women learn to run small businesses and earn an income for their families by selling of surplus clothing.	Western Cape
Small Business Development	Afrique du Sud Bidonvilles: Enterprise Development for Unemployed Women	The creation of 3 new sewing co-operatives will create jobs for approximately 30 women living in the townships around Cape Town.	Western Cape
Small Business Development	Siyakholwa Development Foundation: Essential Oils Project Creates Income for Keiskammahoek Farmers	The expansion of an existing Rose Geranium Essential Oils Project by an additional 25 hectares will create more job opportunities and will generate income for local farmers.	Eastern Cape

**Table 6: Examples of SDH initiatives targeting adults in South Africa**

It is important to note that several other groups are currently working on social determinants and we provide examples of such groups including their core areas of work, accomplishments and future aims.

- i. RADAR (Rural AIDS and Development Action Research programme): RADAR directs clinical and social interventions for HIV, gender-based violence, and other challenges of rural development in South Africa's Limpopo province. The organization successfully implemented a microfinance based poverty alleviation and empowerment programme (IMAGE) in partnership with a Small Enterprise Foundation (SEF) that aimed to reduce interpersonal violence and HIV incidence.  
(<http://ward.wits.ac.za/viewproject.php?projectid=5>)
- ii. EQUINET: The Regional Network on Equity in Health in Southern Africa is a network of professionals, civil society members, policy makers, state officials and others within the SADC region that have come together as an equity catalyst, to promote and realize shared values of equity and social justice in health. EQUINET's work covers a wide range of areas identified as priorities for health equity. EQUINET has established itself as the

regional equity in health experts in Southern Africa by carefully and strategically forming places where different individuals and institutional representatives come together to learn, dialogue, and strategize (<http://www.equinafrica.org/>)

- iii. SAHA: SAHARA is an alliance of partners who seek to conduct, support and use social sciences research to prevent the further spread of HIV and mitigate the impact of its devastation in Africa. It conducts research in three main areas: behavioural and social aspects of HIV/AIDS, epidemiology, strategic research and health policy and Health systems and social determinants of health. SAHA has contributed both directly and indirectly, to the development and implementation of the HIV and AIDS and STI Strategic Plan for South Africa 2007-2011 (<http://www.hsra.ac.za/SAHA.phtml>)

See Annex 3 for further details of on-going SDH work in the country.

#### **d) SDH-related policies in South Africa**

The next section presents an appraisal of policies that have the potential to reduce health inequalities in South Africa. This includes policies or actions by national/local governments, non-governmental organizations and actions by international agencies. Because most policy documents did not refer directly to social determinants of health, we included policies that did refer at least indirectly to some *determinants* of health – for example, by describing how the policy may affect employment opportunities, income inequality, poverty, sanitation. We also included policies that had an impact on the health system as the health system is itself a social determinant of health. To obtain information about upcoming policy reviews, we searched the relevant government websites. The policies reviewed are briefly described below. We first give an account of existing policies which include free health care policies and social assistance grants. We then review upcoming policies/ policy suggestions beginning with the universal health care policy that will be piloted in 2012.

##### *i. Free health care policy*

South Africa implemented a free health care policy in 1994 following the fall of the apartheid regime. In South Africa, free health care refers to health services that are rendered free at the point of contact at public sector clinics, community health centres, and hospitals (28). Free health care at hospitals is also offered to particular vulnerable groups, namely; children under 14 years of age, pregnant women, pensioners, persons receiving social grants, and the formally unemployed; tuberculosis services; HIV voluntary counselling and testing; prevention of mother-to-child transmission of HIV; cervical screening at primary healthcare services; and medico-legal services for survivors of sexual assault and people with disabilities. Pregnant women and children covered by private medical insurance and/or living in households with an

income of more than US\$14,000 per year are not eligible for free healthcare. (An average exchange rate of US\$1=R7.20 for 2010 was used, here and elsewhere in the report (39))

A formal evaluation of the South African free healthcare policy found that the policy has been effective in removing financial access barriers, especially for rural people, informal settlements, and on white-owned farms. Furthermore, the free healthcare policy has resulted in increased service-use, particularly for preventive services, such as family planning and antenatal care.

Despite the positive impacts, negative unintended consequences prompted some criticism. For example, public health professionals perceived that this policy aggravated existing health problems e.g. poor working conditions, shortage of medicines and overcrowding. They also expressed dissatisfaction with the inadequate consultation prior to policy implementation.

*ii. Social Assistance grants*

Social security is one of the most important initiatives implemented by the South African government to reduce poverty and inequality. There are five major social security grants in South Africa namely: the State Older persons grants (formerly called Old Age Pension grant), the Disability Grant, the Child Support Grant, the Foster Child Grant and the Care Dependency Grant. Eligibility for each grant is dependent on an income-based means test. For example, the older persons grant is awarded to women over 60 years and men over 65 years of age who do not earn more than US\$6,600 per year or own assets worth more than US\$110,000 if they are single. If married, the combined income must not be more than US\$13,000 per year. The maximum amount a person can get is US\$170 per month in 2012. Because this study is focusing on adults aged 18 years and above, we shall briefly review the health impacts of the older persons grants even though it is acknowledged that the impact of the child support grant may have filtered to the older population through reducing household poverty.

One study investigates the impact of Old Age Pensions on health status (8). The analysis is based on a 1999 stratified random sample of 300 households in the Langeberg health district of the Western Cape. This district includes a mix of African, white and coloured households. The study finds that Old Age Pension income is pooled in 84% of households. Where income is not pooled, beneficial health impacts are experienced only by the pensioner. Where income is pooled, children's height is found to increase, suggesting a beneficial impact beyond the pensioner. The study suggests that this impact works partly through improved sanitation, partly through improved nutritional status, and partly through reduction in psychosocial stress.

A similar study, based on the same dataset, finds that the presence of a pensioner is associated with an increase of about five centimetres of children's height for age after controlling for a

range of household and individual factors (11). This is equivalent to about half a year's growth for children aged zero to six.

**e) Forthcoming policies**

*i. Universal health care access*

Achieving universal health care coverage is not a new form of reducing health inequalities globally. This strategy is recognized as a means of protecting the poor from catastrophic health expenditures and from a potential vicious cycle of poverty and ill-health. Although South Africa has a free health care policy (described above), the two-tiered health financing system affects the type and quality of health care services offered within the public system. Presently, a relatively large proportion of funding is allocated through medical schemes, various hospital care plans and out of pocket payments. This current funding arrangement provides cover to private patients who have purchased a benefit option with a scheme of their choice or as a result of their employment conditions. It only benefits those who are employed and are subsidized by their employers – both the State and the private sector. The other portion is funded through the fiscus and is mainly for public sector users. This means that those with medical scheme cover have a choice of providers operating in the private sector which is not extended to the rest of the population. A larger part of the financial and human resources for health is located in the private health sector serving a minority of the population.

Recognizing that the South African health system is inequitable, with the privileged few having disproportionate access to health services, South Africa is in the process of introducing an innovative system of healthcare financing in the form of a National Health Insurance (NHI). The NHI will be phased in over a period of 14 years, with piloting beginning in April of 2012. As stated in the Green Paper on NHI, "This system is intended to have far reaching consequences on the health of South Africans". Nonetheless, the benefit package has not been explicitly defined making it difficult to infer the potential impact of this policy.

The proposed policy on NHI has faced criticism with interest groups expressing concern with the manner in which it will be implemented. Private schemes are concerned about what the NHI means for their future; whilst some individual taxpayers and employers are concerned that mandatory contribution would increase an already high tax load (40). Proponents of the policy who include the Department of Health and independent researchers strongly believe that such a system would ensure risk pooling and help attain a more equitable health system in SA. Since, the NHI is a forthcoming policy, it remains to be seen what the impact of the policy on health inequalities is. Thus it is pertinent to monitor and evaluate from early stages of implementation.

ii. *SDH relevant policy proposals laid out in the South African National Development Plan*  
National Development Plan 2030 is a plan that was released in November 2011 that proposes policy approaches and/or recommendations to eliminate poverty and reduce inequalities in South Africa by the year 2030. The intent of the approach is to move away from a passive method where citizens receive services from states to an approach that systematically includes socially and economically excluded. The policy proposals/recommendations outlined in the document are longer term initiatives that are unlikely to be implemented within 18 months. Thus, we give a very brief account of these policies and refer the reader to the full NDP document (41).

