UNIVERSITY of the WESTERN CAPE

SoPH BULLETIN

The UWC School of Public Health Newsletter **April 2013**

UNIVERSITY of the WESTERN CAPE

HIV IN CONTEXT
UWC HIV & AIDS Research Centre

March 12-15, 2013: 5th Annual HIV-in-Context Research Symposium Urbanisation, Inequality and HIV

Prof Zarowsky, Penny Morrell and Tamlin Petersen

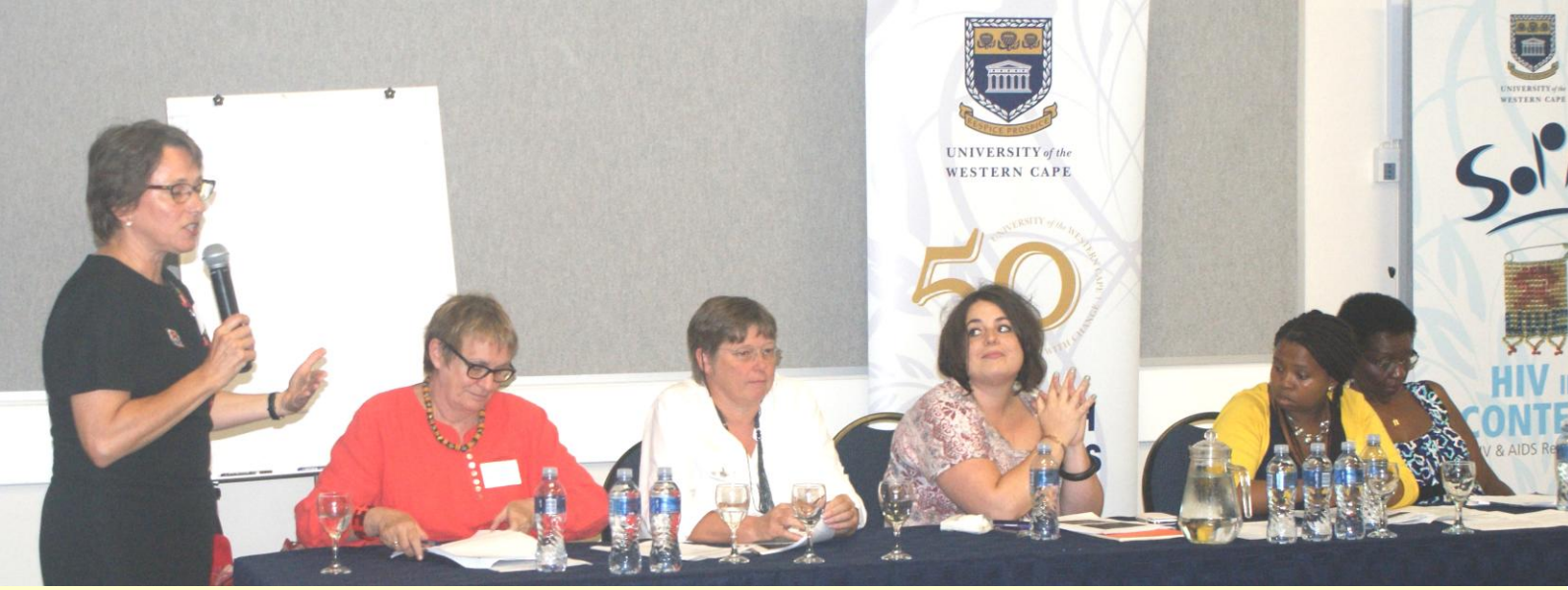
Report by Christina Zarowsky and Penny Morrell

Symposium programme and presentations now available on the CRHA website: http://www.hivaids-uwc.org

HIV reveals and is produced by social inequalities. It remains highly unevenly distributed across countries and across communities, and is increasingly concentrated in urban centres. HIV can galvanize creative societal responses: through both conflict and cooperation, South Africa has made significant progress in the medical management of HIV. Yet the challenges of HIV as a chronic disease requiring lifelong treatment are increasingly clear - particularly with South Africa's high rates of internal and cross-border mobility and migration.

In addition, inequality itself is increasing. UWC's Centre for Research in HIV and AIDS (CRHA), based in the School of Public Health, hosts an annual flagship Symposium to bring together scholars, practitioners and civil society to reflect on issues in ways which both draw on and challenge each constituency's perspectives and experience, seeking to find and develop common ground and new approaches to persistent and emerging challenges related to HIV.

