



# SoPH BULLETIN

The UWC School of Public Health Newsletter

February 2013

***New Leadership at the Helm!  
All good wishes to you!***



***Prof Helen Schneider, new Director of  
the School of Public Health***



***Prof Jose Frantz, Acting Dean of  
the Faculty of Community and Health Sciences***

***Prof Uta Lehmann***



## ***Interview with Prof Uta Lehmann, outgoing Director of SOPH***

**Shun:** Leading a School of Public Health no doubt comes with its own challenges and opportunities! What were the some of the institutional and operational challenges and opportunities that you faced as Director of SOPH?

**Uta:** I had quite a long lead-in time because I was acting Director before I took over the directorship of the School. So I felt quite familiar with the work. In addition Prof. David Sanders – the first Director of SOPH - and I had been working together for a long time and we had a shared vision. He had mentored me so there was continuity.

A key challenge at the time was that we came out of a period when the School had grown quite rapidly. At the time we had very cramped accommodation. We had been so busy building our work we hadn't paid enough inward attention to the health of the organisation. So we initiated a process with Sue Davidhoff and Alan Kaplan in 2007 to pay attention to what was going on in the centre of the organisation: we had to deal with issues of organisational structure as well as spaces where we could engage intellectually within the School.

Out of this process came our weekly Journal Club, the new organisational structures of Academic, Research and Administration Domains. It was also in this process that we decided to rotate the directorship of the School amongst our senior staff. A full-time directorship of a large School is not really a feasible option in an academic environment, as it carries little incentive. And yet, leading and managing a School of the size ours is now is a fairly full-time job, if you want to do it justice.

*Shun: Was this a kind of 'new thinking' in the larger context of the university?*

*Uta:* Well, UWC at the time only had very few Schools, and each of them emerged out of very specific contexts and histories and were structured to suit these contexts. Some had permanent heads and a number of departments under them, like the School of Government. Others were a one unit, with an elected head, like the School of Pharmacy. So our context was and is also specific, and we have tried to shape the SOPH to take cognizance of that: we are a post-graduate outfit; we have a very large research portfolio; we work very closely with the health service; we have a distance education programme. All of this is different from what most departments and even the other Schools do. Not better or worse, just different. This has now changed and is more alignment, but there are still differences in the way the Schools are configured.

I recall the words of David Sanders at his valedictory event last year where he said that at the time when he was building the School the administration of the university was so loose that you could drive a bus through it! And he thought that's how it should be! I think that's been the big change institutionally. When we built the School we had a lot of creative space. As long as we stuck to the basic rules and were successful and graduated students and brought in grants, we were given a lot of leeway.

The other challenge, surprisingly has been the building! I took over as Director as we were moving from our old premises to this new building. And we discovered that being in a big building presents a lot of challenges. We are dispersed, we don't see each other. It is much more difficult to have quick engagements regarding work. It is also difficult to maintain close relationships when you are physically so far apart from each other. It is no longer possible, as it was in the past, to 'call colleagues down the corridor'. Now we don't know who is in the building. This is an ongoing challenge. It's tricky. We've tried to institute ways to bring people together, like the Monday teas, but everybody is also very busy.

*Shun: How does one cope personally - as an already committed full-time academic - with the additional load of responsibilities of leadership?*

*Uta:* One of the things in my view that applies both for the university and the School's leadership has to do with how one leads an organisation. I'm a very firm believer that all you can do, all you should do, in any organization, but particularly in an academic organization, is build an environment where people can grow, where they want to work and collaborate. It's very much about relationships.