*SDH-relevant policy 1: Reduce unemployment*

Reducing unemployment rate to 6% by 2030 is a key goal outlined in the NDP. The intent is to phase in the policies in 5 year time frames. During the first phase of implementation (year 2012 – 2017), the plan is to absorb the unemployed people, particularly the young into the workforce. To facilitate this, the commissioners suggest an increase in mining exports, urgent investment in rail, water and energy infrastructure amongst other things (NDP document, pg 135). However, it is unclear how each of the proposals will be executed within the specified time frame, particularly since the proposals are broad and potentially time and resource intensive.

*SDH-relevant policy 2: Transforming human settlements*

The National Development Plan Commission states that where people work and live is important and proposes a strategy to address the challenges brought about by apartheid which resulted in socially excluded groups residing further away from economic opportunities. The intent is to create conditions for more humane and environmentally sustainable living and working environments. During the first phase (2012-2017), the commission proposes the following actions:

- Develop a more coherent and inclusive approach to land
- Radically revise the housing finance regime
- Revise regulations and incentives for housing and land use management
- Recognize role played by informal settlements and enhance existing national programme for informal settlement upgrading by developing range of tailored responses to support their upgrade
- Support rural spatial development

However, as with the policy highlighted above, it is not clear how each of the comprehensive plans will be executed within the 5 year period.

*SDH-relevant policy 3: Improving training, education and innovation*

Improving training, education and innovation is recognized as being central to South Africa's long term development and as an essential element for eliminating poverty and reducing inequality. Amongst the key advantages of education highlighted in the document, is the ability to empower people to raise healthy families. Specifically, the commission proposes that a solid foundation for a long and healthy life be laid through early childhood development. Whilst early childhood development is a goal within the education sector, the policy recommendations would require inter-sectoral action with the Department of Health. According to the commission, measures will be put in place to ensure that women are able to plan their pregnancies, and that teenage pregnancy is no longer an issue. Amongst other things, pregnant women will be assisted with access to emotional and material support to support a healthy pregnancy.

See Annex 4 for further details of SDH policies and policy reviews in the country.



## 7. Stakeholder Interviews

### a) Aims

The aims of the stakeholder interviews were to:

- Learn about respondents' knowledge of and attitudes towards SDH
- Identify the most important SDHs, and the most important related sectors (e.g. transport, justice etc)
- Establish where there are gaps in knowledge and action about SDH
- Establish means of addressing these gaps and identify the challenges inherent in tackling these
- Validate and discuss findings from reviews (epidemiological, literature and curricula) on SDH and health inequities

### b) Findings from interviews

The themes from the interviews fell into four broad categories: (i) *cross-cutting policy and mainstreaming*, referring to collaborative efforts between government departments to develop strong, integrated policies to tackle SDH; (ii) *the role of research*, referring to the type of research evidence and manner in which research is conducted and disseminated; (iii) *framing the message* referring to the extent to which the concept of SDH is disseminated, understood or accepted within and outside the health sector and; (iv) the *role of politics* referring to the influences of the political environment and role played by policy champions in translating research to policy

#### i. *Cross-cutting policy and mainstreaming*

Cross-cutting policies are described as those policies that address issues irrespective of institutional or organisational boundaries. Such policies require coordinated inter-sectoral action and are particularly relevant when addressing SDH given that these are based in a number of sectors outside of health. Among interviewees there was a general commitment to the principle behind inter-sectoral action and development of cross-cutting policy on SDH:

*“At the moment addressing SDH is done haphazardly e.g. organizations that deal with tobacco work independently, so do those on alcohol, safer sexual behaviour etc. However there is a need to coordinate activities” (NGO representative)*

Initiatives to co-ordinate activities across sectors have begun in South Africa. A specific example shared by one of the respondents is the most recent initiative to establish a health promotion fund (HPF) that begun at the end of 2010. The proposed HPF has a strong commitment to working in partnerships across sectors to influence the ‘social determinants of health’ and will include civil society organizations, the Medical Research Council (Alcohol

Research Unit), National Council Against Smoking, Soul City, academic institutions, WHO country office, and other government departments outside the health sector. The Department of Health is also in its early stages of designing an intervention to improve nutrition particularly amongst the poorer groups. This will be a structural intervention involving the Department of Agriculture. The intent is to promote farming and selling of healthier produce (Agriculture department) and monitoring of health interventions (Department of Health). Nonetheless both of these initiatives are still in the early planning phases and respondents could not furnish any significant details about components of the initiatives.

Despite the positive strides being taken towards inter-sectoral action to address social determinants of health, enthusiasm and hope for its practicality was not found everywhere.

*“The same issue exists on the decision maker’s side [referring to the challenge of collaboration amongst SDH researchers] where networking by the different sectors is almost non-existent”. (Academic)*

*“On the ground, there are service delivery issues that have been addressed in Khayelitsha [Western Cape province] and sanitation improved. The problem however is that sectors in South Africa are siloed and pockets of action are evident within the different sectors, not as inter-sectoral action”. (Academic)*

Some interviewees also drew attention to the difficulties in inter-sectoral action when outcome measures are not tangible and difficult to measure.

One suggestion for monitoring progress on SDH social determinants of health outside the health sector has been to institutionalise health impact assessments (HIA) as part of any policy proposal. By mainstreaming or institutionalising HIAs, the exercise would become more than just a one off exercise, and it would embed certain health outcome measures as routine policy outcomes.

It was interesting to note that some interviewees did not readily buy in to the idea of a health impact assessment. Specifically, respondents were sceptical about the outcome measures that are used to link non-health initiatives to health outcomes and were not convinced that to date proper methodology had been developed to allow this. One of the respondents argued that whilst diarrhoea has been the most common outcome measure used to track the impact of local sanitation programmes, in reality other factors such as improved hygiene are important confounders that are often underplayed when making health impact inferences. In addition to this, the respondent expressed concern at the exaggerated health claims and perceived this exercise a tool that is exploited for advocacy and to motivate for budget increases by non-health sectors.

In response to the question of whether the respondent's non-health sector would consider performing a HIA in the future, one of the interviewees highlighted that outcome measures are determined by beneficiaries and health is not the first thing that people think of when discussing issues to do with need:

*“Outcome measures are designed by beneficiaries and health is honestly not one of the things that people think of when discussing issues regarding need e.g. people want proper sanitation because open toilets are dehumanizing and embarrassing, they want clean water so they can cook and do not have to go far to fetch water. It is only recently with advocacy that people make the link between proper sanitation and diarrhoea” (Policy maker, non-health sector)*

Other respondents expressed concern at the explicit focus on health in all policies and were weary of the effect that such a policy would have on other sectors.

*“Social determinants model turns to look at the perspective that policies outside health have to be optimal for health to be optimal. E.g. better education equals better outcomes but better education has to be an objective in itself. This is an egocentric view and one approach at looking at SDH. E.g. National planning commission would use health as a primary outcome measure for all policies as everything impacts health. However, whilst health is important it is a bi-product and must not be viewed as the most important.” (Policy maker, Department of Health)*

Nonetheless, one respondent was positive about the idea of a HIA and felt that this would reinforce the position non-governmental organizations hold, potentially assisting in advocacy for policy changes.

#### *ii. Role of research*

The majority of interviewees acknowledged the importance of research evidence in making argument for SDH policies as *“policy-makers rely on information to make decisions.” (Policy maker, provincial department of health)*. However, the lack of research evaluating the relative costs and benefits of interventions designed to tackle health inequalities was identified as a key gap. Economic data was perceived to be instrumental in reinforcing the argument for SDH policies:

*“What would be most interesting is for researchers to put some economic costs to these issues, for example what it would cost to improve sanitation and what diarrheal costs are averted by doing so... Without an indication of such information (basic building blocks) it is difficult to make decisions.” (Policy maker, Provincial Department of Health)*

Not only was the type of information collected considered important but the manner in which research was conducted. In light of the political history of the country, collaboration with and participation of universities that were historically reserved for disadvantaged groups was seen as crucial in attracting attention from policy makers. This perhaps, reflecting the importance placed towards equity (even equity in participation) in South Africa.

Others argued for more interventional research, pointing to the strengths of the latter to produce a strong case for causality. Interestingly, when it came to the question of barriers to bringing together researchers and policy makers to facilitate translation of research into policy, two conflicting opinions came to surface. On the one hand, researchers felt that it was extremely difficult to (i) engage policy makers in a meaningful way from execution of study to implementation and (ii) find people who are sincere enough to listen and be actively involved with researchers. On the other hand, policy makers felt that they were quite open to engagement but were weary of researchers telling them what to do.