This year's HIV in Context Research Symposium looked beyond biomedicine at some of the social determinants of HIV, and of responses to HIV, within and outside the health sector. This 5th Annual Symposium examined the links between HIV, inequality and the dynamics and impacts of urbanisation – dynamics which play out between settings as people move permanently or temporarily to urban centres, and within the highly unequal spaces constituting South African cities. Over 140 participants from research, government, NGOs and community-based organisations listened, discussed, debated, and proposed ways forward on key issues. The Symposium was preceded by a very successful capacity strengthening workshop for emerging researchers and practitioners whose poster abstracts had been selected for oral or poster presentation at the Symposium – CRHA team member and SOPH PhD student Emma Chademana shares her reflections on this workshop below. After the Symposium, working groups met to develop curricula on urbanisation and health, migration and health, and human trafficking.



Prof Zarowsky leading a Symposium panel discussion

The programme opened by outlining key concepts for the Symposium deliberations, laying out some of the debates in the relevant fields and proposing a shared set of working definitions to

facilitate productive interaction among participants. This was followed by locating the issues of urbanisation, inequality and HIV within a context of globalisation, identifying the impacts this has on the wellbeing of people in South Africa and the region.

Using Cape Town as a starting point for raising more general issues and informing discussion, the city was introduced on the first evening through a panel presentation on "Persistent patterns of the past: Health, social and economic inequalities in Cape Town". Open to the public, this event featured 5 eminent public intellectuals: The rector of UWC, Prof Brian O'Connell was joined by Prof Willam Pick (of the universities of Cape Town, Stellenbosh and Wits) and Josette Cole (from the Development Action Group) to interrogate the history of urbanisation and inequality in Cape Town, reflect on the roles disease and health have played in this, and engage in the current challenges faced in providing decent spaces and conditions for all. The panel was actively chaired by Prof Francis Wilson of SALDRU, UCT – who is heading the Carnegie3 process which is looking into poverty and inequality in South Africa.

This opening reflection was deepened the next morning with more detailed accounts of the nature and extent of urbanisation, inequality, (un)employment, HIV and intersectoral collaboration for health in Cape Town. All of these panels were in a sense "background" for the heart of the Symposium: four focussed commissions offered participants opportunities to engage with issues that are, by their nature, inter-sectoral and cross-cutting. Framed by the concepts of urbanisation, inequality and HIV, the commissions' themes were as follows:

- **People on the move: Ensuring continuity of care** – what it would take for the South African health system to enable continuity of care across services and spaces - for various mobile populations.
- **Falling between the cracks. The challenges of inter-sectoral action for health -** what promotes and undermines inter-sectoral action for health – and what are the mechanisms for preventing people falling through the cracks between sectors and services.
- **Urban contexts: Spaces of vulnerability and opportunity** – what it would take for the urban areas in which the poor in South Africa live to become health promoting spaces for all the people who live in, and move through, them.
- **What is a dignified urban settlement, and how do we get there – in the absence of a national vision? – Reflecting on and engaging the politics of participation and representation -** what it would take for the political and

The Tasks of the Symposium Commissions

Commission 1: People on the move: Ensuring continuity of care

The main question asked *what it would take for the South African health system to enable continuity of care across services, spaces and its own organisational divisions - for various people and populations on the move*. This commission started by summarising why continuity of care is an issue in the context of HIV and what the current challenges are with respect to systems, services and patients. It included a description of systems (both local and abroad) which attempt to address continuity of care and what the mechanisms and ingredients for success may be (including patient-held records, budgeting and referral across districts and provinces, information systems, quality of care etc).

Working with a realistic frame of what is possible, the commission then addressed the main questions of what it would take for the South African health system to enable continuity of care across services and spaces - for various kinds of mobile populations.

Commission 2: Falling between the cracks. The challenges of inter-sectoral action for health.

The main question here was what promotes and undermines inter-sectoral action for health – and what are the mechanisms for preventing people falling through the cracks between sectors and services. This commission looked at these issues through the case of children – with the more focused questions being what would it take for children living in poor, high density urban areas and in the context of HIV to have a proper chance of being healthy and realising their potential.

What are the major obstacles to this and how are the various provisions and institutions in South Africa, intended to secure the fullest wellbeing of economically and socially vulnerable children, held accountable for their mandates? The emphasis here was on how systems, services, spaces and people collude to support or neglect children from early childhood development through to the social and health challenges of adolescence.

Commission 3: Urban contexts: Spaces of vulnerability and opportunity

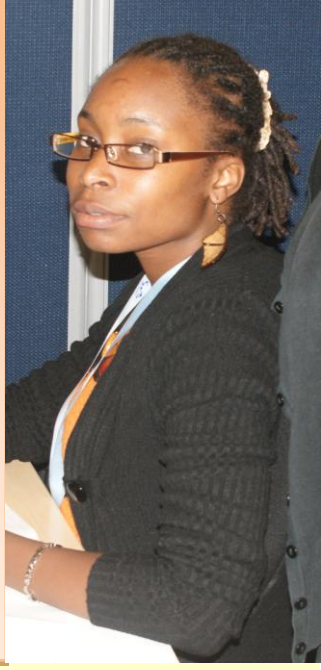
The main question asked what it would take for the urban, urbanising, or "rural slum" areas in which the poor in South Africa live to be health promoting spaces for all people who live in, and move through, them.

