

Inefficiency quantified by how many say 'they' instead of 'us'

Most local rural doctors who work alongside foreign-qualified colleagues (without whom they could probably not deliver any kind of reasonable service) would be horrified to hear that these stalwarts experience personal and systemic xenophobia in their jobs.

While locals might understand systemic xenophobia as an ugly extension of the all-too-familiar bureaucratic dysfunctionality, the more subtle collegial xenophobia would probably be news to them. These sentiments emerged from foreign-qualified doctors attending this year's Rural Doctors of Southern Africa (RuDASA) conference at Rhodes in the Eastern Cape last month. While they went to great lengths to avoid generalising, being 'shut out' in casual conversation during a clinical huddle or, far more debilitating, being threatened with eviction because the province forgot to pay their accommodation rental, or having their salaries suspended while their contracts were renewed, was enough to send 20% of one Tunisian contingent packing.¹ Unsolicited, former UK health chief Dr Mark Britnell, sharing post-NHS inception wisdoms at a Hospitals Association of South Africa (HASA) conference a week later, urged delegates to treat foreign-qualified doctors as 'respected guests in your country' and to give them appropriate support. His work philosophy? 'There is no "them" – only "us".'²

Climate change and health

Several of the US Republican presidential candidates are apparently climate change denialists. Such a belief is of concern as the world population approaches 7 billion people. Increasing conflict over diminishing resources, including clean water, is likely to occur. Myers and colleagues provide a timely analysis of the impact of climate change on health in southern Africa.^{3,4}

Climate change resulting from the influence of human beings on nature is due to economic activities increasing the emission of greenhouse gases (GHGs) such as carbon dioxide and methane, which increase the heat-trapping capacity of the lower atmosphere, resulting in global warming with increasing surface temperatures and the annual number of dry days and hot nights increasing. The global sea level has been rising for decades as a result of thermal expansion of ocean water and melting glaciers and ice sheets. Precipitation has increased in some regions while decreasing in others.

Climate change affects the fundamental requirements for health – safe drinking water, clean air, sufficient food and secure shelter – and has many direct and indirect adverse health impacts. These result directly from extreme weather events (e.g. heat and floods) and indirectly from socially mediated risks (e.g. displacement, conflict, damaged infrastructure, crop failure) and/or ecologically mediated risks (e.g. food, water, vectors). The World Health Organization has estimated the global burden of disease attributable to climate change risk factors at 2000 (relative to the 1961 - 1990 average base climate) as 1 600 000 premature deaths and the loss of 5 500 000 disability-adjusted life years based on climate-sensitive conditions such as malaria, malnutrition, diarrhoeal disease, heat waves and floods.

Projections show that the effect of climate change in Africa will not be uniform over the region. The region is extremely vulnerable to climate change because of poverty, a high pre-existing disease

burden, fragmented health services, and water and food insecurity. More comprehensive information is urgently needed for the southern African region to estimate the health risks from projected future changes in climate.

Prisons and the TB time bomb

The USA has 5% of the world's population but a quarter of its incarcerated population (much of it drug-related). South Africa also has an appalling prison record, with the fourth-highest global incarceration rate. Johnstone-Robertson and colleagues analyse the prison population at a Western Cape prison⁵ and, by applying epidemiological modelling, come to some sobering conclusions about South African prisons and their potential to affect the health of the entire community.

Prisons have a high burden of tuberculosis (TB), with overcrowding, lack of ventilation and poor prevention practices dramatically increasing transmission risks. The study showed that conditions prevailing in a South African prison are extremely conducive to ongoing transmission of TB. Crowding, substandard living conditions and a poorly functioning prisons TB control programme all contribute to high TB transmission risks. The conditions in which awaiting-trial prisoners are confined fall far below international (and our own national) standards for incarceration. This has important implications for the broader society.

The authors address practical points about improving the conditions of prisoners that would diminish the likelihood of the spread of diseases. However, not addressed in the paper is the importance of giving attention to measures that could reduce our prison population (including reconsidering our drug policies).

Reducing necrotising enterocolitis

Necrotising enterocolitis (NEC) is an acute gastro-intestinal emergency occurring almost exclusively in preterm low-birth-weight infants. Joolay *et al.* demonstrate how simple measures can effectively reduce the occurrence of this serious condition.⁶

NEC carries a high mortality and morbidity in affected infants and was the cause of death of 10% of very low-birth-weight deaths in a South African tertiary neonatal unit. Its aetiology is uncertain but is almost certainly multifactorial, including prematurity and infection.

By various strategies (earlier introduction of breastmilk feeds and substantially more donor breastmilk; pasteurisation of breastmilk of HIV-positive mothers; and introducing sterile, ready-to-use infant formula) the authors substantially reduced the NEC rates in their unit.

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