### *iii. Framing the message*

It has been reported that the concept of SDH is not well understood or accepted amongst many audiences, particularly policy makers outside of the health field (42). The value-laden nature of the SDH is cited as a key factor challenging the manner in which the concept is interpreted. In this study, the concepts behind SDH were mostly well understood amongst interviewees both within and outside the health sector. Interviewees acknowledged SDH as factors that affect health that fall outside the health sector but including the health system itself and below are a list of responses.

*“Basically SDH is a term that looks at factors/ risk factors affecting health linked to non-medical causes (social, political, and economic)” (Policy maker, Department of Health)*

*“Those factors that are indispensable to health such as sanitation, water, waste management, education” (Policy maker, Department of Health)*

*“Those factors that are broader socio-economic and political factors including the health system which is a social determinant on its own” (academic)*

*“Anything that is not biomedical or psychological is a social determinant of health. Things that cause ill-health, and are societal related including health systems.” (Policy maker, department of health)*

Most respondents were confident that the key SDH are well known in South Africa, and could be ordered by magnitude of importance. Nonetheless, as the responses below show, the key determinants differed from person to person with sanitation and/or education being the only

two that were mentioned by almost all respondents. The following are extracts of responses to the question, “What are the key SDH in South Africa?”

*“Sanitation, water, waste management, education” (Policy maker, Provincial Department of Health)*

*“Education, sanitation, electricity, housing, residential areas” (Policy maker)*

*“Unsafe sex practices, poverty and socio-economics, tobacco, alcohol, physical inactivity and reducing salt intake, education of health care providers” (NGO representative)*

*“Health system issues would include private & public sector issues, rural/urban divides, health resource divisions/ financial and human resources and education of health care providers. Social issues include, trade policies, gender/violence, education and agricultural policies” (Policy maker, National Department of Health”*

*“Socio-political history and socio-economic environments of the country” (academic)*

An interesting related finding of this study was the perception amongst some respondents that social determinants of health were not new and therefore not newsworthy. According to one interviewee, it was still not apparent why there was a resurgence of SDH in high profile reports and if any new information had come to light on this topic that warrant new policy attention.

*“Looking at the concept of SDH and issues to deal with water and sanitation is a 50 year old question. Public health professionals have lost sight of issues for a long time and the sudden interest in SDH [in the current form] is surprising as they are known and not something that is new to the field.” (Policy maker, non-health sector)*

Whilst this comment was specifically made by a policy maker outside the health sector, it was interesting to note that some of the respondents including those within the health sector seemed to share the same sentiments without explicitly saying so. For example, by questioning the rationale behind the current project and suggesting references to dated documents that had “*comprehensive information on social determinants of health in South Africa*”. The latter seemed to be driven by the perception that data to address SDH was available, despite literature on SDH indicating that this is a major gap. Others simply expressed doubt that significantly new information could be furnished on this topic. However, despite some of the scepticism, it is important to note that all interview participants acknowledged that they were enthusiastic to learn of the findings of the report.

Investing time framing the key messages on SDH was thus seen as the solution to influence policy-makers. Some felt that researchers were not spending time “*selling the research enough*”, and much of the research lacked provocative evidence that highlighted the costs of not addressing SDH. According to policy-makers it would be useful if success stories on SDH were shared that captured the social determinants in tangible, measurable terms.

*iv. Role of politics*

International literature acknowledges that policy development process is strongly influenced by the political context. Political transitions often open windows of opportunities for wide-ranging policy reform and in some cases create a demand for speedy change. Not surprisingly, much of the progress in addressing SDH that were shared by interview participants were linked (in one way or the other) to removal of apartheid regime in 1994. Most of the participants highlighted that significant improvements in availability of water, sanitation and employment opportunities had occurred in the first few years post-independence. According to one interviewee, this period was characteristic in that the government actively engaged with the masses (general population) and was more receptive to research and ideas that would facilitate rapid change.

Whilst overall political context is important, some of the interview participants felt that progress in addressing the social determinants in SA has also been driven by the individuals occupying leadership positions at the time. A specific example shared was the introduction of the national health insurance in South Africa. Participants noted that, whilst the Minister of Health in the first term of a democratically elected government was instrumental in implementation of a free health care policy, her broad opposition to the national health insurance policies (then termed social health insurance) prevented their implementation. In contrast, the current Minister of Health who is hailed for his commitment to health systems reform, has been strongly supportive of the national health insurance (NHI) policy. As a result, the pilot phase of the proposed NHI finally began in April of 2012, more than 15 years after the first proposals were drafted.

Whilst all the interviewees acknowledged that SDH are seen as important in South Africa, competing demands at a national level, affect the level of priority assigned to SDH-related issues such as monitoring of health impacts and investment in research. In a country that has seen a wave of service delivery protests,

*“Decision makers are mostly concerned about addressing today’s crisis rather than tomorrow’s problem.” (Academic)*

**c) Summary**

As expected, the qualitative interviews were able to explore underlying issues in considerable detail. The information collated from the key informants indicated that SDH are viewed as important in South Africa, and the perception is that SDH are addressed indirectly within other sectors even though this might not be explicit in policy documents. The respondents understood the concept behind SDH and could cite what they perceived to be the key SDH in South Africa. However, the latter is not unexpected as we purposively sampled respondents

who are either involved in social determinants of health through their work or express an interest in the area.

Nonetheless, identifying the key SDH that still need to be addressed through key informant interviews was a challenge. Collectively, participants identified almost all social and economic factors as needing attention. One explanation is that this reflects the situation on the ground and indicates that much still needs to be done to address many of the social determinants of health. Evidence from previous studies corroborates this and has shown that progress with regards to SDH has not been all positive since independence. For example, the poverty gap, income inequality and unemployment seem to have increased (43, 44). On the other hand, the small sample of respondents also makes it difficult to draw any meaningful conclusions specifically pertaining to this question.

Interestingly though, whilst published literature indicates that poverty, unemployment and migration are some of the key SDH (29, 33, 35-38), these did not appear at the top of the list of our respondents. Instead, at least two respondents highlighted that inadequate training of health workforce in the social determinants of health is a key determinant of health in itself. Whilst much of the literature has listed education as a key SDH, most of this referred to early childhood development, and education of women. To the best of our knowledge, this could be the first study to show that education of health care providers in social determinants is perceived to be a key SDH in South Africa.

With regards to gaps in knowledge, it was clear from the key informant interviews that evidence linking SDH to health was perceived to be inadequate. Respondents were unable to narrate specific success stories on SDH as the links to health were usually not overtly made. Other studies have reported similar findings, and concluded that more research is needed that links SDH to tangible health outcomes (45). The perception that SDH were not newsworthy also indicated critical gaps in knowledge. It was clear that respondents were not aware of new developments in the area of SDH. An important question recently posed in literature is whether the message on SDH lacks provocative evidence necessary to attract attention from a variety of audiences ranging from the general public, policy makers to media (42). Whilst this may not be necessarily a gap, there is a need to address underlying perceptions regarding policy-maker – researcher engagement. It was clear from the informant interviews that both researchers and policy-makers hold strong yet conflicting opinions about barriers to communication.

Finally, the interviews suggested that there is considerable support for inter-sectoral action to address social determinants of health. Nonetheless, there was still uncertainty that this could work and this is echoed in some studies that have investigated the role of ISA in improving

health and well-being (10). There were also pockets of resistance to the idea of mainstreaming health impact assessment, including scepticism that links to health outcomes will be exploited for budgetary purposes. The South African National Sanitation policy of 2001 is an excellent example of challenges faced in implementing “health in all policies’ and lessons that could be learnt<sup>4</sup> from the experience. This policy, which was a collaborative effort of six government departments<sup>5</sup>, stressed the importance of including health and health education as well as monitoring of health impacts in the delivery of a basic sanitation service. Whilst on paper this policy has been hailed as an excellent example of inter-sectoral policy (46), translating this policy into practice has not been as successful. According to a 2010 report (47), health and health education have not been prioritized, with most municipalities providing this as a once-off intervention during the implementation of basic sanitation infrastructure and not as a component of a basic sanitation service. Because compliance was not enforced and the health and health education component not monitored, funds allocated for this were used for other items. In addition monitoring and evaluation was restricted to the counting of toilets and number of jobs created, whilst neglecting monitoring of proposed health indicators: diarrhoeal incidences and other hygiene-related infections such as trachoma, conjunctivitis and parasites. Thus, despite health improvement being cited as the main objective of sanitation service delivery, health impact assessment was not prioritized.