We examined the social determinants which make many settlements particularly unhealthy places, while simultaneously being seen as places of opportunity. The reasons for the high HIV prevalence in informal settlements - double the average urban levels - will also be considered. A focus on three informal and formal high density areas facilitated reflections on successful and unsuccessful efforts at inter-sectoral action for health.

Commission 4: Dignified urban settlements: What are they and how do we get there?

This commission addressed the same main question as in commission #4 – namely what it would take for the political and social provisions intended to eradicate inequality to achieve this, with particular reference to what can be done at local level – but approached it from a planning point of view. It reviewed planning processes and interests to ascertain how these might and do, or do not, promote healthy people and communities – form the point of view of urban planners and from residents who are taking on issues in their own areas

Emma Chademana



The pre-Symposium workshop

The poster session of the symposium aimed at giving emerging scholars a platform to present their work and network with professionals in the field. A total of 21 abstracts were selected for poster presentations with 13 abstracts selected for oral poster discussion.

Oral poster presenters had the opportunity to attend a pre-symposium workshop on effective presentation skills. The workshop aimed at improving presentation skills as well as de-signing and presenting effective posters. Participants were given an opportunity to present their PowerPoint presentations and received feedback from the workshop convenors and peers allowing them to rework their presentations before the Symposium.

At the Symposium, I listened to the previously nervous participants deliver their presentations with such confidence and poise which was indeed evidence of how this workshop had empowered and equipped the presenters in such a short period.

The workshop was also beneficial to me as a research student, as I learnt the importance of voice projection, eye contact and gestures in delivering effective presentations.

social provisions intended to eradicate inequality to achieve this, with particular reference to what can be done at local level.

On the second day, participants in the pre-symposium workshop presented their posters on the related themes of

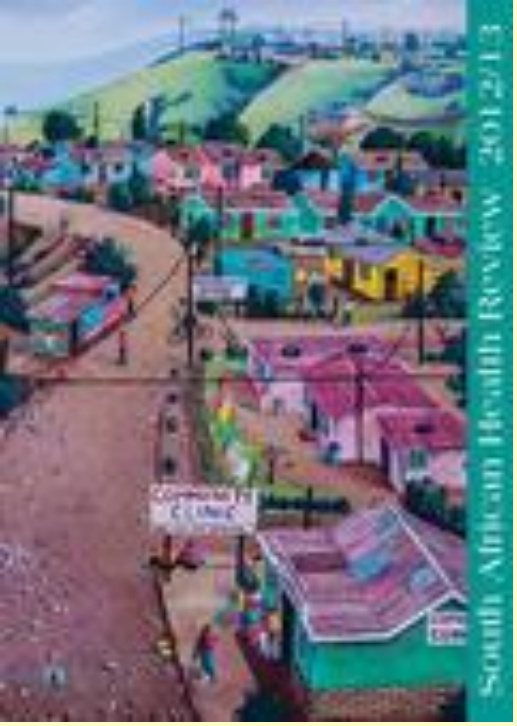
- service delivery and quality of care within the context of urban poverty;
- access to health services for migrant and mobile populations; and
- vulnerability and HIV prevention and care in urban settings.

The final day, unlike many conferences, opened to a full plenary hall. We collectively summarised and discussed the challenges that have been identified, reviewed the utility of the initial shared understanding of key concepts, and began to develop strategies for taking the commissions' deliberations further in each of our areas of work. At tea and over lunch, many participants waited in line to offer their views on video to two questions: what did you most appreciate about the Symposium? What did you change your mind about?

A closing address by Prof Steve Reid of UCT on "The Urban Future of Africa?" challenged us to hold on to the deeply human and interpersonal dimensions of life brought to the fore in rural settings, while engaging with the complex dynamics of cities in ways which to do not attempt to erase or ignore this complexity. Prof Reid's talk led into a powerful multimedia composition of photographs, narrative, poetry, song, and instrumental music by visiting scholar Prof Patricia Repar, a musician, composer, and internal medicine specialist who has worked with Prof Reid with community health workers in KwaZulu Natal. It was an extraordinary close to a Symposium that marks the coming of age of the Centre for Research in HIV and AIDS, and a consolidation of its focus on "HIV in Context".

Profs. Steve Reid and Patricia Repar

This symposium was made possible by the generous support of the VLIR-UOS through the project "Transforming health and education policies and systems for improved HIV prevention and care" and the Centres for Disease Control (CDC) South Africa under the CoAG U2GPS001083-05 "Human capacity development to address HIV and AIDS in South Africa".