You can force an organization to conform and people to conform, but you cannot force

I think the biggest institutional challenge for us has been that those spaces are narrowing. To some extent this is understandable because the university at the larger institutional level has to have more of a handle on what's going on. There is a need for better processes because there needs to be accountability. And we have seen of incidents of abuse in the University, where the trust of funders and others has been exploited. Thus some of the controls had to be tightened around grants and money

But I also think that it is a huge threat to the creativity of the university – in fact a threat to any academic institution – if you close these spaces completely. That's a real battle at the moment, and one that I certainly have fought. If there are too many rules and regulations – too much bureaucracy – then one does not have the space to do the creative things. I see a real danger which could eventually threaten some of our flagship programmes like the Winter School and some of our innovative research. Ultimately the measure of accountability should be two things: whether our activities create public value, advance the common good of this country; and whether we spend the money we are given to serve this purpose responsibly and legitimately.

people to perform. For that you have to have buy-in. You can force people to stick to the rules, but you need buy-in to get people to do new things, to do them creatively, to push themselves.

That's a challenge which grows exponentially as the organization grows, simply because there are more and more and different people who need to work together, depend on each other, get along with each other – and work very hard. When we started we had a few like-minded people and we could have a meeting over tea and then go out and do what was decided on. But the bigger the organization got the more structure it needed. It is tricky to get the balance right: how much accountability do you need to ensure that things get done and resources not abused versus when does it become stifling and merely a control mechanism? That's not something you get right once; it is a constant balancing act.

*Shun: You raised issues as challenges to management and leadership of an organization. What opportunities did you encounter in this regard?*

*Uta:* It has been about trying to create spaces for all of us to do what they're good at and what we enjoy. What we have been able to do is to attract an amazing team of people across the board. Of course, there are some people who are more creative and hardworking than others, and that brings its challenges. One has to sometimes be more directive with such persons, particularly when there is the pressure to get things done. In the main however, we have a group of people who are passionate about what they do. This is true both for our academics and our administrative support staff. Sometimes the administration team does not see sufficiently that they have an own creative role to play. Wherever I go and talk to colleagues in another School or comparable environment, I think; 'we are so incredibly lucky for the staff we have'. We made a strategic decision to invest quite heavily in having very good administrative and financial staff to help run this ship. There are very few institutions that have this. And for that to happen we need adequate financial resources, including the money that the School generates itself.

*Shun: The role that you had been called on to play and in which you grew and gained experience would have had some personal impact on you. You came into the directorship as a fully committed academic to take on the added responsibility of leadership. What did that mean for you, and how would describe your leadership style?*

*Uta:* What makes this job difficult, and why one cannot do it for too long, is that one has to invariably carry a pretty full academic load. The management of the School is additionally. I always said that I really enjoyed every piece of the

job. I enjoyed being director and giving shape to the direction of the School, as much as I enjoy my academic work and leading on a number of research projects. I enjoy the teaching and supervision of students in particular.

All of the above is great but it is simply too much. When you get to the point where even if you work 24/7 you wouldn't do justice to all of the work, then it becomes unsettling because you start running behind even on important deadlines, and "good enough" too often replaces "the best I can give". In the last two years I felt this pressure all the time, which was mentally exhausting because you struggle to have new ideas. That is why it is so important to have a change and have someone come in who has new ideas which makes new things possible. Having time-limited directorship I think is very important for the School but also for the individual. I am happy to hand over the reins!

*Shun: What advice would you have about how to cope with issues such as the pressures on one's time, on one's workload?*

*Uta:* I don't know! It's an issue that we discuss among ourselves, how to find ways to achieve a better balance. When I look around at organisations that are similarly engaged, I see people there who are chronically overstretched. This applies equally to people who are actively engaged in the government health service sector.

I think that it has to do with the fact that we do not have enough depth in our human resources simply in terms of quantity as well as experience. If you compare us with other Schools overseas, they have broad bands of mid-level staff that carry a huge load. But this is changing in Europe too as resources are becoming limited with fewer people. It is probably a sign of our times.

*Shun: Leadership is lonely at the top. Did you have places where and people with whom you could share as Director in a trusted circle?*

*Uta:* I think there is an amazing team in the School and while I perfectly acknowledge that there are hierarchies, and some people have a keener sense of the hierarchy than others in the School, I do think that we have a relatively flat structure. We can engage with different staff regardless of whether they are senior or not. I found that relatively easy. That is not to say that in the end you as Director have to make some decisions, but there is ample space for collective decision making.