In line with the suggestion that inadequate training of health care providers is a SDH in itself, it was felt that revising the teaching curricula of health professionals to include teaching on social determinants of health will be a significant step towards addressing the social determinants of health in South Africa.

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<sup>4</sup> Summary of National Sanitation Policy can be found at:

[http://www.dwaf.gov.za/dir\\_ws/content/lids/PDF/summary.pdf](http://www.dwaf.gov.za/dir_ws/content/lids/PDF/summary.pdf)

<sup>5</sup> The government departments included Ministry of Water Affairs and Forestry, Ministry of Education, Ministry of Environmental Affairs and Tourism, Ministry of Health, Ministry of Constitutional Development and Provincial Affairs and Ministry of Housing



## 8. Conclusions and Recommendations

### a) Key Issues identified

There is an increasing interest amongst researchers regarding social determinants of health in South Africa. In recent years, some studies have examined trends in SDH and also attempted to assess the impact of SDH related policies on health inequality. Such research has been instrumental in painting a picture of the current context or situation with regards to SDH in the country. However, much of the research has utilized survey data and very little has assessed the extent to which a policy intervention and/or initiative has explicitly impacted upon health inequalities. Moreover the lack of measurable outcomes that could assess trends in determinants such as cultural or social cohesion makes it an even greater challenge to track progress on some of the key social determinants.

The widespread initiatives targeted at social development in South Africa are an encouraging step towards moving the SDH agenda forward. Nonetheless most of these initiatives are small-scale, and they rely on external funds, making sustainability an issue. Tracking the impact of these programmes into the longer term has also not been possible, making it a challenge to measure the impact on health inequalities

With regards to policies on SDH, many of these have an explicit focus to address the legacy of apartheid, and showed positive impact a few years after independence. It remains questionable whether the impact has been sustained. Recent “policy initiatives” seem to target broader social determinants of health and offer hope for addressing underlying issues that impact health inequalities in post-apartheid South Africa. The National Development Plan is one specific vision document that maps South Africa’s problems and outlines several optimistic approaches to address these. Whilst some of the policy proposals outlined in the document are pointed and clear, others are general exhortations, where it is not always clear who is supposed to do what to facilitate policy process. Nonetheless, the document is still undergoing public consultation and revisions are anticipated that could very well reduce health inequalities.

Strengthening institutional capacity to collect, analyse and utilise health data that would facilitated evidence-based decision making on SDH has been a major recommendation in literature and South African specific studies. One of the ways in which this could be done is by strengthening teaching on social determinants of health. In this study, the curricula review highlighted the extent to which the concepts behind SDH are taught in South Africa. Whilst it would seem that there are a number of courses that are SDH related, it is difficult to assess the quality and depth of the training courses. What is clear is that teaching on methodologies required to conduct/assess SDH-related research is limited. Other key issues include that

“Social determinants of health” is primarily taught as a public health course, potentially limiting access to those within the Schools of Medicine. An interesting finding from the review was that lack of human resource capacity to teach on SDH seems to be a factor that is currently limiting capacity building initiatives in the country. Other areas of concern relate to the teaching methodologies employed. Presently many of the SDH-related courses are taught as face-to-face/ class-room based courses, potentially limiting access to those who can physically attend. Information gathered through key informant interviews expressed rich perspectives and insights into the concept behind SDH.

Fortunately, social determinants of health are perceived to be important, and also key to addressing underlying health inequalities in South Africa. However, the concepts behind SDH are not perceived as new and the newsworthiness of social determinants of health questioned, reflecting underlying problems with the manner in which the current message on SDH is framed. Based on interviewee comments, it is clear that much still needs to be done in the area of social determinants of health in the country. Specifically in the area of research that links SDH initiatives to health outcomes. Whilst research is considered crucial in moving the agenda on SDH forward, engagement between researchers and policy makers remains a challenge, and approaches on how to facilitate engagement critical. Although recent proposals suggest mainstreaming health in all policies, views expressed in this study indicate that “pockets of resistance to the idea” exist and ensuring buy-in from stakeholders is needed.

## **b) Recommendations**

On the basis of the findings of this study, a number of recommendations to address SDH are made for stakeholders interested in SDH generally, and for the INTREC initiative more specifically. Consideration is also given to the practical opportunities that already exist, onto which INTREC could build.

### ***i. Research on SDH should be strengthened***

Research efforts need to be intensified with regards to measurement of health inequalities, including the extent, degree and gradient of these inequalities. In addition, monitoring longer term health impacts of SDH-directed initiatives – such as the new National Health Insurance programme – is imperative in tracking progress on SDH. The widespread initiatives on SDH in South Africa provide an opportunity to nest monitoring and evaluation exercises, but funding to carry out such exercises may prove inhibitory

### ***ii. Components of the SDH teaching curricula should be strengthened to:***

#### ***a. Sufficiently prepare students for the practicalities of conducting research on SDH***

Teaching curricula needs to incorporate training on methodology for conducting research on social determinants of health. Students should be made aware of both the quantitative and qualitative tools of analysis that are available and challenges of measuring health inequalities. Initiatives such as INTREC are better placed to develop curriculum that incorporates topics on research methods specific to the SDH. In the long run, such topics could be adapted into existing curricula of other institutions.

*b. Increase awareness of the challenges of inter-sectoral action*

Inter-sectoral health policy should be covered in training courses for people planning careers in civil service management. These could include case studies of multi-sectoral cooperation, in which students examine what was done, what challenges were faced, how much these challenges were contextual or generic, and what were the successes. Such training should also be offered through short-courses for people who plan to embark on initiatives that demand inter-sectoral action.

*c. Highlight the economic burden of not addressing SDH*

Due to the scarcity of resources and competing health demands, highlighting the cost to the government of not addressing SDH has become increasingly important. Thus, courses on social determinants of health should include economic analysis as one of the topics to equip students with the basic skills necessary to carry out or interpret economic analysis related to social determinants of health.

**iii. *There is a need to increase human resource capacity to teach about SDH***

INTREC initiative could demonstrate the opportunity to meet some of the human resource capacity challenges currently faced in South Africa. Collaboration with institutions that have failed to offer SDH-related courses due to lack of human resources offers a good starting point.

**iv. *To gain attention, research on SDH should be disseminated in a compelling manner***

More attention needs to be paid when disseminating messages around social determinants of health. For INTREC, this could be achieved by headlining the most important “unexpected findings” that challenge conventional wisdom and can persuade, elicit interest, engage, and initiate action amongst both the policy makers and the general population.

**v. *Use of online media as an SDH teaching platform should be encouraged***

There is an opportunity for INTREC to maximize coverage of SDH-related training through use of distance education platforms, but current broad band coverage in Sub Saharan Africa may hamper access and could prove costly.

**vi. *Inter-sectoral health policy should be organized around concrete objectives***

All stakeholders should be involved in formulation of the objectives as success can only be guaranteed when all parties support the objectives and incorporate them into their own policy plans. It is necessary that all parties assume ownership of the programme as this creates a sense of responsibility towards success or failure. Implementation of all components of an inter-sectoral policy should be enforced and monitored, including allocation of budgets. Most importantly, roles and responsibilities should be carefully defined, particularly regarding monitoring of key indicators.

**vii. *Support on-going inter-sectoral partnerships***

Efforts to integrate programmes that address social determinants of health should continue e.g. the health promotion fund. This initiative provides a platform by which funders and other interest groups can contribute towards addressing social determinants of health in the country

**viii. *Identify policy champions who can bridge the gap between research and policy***

Whilst engagement between policy-makers and researchers seems to be a long-standing problem, it is important to explore innovative ways by which researchers can be positively engage with the research process. Identifying individuals who can champion and are prepared to be accountable for research is crucial. For example some individuals were identified through this study who expressed interest not only in the policy-making process but also in the research components, and it is crucial that these people are kept informed of developments in the area.