SOPH Staff Publications...

SOPH Staff contribute to the HST 2013 South African Health Review

1.

Chronic Non-communicable Diseases in South Africa: Progress and Challenges

Thandi R Puoane, Lungiswa P Tsolekile , Sam Caldbick , Ehimario Igumbor , Kashmeera Meghnath, David Sanders

Increasing attention is currently being paid to NCDs in South Africa but this heightened focus has to be strengthened and sustained over the next decades to combat the current trend and achieve a real reduction in the NCD-related burden.

Abstract

In recent years, recognition of the rising threat of chronic non-communicable diseases (NCDs) as major contributors to preventable disease and premature mortality has placed these conditions firmly on the global development agenda. A United Nations resolution taken on 13 May 2010 set in motion processes that culminated in a United Nations Security Council summit on NCDs in September 2011. This action has been important in highlighting NCDs, especially in low- and middle income countries such as South Africa, and placing them on a par with other global health priorities such as HIV and AIDS.

In this chapter, we describe the current status of chronic NCDs in South Africa and point to the drivers of the high and increasing burden of NCDs in the country. Building on the review of NCDs in the 2008 South African Health Review, we reflect on progress in local policies and practices over the past five years. Our review shows that increasing attention is currently being paid to NCDs in South Africa but that this heightened focus has to be strengthened and sustained over the next decades to combat the current trend and achieve a real reduction in the NCD-related burden. Specifically, more stringent measures are required to address the common risk factors of chronic NCDs and reverse the burden of NCDs. To achieve this, action is required from several constituencies. Ultimately, South Africa will need to invest in NCD prevention and control as an integral part of sustainable socioeconomic development.

Introduction

"Chronic non-communicable diseases" (NCDs) refers to a group of slowly progressive medical conditions or diseases of long duration (chronic), which are characteristically non-infectious and non-transmissible among people (non-communicable). They include heart disease, stroke, cancers, diabetes, chronic obstructive pulmonary disease (COPD), asthma, cataracts, and more. The chronic character of these diseases demands long-term care and they impose a continuous burden on an already overstretched health system similar to the way HIV infection does. Their noninfectious cause however points to a different set of determinants that need to be targeted.

Chronic NCDs, which account for approximately two-thirds of all deaths globally, are the leading cause of mortality worldwide. Cardiovascular disease, cancer, type II diabetes, and COPD make up the majority of the NCD-related burden. This burden is increasing in many countries that still suffer widespread infectious diseases, resulting in a double burden of disease. For example, approximately 83% of the global mortality from NCDs occurs in low- and middle-income countries (LMICs). Furthermore, it is estimated that the total deaths globally attributable to NCDs will increase by 15% in the next decade.

In South Africa (SA), NCDs account for an estimated 37% of allcause mortality and 16% of disability-adjusted life years. Ischaemic heart disease, stroke, diabetes mellitus, and COPD account for 6.6%, 6.5%, 2.6%, and 2.5% of all deaths respectively. This burden varies significantly between population groups. For example, the age standardised cardiovascular disease mortality rate is 606.9 per 100 000 for Asians and 375.3 for 'Africans'. Evidence exists of a growing interest in tackling the burden of NCDs in SA. In September 2011, the South African government convened a summit on the "Prevention and Control of Non-Communicable Diseases".

The summit, which included various governmental departments, researchers, private sector stakeholders, and civil society, produced a declaration that endorsed action aimed at various levels of risk factors (behavioural, environmental, and structural). It also acknowledged the need for intersectoral collaboration. Furthermore, the national government will soon be releasing a "Strategic Plan for Non-Communicable Diseases, 2012-2016", which will provide a short-term framework to reduce the burden of NCDs.

The recent acknowledgement given to NCDs in SA is important progress. Aside from the tremendous burden NCDs place on individuals, they also pose significant economic challenges to the country. NCDs can deepen poverty, reduce economic productivity, and strain an already under-resourced healthcare system. Action is urgently required: as a result of the demographic transition, NCD rates will increase regardless of progress made in reducing the prevalence of leading risk factors. For example, it is estimated that between 2001 and 2025 the proportion of the population aged 60 and older will increase from approximately 7.1% to 10%. However, there is reason for optimism. Many of the risk factors for NCDs are modifiable, which provides considerable opportunities for intervention. However, progress in reducing these risk factors will only be attained if appropriate attention is given to their social and structural determinants. A concerted effort from all government departments and sectors in society is required to mitigate the future threat that NCDs pose to the country.