*Shun: What is your sense of the road ahead for the School?*

*Uta:* Compared to others, I think we are in an incredibly good space. We've been lucky that we've had a lot of resource support from outside. To name a few:

- We may have views about this building's architecture, but it gives us great possibilities for convening, for bringing people to us, for running meetings and workshops. In this regard the role that Atlantic Philanthropies played in providing the funding has been incredible.
- We now have the SARCHI chair from the NRF.
- The new Director, Prof. Helen Schneider, is eminently well prepared to take the School further.
- Compared to other organisation we are on a very sound financial footing.
- In some of our research niche areas we have really established ourselves very well.
- The fact that we will host the next global symposium as a Cape Town consortium is a feather in our cap.

There are areas of public health, however, where we could be doing more vanguard work to push the field further.

- We are talking right now among ourselves about our leadership role in public health education and education that is flexible – distance education – and how we can hold the leadership in these areas and take it further. We don't have brilliant ideas at the moment and we have to give this urgent attention.
- There is a cluster of work around chronic and non-communicable diseases and social determinants of health which presents huge opportunities. We have pockets of work in these areas but it has not come together. These are key areas where we have to build capacity, get some good grants so that we can consolidate this work. Another area is health promotion and health promoting schools where we have done some good work but it is still fragile.

*Shun: Do you see that giving attention to the points you have raised, namely, growing depth and content in the public health research, teaching and learning, would lead to an expansion for the School, especially in light of the wider African focus of the School's engagement?*

*Uta:* It might mean some expansion. We have people who are broadly working in these areas but all in quite fragile situations, often on very short term contracts – sometimes shorter than a year, and on grant funding. This is what we have to stabilize. For this to happen we need big grants and pro-active people at mid-level and senior academic positions to drive this.

I am not so sure that we want to grow into a larger organization. Do we really want to be a School with two hundred academic staff? Obviously there are a lot of European and North American outfits that do work like that. If we wanted to go this route, we would have to completely rethink how we operate. In such a scenario we might then have quite independent Centres within a School, such as at Wits, with a Centre for Rural Health, a Centre for Health Policy, etc. This can be done, but then the School becomes more of an umbrella organization for its sub-units, with maybe its formal teaching holding the core. That's a different configuration and a different kind of operation. However, I see lots of advantages to being a medium-sized organization: it's easier to hold the whole together; there is more conversation across different sub-fields, more cross-fertilization. It would be sad to lose that.

If we grow too fast we would also run the risk of not paying attention to our core business anymore, which is training public health practitioners in Africa. We would shoot ourselves in the foot if we did not turn out graduates who have really good public health competencies and capabilities and are good at what they do. So for example, I don't think that we'd want to run

online courses for ten thousand students. That would be a different kind of undertaking.

I think that what we are doing now, namely focusing on strengthening the institutional capacity of other African institutions to run a solid public health programme possibly through flexible delivery, through partnerships and collaboration, is the key challenge and priority. I think that our public health education and services will ultimately suffer from 'massification' if we do not have very solid institutional and personnel foundations.

Shun: *What will you be doing over the next months?*

Uta: I am hoping to write up a lot of my research of recent years for publication. Also with all the health systems work we are doing, with the new SARCHI chair being established and the global health systems symposium we will host together with UCT, US, MRC and HST, there will be a lot of work to be done. This provides us with a huge opportunity but also hard work ahead!

## Utilising mHealth Technology for Supervision, Monitoring and Evaluation of Primary Health Care (PHC) Outreach Teams



By **Sunisha Neupane**

**Project team: Sunisha Neupane, Tanya Doherty, Sarah Rohde, Willem Odendaal, Helen Schneider**

***At times, merely a phone-call or a text can alleviate a helpless situation in a health emergency. According to World Health Organization (2010), 1.3 billion people have no access to health services. Few would disagree that financially, emotionally or physically it is difficult for disadvantaged populations to seek needed health care or to move to areas with better health care facilities. With advancing technology and communication, one would think it is plausible to make health care services accessible to all. However, that is not the case. While there has been significant progress in making health care available in remote and less affluent areas, challenges still persist in many communities.***