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## Annex 1: Courses given on Social Determinants of Health in South Africa

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
<b>(a) Courses Offered within Schools of Public Health</b>					
1.University of Cape Town	Economics of Health systems Module Sessions offered: 1: Social Determinants of Health 2:Political economy of health 3: Globalisation and health: HR migration, commercialization and related issues	Face-to-face, 2 and half day block sessions (equivalent to 6 scheduled teaching weeks)	Programme Administrator: Ms. Zerina Davis <a href="mailto:Zerina.Davis@uct.ac.za">Zerina.Davis@uct.ac.za</a>	The Economics of Health Systems module looks at health systems from a broader economic perspective. Module places emphasis on financing functions of health systems and related issues namely: social determinants of health, globalization and health.	WHO (2005) Achieving health equity: from root causes to fair outcomes, CSDH. Geneva: WHO  WHO (2005). Action on the SDH. Geneva: WHO  Marmot (2005). The social determinants of health inequalities. Lancet; <b>365</b> : 1099-1104  Rest of course literature in appendix 1
2.University of Cape Town	Public Health and Society	Face-to-face, one half-week block in January / February & one two hour session approximately every second week during the semester	Administrator Mrs Zerina Davis Ph: +27 - 21 - 406 6578. Email: <a href="mailto:mph.enquiries@uct.ac.za">mph.enquiries@uct.ac.za</a>	Module looks at how the idea of public health has changed over time, depending on its particular socio-historical and scientific context; how public health has been taught in universities and translated into legislation over time; the major disciplinary contributions, key concepts, and core research tools that are central to public health knowledge and practice; Describe the state of the —public’s health   in South Africa, with special reference to	

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
				distribution, causes and control of race, class, gender and geographic disparities in health.	
3.University of Pretoria	Society and Health (offered in the School of Health Systems and Public Health	Face-to-face, 2-day block session	Sannah Gomba, Ms, Administrator, +27 12 354 2080 Email: <a href="mailto:sannah.gomba@up.ac.za">sannah.gomba@up.ac.za</a>	This course facilitates an understanding of the determinants of health at a population level & insight into the complexity of the challenges facing public health & community dvpt. Models for understanding health related behaviour are introduced. This course provides the background necessary for the primary health care course.	Prescribed readings (offered as handouts are given as appendix 2 at the end of the page)
4.University of the Western Cape	Health and Social Change	This course is offered as a distance learning course and can be taken up as an elective for the Master of Public Health Programme. It is assessed through 2 assignments and comprises 10% of the overall MPH programme	Ms Lungiswa Tsolekile (Co-ordinator for MPH coursework modules) <a href="mailto:ltsolekile@uwc.ac.za">ltsolekile@uwc.ac.za</a>  Ms Corinne Carolissen - Student Administrator - <a href="mailto:ccarolissen@uwc.ac.za">ccarolissen@uwc.ac.za</a>	This module brings together international experts in the fields of Public Health and policy-making in the context of societies undergoing rapid social change. By focusing upon three case studies of countries undergoing rapid transition – Sweden during industrialization, Russia from 1985 - 2000 and South Africa from 1990 onwards. Participants will examine in-depth the demographic and health changes that have accompanied social transitions. The role of concepts such as social capital, cultural capital, politics, globalisation and health policy in explaining these changes will be explored in-depth. Finally the lessons learnt from these changes will be interrogated as will their application to policy-making and implementation in South Africa or your context.	Prescribed readings not available online – waiting for response from course administrator

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
5. University of KwaZulu Natal	Social Epidemiology (a course that is part of the Master of Public Health specializing in Epidemiology and Biostatics but not yet formally taught). However, it has been informally taught to the public health registrars in the field of medicine in 2011	Face-to-face, Four-day module	Epidemiology and statistics Stephen Knight <a href="mailto:knights@ukzn.ac.za">knights@ukzn.ac.za</a> Tel:+27 31 260 4226	Module will provide a systematic and selective overview of conceptual approaches and research findings related to the impact of social context on the health of populations. Among the social processes to be examined are social inequities (including those related to socioeconomic position and race/ethnicity), social integration (including social capital, social networks and support), and the role of residential neighbourhood characteristics. Emphasis will be placed on extending the causal chain thought to be associated with patterns of acute and chronic disease to include “upstream” factors that are properties of social context rather than of individuals. The module will include discussion of methods related to the study of social factors and health, however this is not a methods module. The emerging epidemic of obesity will be used as a running example to illustrate connections across topics.	Core readings for the module appear in Appendix 3
6. University of the Witwatersrand	Master of Public Health in Social & Behaviour Change Communication		Course Administrator: Ntokozo Dube +27 11 717-2087 <a href="mailto:Ntokozo.dube@wits.ac.za">Ntokozo.dube@wits.ac.za</a>	This module looks at the growing need for quality health communication interventions to bring about social and behaviour change in Africa. This course provides students with the skills to analyze the social and behavioural determinants of health and access to health services in Africa. Students will develop skills in applying social and behavioural theory to research and health communication programmes.	

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
7.University of the Witwatersrand	Health and Society (Offered in the School of Public health )	One week face to-face module	Block coordinator: Nicola Christofides <a href="mailto:nicola.christofides@wits.ac.za">nicola.christofides@wits.ac.za</a>  Course administrator: Ntokozo Dube <a href="mailto:ntokozi.dube@wits.ac.za">ntokozi.dube@wits.ac.za</a>	Module provides an overview of the role of social determinants and context on health and wellbeing. A range of social determinants including gender, income inequality, rural/urban, age, political stability, migration will be explored. It introduces some of the current socio-political issues in the sub-Saharan Africa region and how they impact on health. It is a core module for the MPH as it establishes social/political context for health and illness.	Not able to get the full list of prescribed readings
8.Walter Sisulu University	Master of Public Health (MPHE): Courses/Modules related to SDH  1.Health Measurements including Epidemiology, Biostatistics and Demography 2. Medical Sociology and Anthropology		<a href="http://www.wsu.ac.za/academic/academic.php?id=fhsvision">http://www.wsu.ac.za/academic/academic.php?id=fhsvision</a>		Module outlines not available online for this MPH programme.
9.Walter Sisulu University	1.Advanced Epidemiology 2.Advanced Environmental and Occupational		<a href="http://www.wsu.ac.za/academic/academic.php?id=fhsvision">http://www.wsu.ac.za/academic/academic.php?id=fhsvision</a>		Module outlines not available online for this MPH programme.

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
	Health 3.Rural Health				
<b>(b) Courses offered outside Schools of Public Health, and as part of postgraduate curricula</b>					
10. Nelson Mandela Metropolitan University	Health & Welfare-A Development Approach	Offered as a part-time or full time face-to-face course. Charged at a fee of R3160 (approx US\$500)		This module focuses on South African development challenges, and the various policy frameworks, strategies/approaches that a student can use in order to address them: Inequality and social exclusion; poverty and unemployment; HIV and AIDS; gender issues; youth challenges. Amongst other things students identify and critique the influence of socio-political and economic factors on social service delivery.	
11.University of the Witwatersrand Sociology Department	The Sociology of Health and Illness (SOCL4039/7042)		<b>Course Administrator:</b> <a href="mailto:sociology@wits.ac.za">sociology@wits.ac.za</a>	This course aims to fill in the gap in the training of experts in “sociology of health and illness” by providing a systematic and comprehensive introduction to the core concepts and current debates in the Sociology of Health & Illness. It focuses on the theoretical as well as the practical aspects in both the global and the South African contexts. Some of the possible themes covered include: <ul style="list-style-type: none"> <li>• The Theoretical Origins and Development of the Sociology of Health and Illness</li> <li>• Health, Medicine and Society - Key Theories</li> <li>• A Sociological Perspective of Health, Illness, Disease and Sickness</li> <li>• Culture and Health - Medical Pluralism <ul style="list-style-type: none"> <li>• Contemporary Health Inequalities</li> </ul> </li> </ul>	

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
				<ul style="list-style-type: none"> <li>• Health and Social Change</li> <li>• Life-style &amp; Risk -Sociology of Health Promotion ;Sociology of Chronic Illness &amp;Disability</li> <li>• The Sociology of Epidemics</li> </ul>	
12.University of the Witwatersrand	SOSS4011/7017 - HIV/AIDS in Context		<a href="mailto:sociology@wits.ac.za">sociology@wits.ac.za</a>	<p>This is an inter-disciplinary course that examines the sociological, historical and anthropological questions relevant to HIV/AIDS as a global pandemic. The aim of the course is to equip learners with the skills and the insights to better understand the complexity of the epidemic in order to be able to make a meaningful contribution to the efforts to combat its devastating effects. It provides a general overview of the facts, debates and controversies surrounding the current HIV/AIDS crisis, with a specific focus on developing countries, including South Africa.</p> <p>Some of the themes covered include:</p> <ul style="list-style-type: none"> <li>• Social epidemiology - an examination of global and South African statistics</li> <li>• History and ideology of sexually transmitted diseases (STD's) in Africa</li> <li>• Social inequalities, health and HIV/AIDS</li> <li>• Gender and HIV/AIDS</li> <li>• The Treatment Action Campaign (TAC) as a health-social movement</li> <li>• The debates surrounding circumcision as a public health intervention</li> <li>• Medical anthropology of HIV/AIDS</li> </ul>	