In this chapter, we describe the current status of chronic NCDs in South Africa and point to the drivers of the high and increasing burden of NCDs. Building on the review of NCDs in the 2008 South African Health Review2 we reflect on progress in policies and practices in the past five years. We deliberately focus on the 'big four' (heart disease, cancer, type II diabetes and COPD) because of the overall burden they make up in SA and the many risk factors they commonly share. Mental illness, a major contributor to the overall disease burden in SA, is not covered in this chapter. We then provide examples of interventions that have been implemented in SA and other countries. Finally, we conclude by highlighting the current challenges facing public health research in SA and offer a future direction for alleviating the NCD-related burden.

http://www.hst.org.za/sites/default/files/Chapter9_ChronicNCD.pdf

2.

Health Policy and Systems Research: Needs, challenges and opportunities in South Africa – a university perspective

Marsha Orgill, Nonhlanhla Nxumalo, Woldekidan Amde, Ermin Erasmus, Uta Lehmann, Jane Goudge and Lucy Gilson

The last two decades have seen growing international recognition of the need to strengthen health systems in order to deliver already available, cost-effective health interventions. This chapter describes the parallel global growth of the field of Health Policy and Systems Research (HPSR) and outlines what this field of research is and what it is not. The chapter also clarifies how HPSR can contribute to strengthening health systems. The particular relevance of HPSR in SA is discussed, given the range of health system transformation initiatives in place. Drawing both on an HPSR capacity assessment conducted in three

universities and discussions with a wider group of researchers and health system managers, the chapter also considers the existing assets for and challenges facing the development of the field in South Africa. It closes with suggested strategies and priorities for developing and building capacity in this field nationally

Introduction

In November 2012, approximately 1 600 researchers, managers, and health activists met in Beijing for the second Global Symposium on Health Systems Research. The symposium saw the launch of two landmark activities for this burgeoning community: 'Changing Mindsets', the World Health Organization (WHO) strategy on Health Policy and Systems Research,1 and the community's new society – Health Systems Global.

These events represent the most recent milestones in the formal development of the field of Health Policy and Systems Research (HPSR), which has slowly emerged since the late 1980s. As Box 1 outlines, critical events include the establishment of the Alliance for Health Policy and Systems Research, the WHO World Health Report of 2000, two Ministerial summits and their related resolutions (2004, Mexico and 2008, Bamako)2-4 and the first Global Symposium on Health Systems Research, held in 2010 in Montreux, Switzerland.

HPSR starts, therefore, with concern for the health system, the platform from which health services are delivered, and how that system can be strengthened. (See Box 2) It includes concern for how to promote the intersectoral action needed to address the social determinants of health. Several health system conceptual frameworks provide guidance for such research, as well as for action to strengthen health systems. All emphasise the ways in which different system dimensions or elements interact in generating system outcomes. The WHO framework, for example, specifically highlights six building blocks and stresses that: [a] health system, like any other system, is a set of inter-connected parts that must function together to be effective. Changes in one area have repercussions for elsewhere. Improvements in one area cannot be achieved without contributions from others.

Interaction between building blocks is essential for achieving better health outcomes. Therefore, while the longer-established field of health services research tends to focus primarily on service delivery issues, HPSR has a strong focus on the system elements that underpin service delivery (such as financing or human resource issues) and requires that all elements, including service delivery, are considered in relation to their place within and their contribution to the whole system. A 2012 paper on access to medicines provides a good example of this approach.11 HPSR also, for example, encourages consideration of how a specific service (e.g. provision of antiretroviral therapy) influences the system as a whole, or how system interventions, such as management strengthening, influence particular services.

http://www.hst.org.za/sites/default/files/Chapter12_HealthPolicy.pdf

3.

Crises, Routines and Innovations: The complexities and possibilities of sub-district management

Soraya Elloker, Patti Olckers, Lucy Gilson, Uta Lehmann

Districts and sub-districts are crucial to the functioning of the district health system and the successful implementation of health sector reforms, which have been at the centre of public debate in the past few years. While policy intentions and service challenges are much debated, little systematic discussion is held about the internal operations and functioning of sub-districts and districts. These dynamics will strongly influence the implementation of the reforms proposed.

This chapter discusses the complexities and challenges of managing a sub-district, using as a case study the Cape Town sub-district of Mitchell's Plain. Drawing on debates in systems thinking and management theory the role of districts and subdistricts at the interface between strategic policy direction and operational service implementation is discussed. The chapter uses experience from an action learning project in Mitchell's Plain to present examples of innovation aimed at strengthening leadership and routine management functions. We argue that routine management in an environment of stress, constraints and uncertainty requires that managers be resilient, reflective, and continuously able to learn, analyse and adapt. Management and leadership development programmes should focus on developing these capabilities (within and beyond the classroom), in addition to developing technical skills and capacities.