One of the ideas adopted to improve health care consultation, medication and support to people living in remote areas is e-health. E-health is an approach, which uses the medium of electronic communication to enhance access to health care services. One of the examples is usage of mobile phones to monitor different health programs or to send information via text messages to ultimately improve health outcomes. This process has its own term- mHealth (mobile health). mHealth aims to improve health outcomes of people by bringing behavioral changes or by collecting, sharing and monitoring health data, using a mobile phone. This technology has been used in both developing and developed countries to monitor weight loss, physical activity, adherence to chronic medication, promoting smoking cessation, hypertension



treatment, and improving maternal and child health. There are a few different ways to use a mobile phone; occasionally software applications are installed on the mobile phones (especially for data acquisition). Another method is to use sms as a communication tool between clients and health care workers. A client can be informed about health information such as when to seek care, who to contact or how to deal with a certain disease. mHealth has the potential to bring a substantial change in education and awareness, data collection, monitoring, training, tracking diseases (especially epidemic) and treatment support within a short time with limited human resources. mHealth has an advantage of being user friendly therefore anyone familiar with the use of a mobile phone can use it without difficulty .

The University of Western Cape, School of Public Health (UWC-SOPH) has embarked on an mHealth project. UWC-SOPH in collaboration with Health Systems Trust and the Medical Research Council is on the verge of completing a six-month mHealth pilot project for PHC outreach teams. The technology partner is mobenzi ([www.mobenzi.com](http://www.mobenzi.com)). The project, which started in August 2012, has developed an mhealth platform, which allows community health workers (CHWs) to enroll different categories of PHC outreach clients including pregnant women, postnatal women and their new-borns, children under-five and clients on chronic treatment such as HIV/ AIDS, diabetes, high blood pressure, and mental health who need to be provided with adherence support. The system has been developed in line with the national CHW training curriculum.

The system has a web based management console where supervisors and other stakeholders can log in and see the CHW activity real-time and can generate required reports and data. The system has built in visit scheduling for certain client types which require a tight schedule of visits (i.e. antenatal and postnatal clients) as well as automated messages to the team leader when the 'national CHW protocol' is violated such as when visits are scheduled out of range. Phones were also placed at all referral clinics and the sub district hospital where births take place to enable facility-based health workers to receive notifications of referrals from CHWs and to respond to these with the outcome of the referral, and for health workers to notify CHWs of a birth.

The North West Province was chosen for the pilot site since UWC and HST have been working in this province to develop the paper based monitoring and evaluation (M&E) system for outreach teams. The PHC Re-engineering Task Team identified sub-district Taung for the pilot study since it was a deeply rural area, with one of the first established outreach teams. Dr. Irwin Friedman, a public health physician, has played a crucial role in undertaking a monthly support visit to the team for ongoing training. The team on site consists of a team leader (a nurse, who is staff of Greater Taung Sub-district Department of Health) and ten community health care workers. The CHWs each have between 150-200 active clients. The CHWs were given Nokia C5-00 phones and the team leader a Samsung galaxy tablet.

The surveys on the cell phone are adapted from the District Health Information System (DHIS) M&E forms for PHC outreach teams and at the end of every month the DHIS monthly report can be exported from the system. The most exciting aspect of this system is its capacity to enable referral and back referral of cases to and from clinics, through tracking of the outcomes of referrals. During any visit types, CHWs have the option to refer their clients to the clinic. After checking for updates in their Nokia phones, facility staff will see each referral on the phone at their clinic. Clients are encouraged to follow up their referral to the clinics within 14 days. If the client arrives at the facility within the recommended 14 days, the facility manager captures the outcome and sends it back to the respective CHW via the mobile phone provided. Thus, this process provides an effective mechanism to track the referral from patients to the health facility and vice versa. The data collected is instantly available to the managers and the team members, which can be used to generate performance reports and guide planning processes for outreach team activities. Along with the afore mentioned benefits there are additional benefits of the system, which are listed below.