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
13. University of KwaZulu Natal, School of Psychology	Ideology and Health course (Masters in Health promotion module)	Four Face-to-face compulsory study blocks in the year and each of which runs for a period three weeks in each term	Course Co-ordinator: Yvonne Sliep <a href="mailto:sliepy@ukzn.ac.za">sliepy@ukzn.ac.za</a>	The aim of the course is to develop a critical understanding of the political economy of health that informs the ideological rationale for the project of regulating human (health) behaviour. Content: The module is centrally concerned with an interrogation of epistemological and ideological issues in the regulation of human behaviour, contextualized in terms of theories of society and a critical approach to social change. 'Health' is understood within the context of global forces and imperatives, with the development agenda of the South being fore-grounded.	
14. University of South Africa	Master of Arts (Social Behaviour Studies in HIV/AIDS)	Offered as a distance education degree and all courses offered online		Degree has different modules that could focus on SDH i.e.: Advanced Social Behaviour Research In HIV/AIDS; Research Proposal In Social Behaviour Studies in HIV/AIDS; Advanced Practical Research In HIV/AIDS ;- The History And Ethics Of HIV/AIDS - Advanced Research Technologies In HIV/AIDS	
15. University of the Western Cape Interdisciplinary Core Courses- School of Public Health	Health, Development and Primary Health Care	Face-to-face module ( <i>Module offered for students in the following depts.: Psychology, Dietetics, School of Natural Medicine etc.</i> )		The impact of social inequality, poverty and development on health: i) Examining what determines health. ii) Social inequality, poverty and poor development and its impact on health. iii) State of health in South Africa. iv) Analysing the community – a case study	

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
16.Stellenbosch University	HIV/AIDS and Society	Face-to-face <i>elective</i> module offered as part of the BA Hons in Sociology or Social Anthropology	student officer, Cyrildine Fortuin  <a href="mailto:cfortuin@sun.ac.za">cfortuin@sun.ac.za</a> Tel: +27 (0)21 808 2417	This elective commences with a discussion on what HIV/AIDS is, how this is being presented in the media and the effect this has on perceptions. This is followed by a session on theory in the time of Aids, asking how we make sense of this epidemic which has so many facets. The module then moves on to an analysis of gender and sexuality and why it is so difficult to change sexual behaviour even where the consequences of risky sexual practices in an era of AIDS is known. This seminar is followed by the topic on youth cultures and sexual behaviour, which helps us understand why the youth continues to be highly susceptible to HIV infection. The last two sessions move from the individual to the political domain. Here the broader debates relating to HIV/AIDS as a human rights issue and the controversy this evokes is analysed before moving on to a discussion on social movements, NGOs and the culture of Aids activism in South Africa	
17. University of KwaZulu Natal  (Faculties of Humanities, Development and Social Sciences)	<u>The Sociology of Health</u> <u>(SOCY712/812)</u>	Offered as an elective module	Mr Cyril Mthembu for Howard College (+ 27 31 260 7523)  and  Ms Thenjie Duma for Pietermaritzburg Campus	The overall purpose of this course is to introduce students to the Sociology of Health as a field of study, both those students who had a previous under-graduate introduction, as well as students located in cognate disciplines. The importance of the sociological study of health and ill-health is highlighted. Concepts, perspectives and methods used in sociology that have special relevance to public	



Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
			(+ 27 33 260 5320)	health issues as well as health in the workplace are examined, in order to advance an understanding of the social dimension of health and ill-health. Attention will be drawn to power-imbalances in society and the shaping of social perceptions of the ill body. These approaches will be located within the South and southern African context (for example, through the study of such topics as STI/HIV/AIDS), while comparative material will be referred to.	
18.University of the Free State Faculty of Health Sciences	Community based education adopted as part of registrar training			Department of Family Medicine adopted CBE as part of its postgraduate programme. CBE is defined as “a means of achieving educational relevance to community needs, and consequently, of implementing a community-orientated educational programme”. CHC training allows the registrars to utilise the community extensively as a learning environment, while students, teachers and community members engage in the learning experience. This service-learning environment also ensures that the community benefits from the academic programme. The registrar is exposed to the most common problems experienced by the population and learns to deliver appropriate healthcare within the available resources. In the CHC, training is carried out with the academic rigour previously reserved for the hospital environment.	
19.University of Cape Town – Faculty of Humanities	1.Public Health and Society 2. Culture, Health and Illness 3. Health and the		<b>programme convener:</b> <u>Dr. Judith Head</u>	Awaiting Course Outlines for the 3 modules	

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
	Sociology of HIV/AIDS				
<b>(c) Short courses offered within University institutions designed to target health professionals who are not registered for full-time study, and registered postgraduate students</b>					
20. University of Western Cape, School of Public Health Winter School 012	Globalisation and health: Key Aspects for Policy Makers, Managers and Practitioners	1 week face-to-face course  Fees for foreign applications: US \$600 and R3,000 (approx US\$400 for local applicants)	CONVENORS: • Prof David Sanders (SCHOOL OF PUBLIC HEALTH, UWC) • Prof Christina Zarowsky (SCHOOL OF PUBLIC HEALTH, UWC)	The course will examine global economic and political relationships, policies and structures and the international health policy agendas that affect health and health care. It will explore the complex relationships between health and health care and different socioeconomic, cultural, political and structural factors. The political, economic and other causes of disparities in health and health care between and within countries will be discussed. The focus will be on global factors that contribute to inequalities and inequities. Actions that can be taken to address the adverse health effects of globalisation will be discussed.	Course taught on the 25-29 <sup>th</sup> June 2012
21. Institute of Social and Economic Research - Rhodes University		Masters in Social Policy		Research based masters course aimed at providing a rigorous grounding in theories, concepts and methodologies of social policy and their application to contemporary social problems	
22. Institute of Social and Economic Research -		Hosts seminar series that are targeted at social policies, development, equity			

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
Rhodes University		etc.			
23.The Global Equity Gauge Alliance (GEGA) and The School of Public Health (SOPH) University of the Western Cape		Face-to-face training workshop conducted over a week.	<p><a href="mailto:secretariat@gega.org.za">secretariat@gega.org.za</a> Tel: +27 31 307 2954</p> <p>Or alternatively <a href="mailto:rstern@uwc.ac.za">rstern@uwc.ac.za</a> Fax: +27 21 959 2872 Tel: + 27 21 959 2809</p>	<p>The main aim of the course is to sharpen awareness and understanding of equity issues with an emphasis on health systems. Because the achievement of health equity is dependent upon a broad framework of social justice, the course adopts a broader <i>social determinants</i> approach to health.</p> <p><b>The course objectives are:</b></p> <ul style="list-style-type: none"> <li>• To encourage participants to reflect on the issue of equity in health and in their Work;</li> <li>• To introduce the concept of equity in relation to other competing objectives in health and development.</li> <li>• To introduce the participants to the GEGA model of equity.</li> <li>• To familiarise participants with the Equity Gauge approach.</li> <li>• To familiarise participants with mechanisms and strategies to reduce inequities.</li> <li>• To enable participants to consider how the approach may be applied in their own country context.</li> <li>• To go through the preliminary steps of applying the Equity Gauge approach to a specific health equity problem or issue.</li> </ul>	<p>Link to course reader with a list of prescribed readings</p> <p><a href="http://www.gega.org.za/download/ResearchtoAction04.pdf">http://www.gega.org.za/download/ResearchtoAction04.pdf</a></p>

Name of partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
24.University of the Witwatersrand	Chronic disease epidemiology	Offered as a 1 week short course for Wits and non-Wits staff and students <i>Cost: R2750 per course – Staff and students at Wits R5500 per course – Participants outside the University</i>	<i>Mrs Vanashree Moodley</i> <i><a href="mailto:Vanashree.moodley@wits.ac.za">Vanashree.moodley@wits.ac.za</a></i> <i>Tel: (011) 717-2543</i>	This course provides an introduction to the aetiology, epidemiology, risk factors and public health importance of selected chronic diseases with particular reference to developing countries.	Core course literature not available online