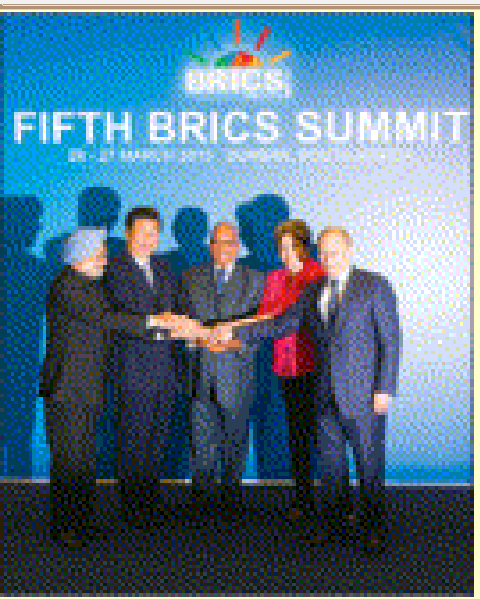
Introduction

The district is the cornerstone of South Africa's health system. Since 1995 a series of policies and interventions have contributed to shaping the South African District Health System (DHS) in its present form. These policies and interventions have ranged from establishing district boundaries to clarifying the relative roles of provincial and local government in delegating authority and drawing up district health planning processes. The 2011 proposals for both Primary Health Care (PHC) re-engineering and National Health Insurance (NHI) reaffirm the foundational role of the DHS within the health system and as the vehicle through which PHC will be delivered. A core objective of the NHI pilot sites is the development of innovative ideas about how to strengthen the DHS.

Alongside structural and organisational innovations and interventions have been discussions and concerns about standards and the performance of the DHS. Politicians, officials, media and researchers have frequently pointed to uneven and often poor access to and quality of health services throughout the country. The Health Systems Trust's annual District Health Barometer provides publicly available data on key indicators of structure and performance across all health districts in the country, which reflect vast unevenness in performance. One of government's responses to its growing concern with quality and performance has been the move towards the establishment of an Office of Health Standards Compliance which will audit standards of care, from patient rights to infrastructure and clinical support in health facilities.

But while poor quality and inequitable access to health services are acknowledged, in contrast, little information is formally available about the dynamics, opportunities and challenges of routine operations in a South African health district (although the 2001 South African Health Review did air the voices of district managers). Yet change in the organisational culture of the South African health system is recognised as a key requirement for implementing current policy priorities and improving performance and quality of care.

http://www.hst.org.za/sites/default/files/Chapter13_CrisisRoutinesInnovation.pdf



The Lancet

Banking on the BRICS for Health?

Leaders of the BRICS (Brazil, Russia, India, China, and South Africa) nations met in Durban, South Africa, last week (March 26—27), for their fifth annual Summit, and made an intriguing decision: to establish between them a new development bank.

The bank would mobilise resources for infrastructure and sustainable development projects in BRICS and other emerging economies and could one day rival the World Bank and International Monetary

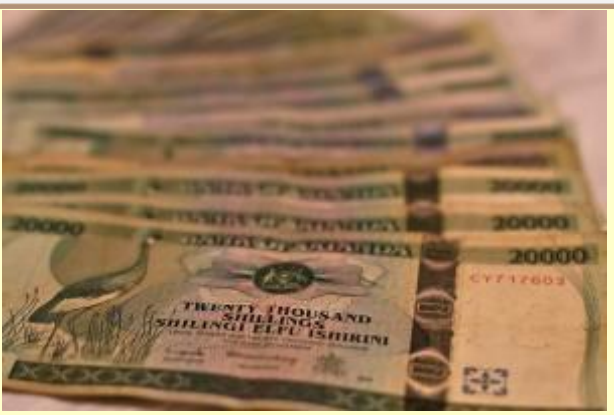
Fund. However, the BRICS leaders could not reach an agreement over the bank's size and infrastructure at the Summit. Some observers have since speculated that it could take years to negotiate contributions from the countries, the location of the headquarters, and the appointment of a leader for this first BRICS institution.

But there are additional issues. A true development bank should support health as well as infrastructure. However, in the final communiqué from the Summit, health issues were notably absent. Furthermore, there was no mention of the Delhi communiqué, agreed by the BRICS health ministers in January, which identified several priority areas for the nations, including non-communicable diseases, mental disorders, multidrug-resistant tuberculosis, malaria, and HIV/AIDS.

This omission is disappointing considering the huge health challenges these emerging economies face. As The Lancet's Series on Health in Europe showed, life expectancy in Russia is shockingly low when compared with countries in western Europe, largely because of high levels of alcohol and tobacco use. China's number one health threat is now non-communicable diseases; the country has the highest prevalence of chronic kidney disease and diabetes in the world. South Africa, meanwhile, has so-called colliding epidemics: HIV and tuberculosis; chronic illness and mental disorders; injury and violence; and high burdens of maternal, neonatal, and child illness and deaths. And, in our 2011 Series, we noted that “a failing health system is perhaps India's greatest predicament of all”.