- A record keeping system is established for each patient attended by the CHWs, hence good documentation is established for follow-ups.
- Enhanced maternal and child health and treatment adherence support.
- Demonstrates the workload, need and efficiency of the CHWs.
- Enables routine data collection, which can be beneficial for reporting, decision-making and monitoring and evaluation.

- The team leader or managers are able to provide timely and immediate CHW visit support, guidance and education when needed.

This is a project with enormous potential in terms of improving health care accessibility. In addition, the project has a two-fold benefit of collecting data promptly and in a systematic manner and also aims to improve the health outcome of clients (maternal health, child health and treatment adherence) by providing timely visits and referral to health facilities as necessary. The whole team is working hard to ensure the success of the mHealth system and to demonstrate to the district health managers how this system can be valuable. It is hoped that the system can prove itself and that it can be introduced at other sites for phased scale up.

## Lessons from the field

# 1

## Eliminating Mother-to-Child HIV Transmission in South Africa

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**Problem** The World Health Organization has produced clear guidelines for the prevention of mother-to-child transmission (PMTCT) of the human immunodeficiency virus (HIV). However, ensuring that all PMTCT programme components are implemented to a high quality in all facilities presents challenges.

**Approach** Although South Africa initiated its PMTCT programme in 2002, later than most other countries, political support has increased since 2008. Operational research has received more attention and objective data have been used more effectively.

**Local setting** In 2010, around 30% of all pregnant women in South Africa were HIV-positive and half of all deaths in children younger than 5 years were associated with the virus.

**Relevant changes** Between 2008 and 2011, the estimated proportion of HIV-exposed infants younger than 2 months who underwent routine polymerase chain reaction (PCR) tests to detect early HIV transmission increased from 36.6% to 70.4%. The estimated HIV transmission rate decreased from 9.6% to 2.8%. Population-based surveys in 2010 and 2011 reported transmission rates of 3.5% and 2.7%, respectively.

**Lessons learnt** Critical actions for improving programme outcomes included: ensuring rapid implementation of changes in PMTCT policy at the field level through training and guideline dissemination; ensuring good coordination with technical partners, such as international health agencies and international and local nongovernmental organizations; and making use of data and indicators on all aspects of the PMTCT programme. Enabling health-care staff at primary care facilities to initiate antiretroviral therapy and expanding laboratory services for measuring CD4+ T-cell counts and for PCR testing were also helpful.

<http://www.who.int/bulletin/volumes/91/1/12-106807.pdf>

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## Social Circumstances that drive early Introduction of Formula Milk: an exploratory qualitative Study in a peri-urban South African Community

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### Abstract

Breastfeeding is widely endorsed as the optimal strategy for feeding newborns and young infants, as well as improving child survival and achieving Millennium Development Goal 4. Exclusive breastfeeding (EBF) for the first 6 months of life is rarely practised in South Africa. Following the 2010 World Health Organization (WHO) infant feeding recommendations (EBF for HIV-positive mothers with maternal or infant antiretroviral treatment), South Africa adopted breastfeeding promotion as a National Infant Feeding Strategy and removed free formula milk from the Prevention of Mother-to-Child Transmission of HIV programme.

This study aimed to explore the perceptions of mothers and household members at community level regarding the value they placed on formula feeding and circumstances that drive the practice in a peri-urban community. We conducted in-depth interviews with HIV-positive and HIV-negative mothers in a community-randomised trial (Good Start III).

Focus group discussions were held with grandmothers, fathers and teenage mothers. Data were analysed using thematic analysis. The following themes were identified; inadequate involvement of teenage mothers; grandmothers who become replacement mothers; fear of failing to practise EBF for 6 months; partners as formula providers and costly formula milk leading to risky feeding practices. The new South African Infant Feeding Strategy needs to address the gaps in key health messages and develop community-orientated programmes with a focus on teenage mothers. These should encourage the involvement of grandmothers and fathers in decision making about infant feeding so that they can support EBF for optimal child survival.