## Annex 2: Social determinants of health, country needs

Reference/ title of article	Name and contact details of first (or other main) author	Objective of study	Methods	Findings	Recommendations
<p>Determinants of health and their trends (3)</p> <p><a href="http://www.hst.org.za/uploads/files/chap4_08.pdf">http://www.hst.org.za/uploads/files/chap4_08.pdf</a></p>	<p>Bradshaw D  <a href="mailto:debbie.bradshaw@mrc.ac.za">debbie.bradshaw@mrc.ac.za</a></p>	<p>To review progress made in South Africa (14 years after democracy i.e. in 2008) in terms of the broader determinants of health, and to reflect on changes in health status in post-apartheid South Africa.</p>	<p>Literature review of trends using data from Statistics South Africa (StatsSA), the South Africa Demographic and Health Surveys (SADHS) and other sources are used to appraise trends. Development reviews, such as the mid-term review of development indicators, and the macro-social review conducted by government, as well as studies that have synthesized the size of the burden of disease information were also used</p>	<p>National economic and social policies have resulted in economic growth, and some improvement in living conditions, through access to basic services such as water, sanitation and electricity</p> <p>Extreme wealth inequalities and high levels of unemployment probably play an important role in the poor health outcomes</p> <p>Management of the environment needs more attention, including the identification of alternative informal sector activities that are more environmentally sustainable</p> <p>High levels of school attendance have largely been maintained, there is little information about the quality</p>	<p>Theoretical understanding of health and its determinants is by no means well formed, and would be a fruitful area of research that might reveal ‘inflection points’ where public health practitioners could best intervene</p> <p><b>Recommendations In line with CSDH’s three Principles of Action:</b></p> <p>----Essential that actions are taken by the South African government and society to build social cohesion.</p> <p>----The structure of the economy, and establishing robust methods of social insurance, would be important longer-term goals to maintain a redistributive element of the economy and ensure sustainability</p> <p>---Efforts to continue improving the health information system and population health data must continue, as it is essential to be able to monitor progress and inequities. Institutional capacity to collect, analyse and utilise</p>

Reference/ title of article	Name and contact details of first (or other main) author	Objective of study	Methods	Findings	Recommendations
				of education and there is much scope for efforts to enhance early childhood development	health data at national, provincial and local levels needs to be strengthened, so that programmes and policies can be responsive to the changing burden of disease profile
Socio-economic related health inequality in South Africa: evidence from General Household Surveys (22)	John E Ataguba <a href="mailto:John.Ataguba@uct.ac.za">John.Ataguba@uct.ac.za</a>	To investigate socio-economic related health inequality in South Africa  To understand how the burden of self-reported illness and disability is distributed and whether this has changed since the early 2000s.	South African General Household Surveys (GHS) data for 2002, 2004, 2006 and 2008 were used, with standardized & normalized self-reported illness and disability concentration indices used to assess the distribution of illness and disability across socio-economic groups. Composite indices of socio-economic status were created using a set of common assets and household characteristics.	Socio-economic gradients exist in self-reported ill health in South Africa.  Burden of the majority of categories of ill health and disability is greater among the lower than higher socio-economic groups  Non-communicable disease also higher amongst lower socio-economic groups	South Africa needs to strive for access to and use of health services  Concerted action between health sector and other social, and economic sectors needed to address the health inequalities in South Africa
<b>Intervention/Programme evaluation studies</b>					
Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa:	Paul M Pronyk <a href="mailto:pronyk@soft.co.za">pronyk@soft.co.za</a>	To assess the impact of a structural intervention that combined a microfinance programme with a gender and HIV	Villages in the rural Limpopo province of South Africa were pair-matched and randomly allocated to receive the intervention at study onset (intervention	Impact of intervention on primary outcome measures: reduced IPV by more than 50% HOWEVER did not show effect on incidence of HIV or arte of unprotected sex	Social and economic development interventions have the potential to alter risk environments for HIV and intimate-partner violence in southern Africa.

Reference/ title of article	Name and contact details of first (or other main) author	Objective of study	Methods	Findings	Recommendations
a cluster randomised trial (24)		training curriculum (IMAGE intervention) on interpersonal violence (IPV) and HIV reduction	group, n=4) or 3 years later (comparison group, n=4). Loans were provided to poor women who enrolled in the intervention group by a Small Enterprise Foundation (SEF). Gender and HIV training, + leadership training was facilitated by RADAR staff	among indirectly exposed young people belonging to households receiving intervention	
What happens after a trial? Replicating cross-sectoral intervention addressing the social determinants of health (23)	James Hargreaves <a href="mailto:james.hargreaves@lsh.ac.uk">james.hargreaves@lsh.ac.uk</a>	To conduct a process evaluation of the IMAGE intervention (IMAGE was an intervention that aimed to address the social determinants HIV and interpersonal violence through economic empowerment (group-based financing) and social empowerment (community mobilization and gender and HIV training  To describe views of stakeholders on the potential for further	6-year mixed method process evaluation Quantitative data in the form of attendance registers, client questionnaires, and financial records was collected  Qualitative component: participant observation, semi-structured interviews, FGDs with programme clients during IMAGE trial.  External stakeholder analysis with informants from 3 policy networks	Managing inter-sectoral partnership was a challenge with a complex partially integrated management structure emerging between health partners and the microfinance partners  Lack of ownership of the IMAGE programme by the microfinance partner created problems with timely decision making as financial and administrative roles fell outside the implementing body	<ul style="list-style-type: none"> <li>• Promise of successful inter-sectoral action amongst sectors addressing SDH</li> <li>• Shared vision and ownership are critical for success</li> <li>• Critical need to define roles and responsibilities of various actors</li> <li>• Important to sensitize staff to the perspectives of new partners</li> <li>• Imperative to harmonize conditions for staff between sectors</li> </ul>

Reference/ title of article	Name and contact details of first (or other main) author	Objective of study	Methods	Findings	Recommendations
		replicating IMAGE to other settings	(HIV/AIDS researchers, Microfinance practitioners, Donors and policy experts)		
Can Social Inclusion Policies reduce health inequalities in Sub-Saharan Africa – A Rapid Policy Appraisal Approach (25)	Laetitia C Rispel Email: <a href="mailto:laetitia.rispel@wits.ac.za">laetitia.rispel@wits.ac.za</a>	To review social inclusion policies in 6 different countries (including South Africa) that could influence health inequalities	Policies or actions by international agencies, national and local governments were assessed as part of the Social Exclusion Knowledge network of the World Health Organization. In South Africa the child support grant (CSG), free health care policies and Bana Pele policies were reviewed. Benefits were assessed by reviewing impact on poverty alleviation, economic opportunities, and access to health services. Impact on the health inequalities was inferred.	<p><b>South African findings</b></p> <p>CSG: Poverty reduction improved, child nutrition intake improved, social cohesion improved, improved HH economic opportunities</p> <p>Econometric modeling showed improved childhood nutrition measured by height –for-age</p> <p>Free health care: reduced access barriers to health care however the impact on health inequalities was not assessed/ is unknown</p> <p>Bana Pele (integrated and comprehensive pro-poor social services to children): improved access to existing free health services but impact on health inequalities not assessed.</p>	<ul style="list-style-type: none"> <li>• Health inequalities must be measured</li> <li>• Social policies need to be carefully designed and effectively implemented</li> <li>• Monitoring and evaluation critical</li> <li>• Need for strong movement by civil society to address health inequalities</li> </ul>



## Annex 3: On-going work on social determinants of health

Name of group/ institution/ Actor	Web address, and name and contact details of key person/ people	Mission of group/ institution	Core area of work, and possible Alliances	Accomplishments, future aims
<p>The Social Aspects of HIV/AIDS and Health (SAHA)</p> <p><a href="http://www.hsrc.ac.za/SAHA.phtml">http://www.hsrc.ac.za/SAHA.phtml</a></p> <p>SAHARA (Social Aspects of HIV/AIDS Research Alliance)</p> <p><a href="http://www.sahara.org.za/network/south-ern-africa">http://www.sahara.org.za/network/south-ern-africa</a></p>	<ul style="list-style-type: none"> <li>• Prof. Nancy Phaswana-Mafuya, Director, +27 (0)41 399 8702</li> <li>• Cleo Mhlanga, PA/Project Administrator/ +27 (0) 41 399 8704</li> <li>• Mercy Banyini, Manager: SAHARA journal, +27 (0) 12 302 2356</li> <li>• Babalwa Boo, Project Administrator, +27 (0) 41 399 8700</li> <li>• Adlai Davids , Senior Research Manager, +27 (0) 41 399</li> </ul> <p>Website for contact details: <a href="http://www.sahara.org.za">http://www.sahara.org.za</a></p>	<p>SAHARA is an alliance of partners who seek to conduct, support and use social sciences research to prevent the further spread of HIV and mitigate the impact of its devastation in Africa.</p>	<p>SAHA conducts research in three main areas:</p> <ul style="list-style-type: none"> <li>• Behavioural and social aspects of HIV/AIDS</li> <li>• Epidemiology, strategic research and health policy</li> <li>• Health systems and social determinants of health</li> </ul>	<p>SAHA has contributed both directly and indirectly, to the development and implementation of the HIV and AIDS and STI Strategic Plan for South Africa 2007-2011</p> <p>SAHA has significant international and regional collaborators</p> <p>SAHA has implementation networks that have facilitated dissemination of research findings to key stakeholders</p> <p>Establishment of a Journal on Social Aspects of HIV/AIDS</p>