These issues are hard to ignore, especially as they represent threats to both the health and economies of these nations. If a BRICS development bank does emerge, a focus on improving population health could be its wisest investment.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60781-3/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=E24A35F



Uganda Government under pressure to boost ARV Funding

KAMPALA, 14 March 2013 (PlusNews) - The Ugandan government's draft 2013/2014 budget allocates US$38.5 million to enrol a further 100,000 people living with HIV on life-prolonging antiretroviral (ARV) drugs. But activists say the money, while welcome in a country still largely dependent on donor funds for its HIV programmes, is not sufficient to meet treatment needs.

"With the current allocation and funding, we still have a long way to go," said Raymond Byaruhanga, the executive director of the AIDS Information Centre (AIC). "We need the government‘s commitment to increase the number of people on ARVs and decrease the number of those getting HIV if we are to achieve universal access."

The country enrolled an estimated 65,493 new HIV patients on ARVs in 2012, bringing to 356,056 the number of those on ARV therapy (ART), according to Uganda AIDS Commission statistics. However, this figure represents less than 70 percent of those in need of treatment. The government has set a target of reaching 80 percent of HIV-positive people with ARVs by 2015.

"The government efforts to contribute more funding for adding more patients on ART is commendable. However, we still need additional resources for scaling up on evidence [-based] interventions in order to be in position to halve the new infections," Monica Dea, senior programme advisor for the US Centres for Disease Control in Uganda, told IRIN.

Playing catch up

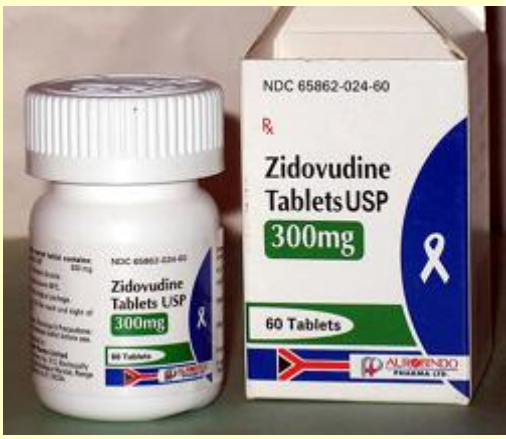
Uganda has seen its HIV prevalence rise from 6.4 to 7.3 percent over the past five years. Experts say the rising prevalence means the government must work doubly hard to ensure even more people are placed on treatment, especially given recent research showing ARVs have a role in preventing HIV transmission.

But limited funding, frequent drug stocks outs, too few CD4 count machines - which measure patients' immune strength - and understaffing in the public health sector continue to hamper plans to achieve universal ART access.

According to Alex Ario, programme manager at the health ministry's AIDS control programme, the financial gap in the public sector for 2013/2014 is about $29 million.

"WHO [the UN World Health Organization] is changing its treatment guidelines in the coming months in order to act on exciting new science that shows that treatment saves lives and is one of the most powerful HIV-prevention tools available. This means that in 2013, the number of people in Uganda clinically eligible for treatment will expand beyond just those whose CD4 is less than 350," Asia Russell, director of international policy at the Health Global Access Project (Health GAP), told IRIN. "Despite this, the draft Budget Framework Paper for the health sector proposes no increase in investment for HIV treatment."

"Ugandan civil society is calling on the government to substantially increase its investment in ART for financial year 2013/14 in order to save lives, slash rates of new infections, and begin to end the AIDS epidemic," she added.



Corruption

Activists have also expressed disappointment in a local pharmaceutical plant - started in 2007 and jointly owned by a local company, Quality Chemicals Industries Limited (QCIL), and Indian generics giant Cipla Limited - that was expected to improve treatment access by providing cheaper ARVs locally. However, the factory's drugs have remained overpriced, and the plant is currently embroiled in a $17.8 million corruption scandal.

In a 20 December 2011 report to Uganda's President Yoweri Museveni, then acting government anti-graft boss Raphael Baku noted that between December 2009 and October 2010, the government's National Medical Stores (NMS) paid $17.8 million more than it should have to QCIL, in violation of its Memorandum of Understanding (MoU) with the government. The funds allocated for ARV procurement in the budget are intended for purchasing drugs manufactured by QCIL.

QCIL and NMS are accused of manipulating the MoU in order to achieve a 15 percent mark-up on imported drugs; the mark-up had actually been intended only for locally produced drugs. QCIL is also accused of continuing to sell imported drugs manufactured by Cipla to the government at inflated prices even after it started producing its own drugs.

QCIL denies the allegations. The inspector general of government, anti-corruption activists and HIV activists have demanded the government recover the funds and prosecute those involved.

"Our government is good at creating institutions, but when it comes to implementing their recommendations, it fails," said Cissy Kagaba, the executive director the Anti-Corruption Coalition Uganda (ACCU). "We demand for an immediate action on the reports of the oversight government organs to specifically recovery all the monies lost. This is the taxpayers' money."

Asuman Lukwago, the permanent secretary at the Ministry of Health, told IRIN that action would be taken on the reports.

"[ARVs] should be readily available to all who need them because they are life-saving drugs. I think it is treacherous for someone to overprice the drugs because this makes them inaccessible to the most vulnerable, who will most likely end up dying," said Stephen Watiti, a senior medical officer at Mildmay Uganda, an HIV treatment centre close to the capital, Kampala.

New ways to fund HIV programmes

According to Ario, the government is seeking alternative ways to fund ARVs. "Strategies are being explored to increase domestic HIV funding, such as establishing the HIV Trust Fund," he said.

The Ugandan government recently developed a draft working paper on establishing this $1 billion fund for its HIV/AIDS programmes.

"I support the establishment of a trust fund by adding a levy on such items like beer, cigarettes, airtime or introducing an AIDS tax to make sure all money needed to sustain ART is available instead of depending on donors [for] 80-90 percent, as is the case at the moment," said Watiti.

[This report does not necessarily reflect the views of the United Nations]

http://www.plusnews.org/Report/97651/Uganda-government-under-pressure-to-boost-ARV-funding

SOPH's Prof Brian Van Wyk on the run...

Prof. Christina Zarowsky

Here is a lovely photograph of our Very Own Endorphin Intoxicated Prof Van Wyk at km 39 of the Two Oceans Ultramarathon. I thought we could put a small blurb in the newsletter pointing out that SOPHers are not couch potatoes! We participated en masse in the Diabetes 10K walk and run over a year ago, we ran and helped and raised funds for the Sartjie Baartman Centre in the UWC Fast and Flat 10km last May, several colleagues regularly run local races (Trish Struthers has shared the secret of the Milkwood 21), and we have a strong contingent of Two Oceans runners. Brian and Christina have now each run one ultra, Wim Van Damme was fully converted to Cape Town after running the Ultra 2 years ago, and Hazel, Helen, Tami, Christina and maybe others have run the 21km. And will continue to do so! Get out there and join us - there are GREAT cheering crowds and supportive signs (such as "It's a hill - get over it!", "Who needs toenails?", "The pain will end, the glory lasts forever").

Saying "Thank You" to Prof Uta Lehmann, former Director of SOPH…

Dr Vera Scott

Uta, one of the stewardship roles that you took on as director, was to give life to a set of values and an organisational culture that enables us as staff here at SoPH to feel valued, recognised for our contribution and supported in our work. This you have done very well. You have been aware of and sensitive to our various life stages and situations. You have supported us so that we can contribute fully and passionately in an environment where there is both accountability and space to grow. You have also encouraged us to jointly develop a sense of community, both in terms of community of practice and in terms of a healthy and happy workplace where we can all, admin and academics with a range of disciplinary backgrounds, feel at home.

So tonight, we come together as the extended SoPH family, and as a family we say 'thank you' for the role you have played as director over the last 4 years. We have invited the youngest members of our family to sing to you this evening:

Uta you have seen us grow
You're a star our parents know
In a busy world so bright
You have been a steady light
Thank you for your constant care
Taking time to play and share

(performed by the children of SOPH staff once to the tune of Twinkle, Twinkle Little Star, and again as a rap)

Farewell to Charmaine Johnson…

Prof Rina Swart, Deputy Dean

Charmaine was a carer at heart, and a very generous one for that matter. She did not reserve her caring for her core family only. Her heart had many rooms and she also cared for everybody who she had contact with as if they were family. Within the faculty office Charmaine had a quiet loving way, with her inviting smile and infectious laugh, she made everybody feel part of the CHS family – from the Dean, to an administrative officer to a student alike (she had seen at least five new Deans during her 22 years in the Faculty office and many more administrative officers and student assistants).

Charmaine's passing leaves a void in the lives of Faculty staff. "Every day we meet many people and most of them you do not remember. And then comes a day when you meet somebody who changes your whole outlook on life. Charmaine was a colleague, a friend, a mentor and a mother figure to me. She always looked out for me and for everybody else in the faculty. Always generous"

Charmaine Johnson

Acknowledgements: Thanks for contributions to the April 2013 SOPH Bulletin to:
Christina Zarowsky, Penny Morrell, Tamlin Petersen, Emma Chademana, Vera Scott, Rina Swart