Name of group/ institution/ Actor	Web address, and name and contact details of key person/ people	Mission of group/ institution	Core area of work, and possible Alliances	Accomplishments, future aims
<p>RADAR- Rural AIDS and development action research programme</p> <p>RADAR is collaboration between the University of the Witwatersrand and the London School of Hygiene and Tropical Medicine</p>	<p><a href="mailto:cmartin@soft.co.za">cmartin@soft.co.za</a></p> <p><a href="http://www.hiv911.org.za/Lists/Mpumalanga/DispForm.aspx?ID=2&amp;ContentTypeld=0x010041AD2D442726AE43AB8E620714EB61D3004DFBF19698F02444BAD28D000772C273#hivpagetop">http://www.hiv911.org.za/Lists/Mpumalanga/DispForm.aspx?ID=2&amp;ContentTypeld=0x010041AD2D442726AE43AB8E620714EB61D3004DFBF19698F02444BAD28D000772C273#hivpagetop</a></p>	<p>Undertaking clinical and social intervention research on HIV and AIDS, with an emphasis on developing model approaches that are appropriate and relevant to the rural African context</p>	<p>RADAR directs clinical and social interventions for HIV, gender-based violence, and other challenges of rural development in South Africa's Limpopo Province.</p>	<p>Successfully implemented a microfinance based poverty alleviation and empowerment programme (IMAGE) in partnership with a Small Enterprise Foundation (SEF) that aimed to reduce interpersonal violence and HIV incidence</p>
<p>Medical Research Council of South Africa (MRC) – Chronic Diseases of lifestyle research unit</p>	<p><a href="http://www.mrc.ac.za/chronic/chronic.htm">http://www.mrc.ac.za/chronic/chronic.htm</a></p> <p>Interim Manager: Ms Jean M Fourie <a href="mailto:jean.fourie@mrc.ac.za">jean.fourie@mrc.ac.za</a></p>	<p>To undertake and coordinate public health research, which addresses CDL whereby healthy lifestyles, early diagnosis, and cost-effective prevention and management of these diseases and their risk factors can be promoted among the South African population, using a life-course approach.</p>	<p>Focuses on chronic diseases of lifestyle:</p> <ul style="list-style-type: none"> <li>• Early diagnosis, cost-effective prevention and management and risk factors</li> </ul>	<p>The Chronic Diseases of Lifestyle Unit has been central in developing the adult health module for the South African Demographic and Health Survey (SADHS)</p> <p>Record of accomplishment in developing tools for example, The Dietary Assessment and Education Kit (DAEK), HealthKick schools project, SADHS adult health module, structured records with prompts for hypertension and diabetes management, multiple questionnaires.</p>

Name of group/ institution/ Actor	Web address, and name and contact details of key person/ people	Mission of group/ institution	Core area of work, and possible Alliances	Accomplishments, future aims
MRC Burden of Disease Research Unit	<p><a href="http://www.mrc.ac.za/bod/bod.htm">http://www.mrc.ac.za/bod/bod.htm</a></p> <p>Director: Debbie Bradshaw  <a href="mailto:debbie.bradshaw@mrc.ac.za">debbie.bradshaw@mrc.ac.za</a></p>	<p>The mission of the Unit is to assess and monitor the country's health status and determinants of disease; and to project the future burden of disease in order to provide planning information to improve the health of the nation</p>	<p>Multidisciplinary approaches are used drawing on epidemiology, demography and biostatistics. Expertise has been developed in the area of summary health measures, health surveys and the analysis of mortality data.</p>	<p>Pioneered the first burden of disease study in South Africa</p> <p>Strong collaboration with academic and international agencies                      Has provided Technical support to government to improve vital registration and health surveys.</p>
EQUINET	<p><a href="http://www.equinetafrica.org/">http://www.equinetafrica.org/</a>                      Dr Rene Loewenson  <a href="mailto:rene@tarsc.org">rene@tarsc.org</a></p>	<p>EQUINET, the Regional Network on Equity in Health in Southern Africa, is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health</p>	<p>EQUINET's work covers a wide range of areas identified as priorities for health equity, within the political economy of health, health services and inputs to health, covered in the theme areas shown below</p> <p>Equity in health; health equity in economic and trade policies, poverty &amp; health; equitable health services; equity &amp; HIV/AIDS; monitoring equity &amp; research to policy</p>	<p>EQUINET has established itself as the regional equity in health experts in southern Africa by carefully and strategically forming places where different individuals and institutional representatives come together to learn, dialogue, and strategize</p>

## Annex 4: SDH policies and policy reviews

Responsible Ministry	Name and year of policy document	SDH-relevant components (incl. details of actions, people affected, etc)	Groups/ individuals in support of policy, and why	Groups/ individuals in opposition to policy, and why	Policy review date (if known)
Department of Health	National Health Insurance (proposal to phase in NHI over a 14 year period)	Will cover a comprehensive package of health services (not yet defined) and services provided at allocated providers. All South African citizens including permanent residents will be covered.	<p>Department of Health, independent researchers and research units (e.g. Health Economics Unit, University of Cape Town, Prof Di. McIntyre, Prof Gavin Mooney) – believe that this would ensure risk pooling and help attain a more equitable health system in SA.</p> <p><b>Source:</b><a href="http://www.consultancyafrica.com/index.php?option=com_contentandview=articleandid=889:affordable-health-care-for-all-south-africans-the-national-health-insurance-green-paper-andcatid=91:rights-in-focusandItemid=296">http://www.consultancyafrica.com/index.php?option=com_contentandview=articleandid=889:affordable-health-care-for-all-south-africans-the-national-health-insurance-green-paper-andcatid=91:rights-in-focusandItemid=296</a></p>	<p>South Africa’s largest trade union, COSATU, is disturbed that the system could be a multi-payer and provider system, and they are critical of the role private health providers may play in a state-funded scheme. Health lobbyists and concerned taxpayers worry about the NHI’s autonomy, given that it would report to the Health Minister and Parliament. The private schemes are concerned about what the NHI will mean for their future. Wealthy individuals and employers are concerned that they will end up paying more for health care than they do currently.</p> <p><b>Source:</b><a href="http://www.consultancyafrica.com/index.php?option=com_contentandview=articleandid=889:affordable-health-care-for-all-south-africans-the-national-health-insurance-green-paper-andcatid=91:rights-in-focusandItemid=296">http://www.consultancyafrica.com/index.php?option=com_contentandview=articleandid=889:affordable-health-care-for-all-south-africans-the-national-health-insurance-green-paper-andcatid=91:rights-in-focusandItemid=296</a></p>	Piloting began in April 2012

Responsible Ministry	Name and year of policy document	SDH-relevant components (incl. details of actions, people affected, etc)	Groups/ individuals in support of policy, and why	Groups/ individuals in opposition to policy, and why	Policy review date (if known)
<b>Department of social development</b>	Free Health Care (Commenced 1994/95)	No user fees in PHC facilities. Free hospital services for children <14years, pensioners, pregnant women, formally unemployed, tuberculosis, HIV VCT, people with disabilities. Pregnant women and children from HHs earning >USD\$10,000 per annum are not eligible.	Previously disadvantaged populations, particularly African and Coloured populations  Department of Health	Public health professionals: perception that policy aggravated existing health problems, for example, poor working conditions, shortage of medicines, overcrowding etc.  Dissatisfied with the inadequate consultation prior to policy implementation	Not Known
Department of social development	Child Support Grant Commenced 1994/94  (Included as the benefits seem to overflow to the adult population as well)	Monthly amount (approx. \$30 in 2011) paid to children from birth to 14 years who meet eligibility criterion. Eligibility: caregiver should be a South African citizen or permanent resident in SA, earn <USD\$ 4500 per year if single or(<USD\$9,000) if married	Previously disadvantaged populations	Some economists and agricultural experts - perception that excessive grants over an extended period will have negative impacts on work ethic particularly subsistence farming  Overextended grants could erode tax base which is already small	Reviewed in 2009