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<http://onlinelibrary.wiley.com/doi/10.1111/mcn.12012>

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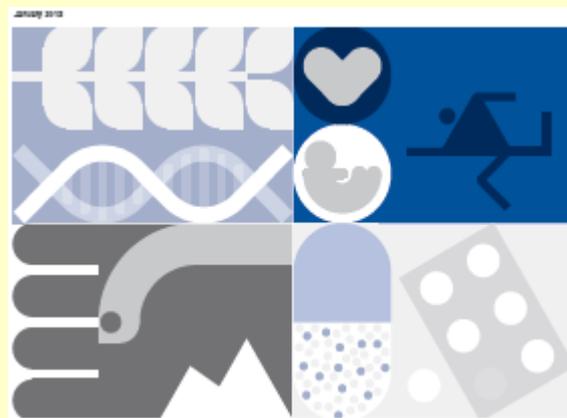
# International Health Policies

headlines in global health policies and reactions from global south experts

*Executive Summary*

Achievements and advances in health and healthcare are a major success story of the past two centuries. However, this success has come at a cost, with healthcare expenditure outstripping GDP growth for decades across the Organisation for Economic Co-operation and Development (OECD) countries. Given the main reasons for rising health expenditures, it is unlikely that focusing solely on improving healthcare supply efficiencies will lead to sustainable health systems in the future. Instead, societies must look outside the traditional institutions, processes and people, known today as the healthcare system, to a broader emerging health system that this report proposes.

In today's economic climate, many governments are targeting healthcare expenditure for cost-cutting as part of broader austerity programs. A discussion on long-term sustainability therefore is timely to ensure that short-term priorities do not damage long-term value. Health system leaders need to think for the future, expanding the group of responsible stakeholders and breaking from the status quo to deliver high quality, full-access, affordable, sustainable health services.



Over the past year, the World Economic Forum, in collaboration with its Partners and McKinsey & Company, engaged over 200 health system leaders, policy-makers and experts in an ambitious global effort to provide a long-term and holistic analysis of sustainable health systems. The central question: what could health systems look like in 2040?

Looking to the future helps to improve the decision-making of today. A longer-term perspective provides an intellectual space devoid of current constraints, vested interests or immediate concerns, and enables us to focus on what really matters. Focusing 30 years ahead, the important trumps the urgent.

Participants used a set of complementary methods, including visions, strategies, critical uncertainties and scenarios. This report presents the thoughts of leading experts and decision-makers on the future of health systems, highlighting the learning and key messages derived. The aim is to equip policy-makers and business leaders around the world with tools, processes and insights to drive the discussion in their own organizations and countries.

*Visions*

A diverse group of health system leaders across five countries was asked to describe their ideal health system in 2040. Their visions are remarkable in their consistency. The preferred health system of the future is strikingly different from the national healthcare systems of today, with empowered patients, more diverse delivery models, new roles and stakeholders, incentives and norms. The country workshops revealed common themes across system archetypes and national borders: creating a financially sustainable health system requires a major re-orientation towards value and outcomes, the involvement of a broader set of stakeholders in a more effective governance structure, and greater engagement and responsibility of patients and citizens.

*Strategies*

With the visions in mind, participants suggested strategic options to achieve those aspirations. From the conversations, three major themes emerged:  
 – Embrace data and information to transform health and care. We are entering the age of precision medicine, fundamentally challenging the past practice of medicine. Improved data

and information are beginning to change the way that health systems operate and make decisions, a transformation that can be enabled by faster and more productive adoption and integration of these data

- Innovate healthcare delivery. While the boundaries of medicine exist at the limits of science, the healthcare delivery model is firmly stuck in the past. Health systems can rise to the challenge of a 21st century disease mix, breaking the traditional delivery mould and creating space and opportunity for innovation to deliver better professionals, better outcomes and better value

- Build healthy cities and countries of the future. To achieve a sustainable health system for the future, societies must reshape demand for health services, reducing the disease burden by helping people to stay healthy and empowering them to manage their health. Health systems can encourage people to develop healthier habits, incentivize healthier consumption and develop an environment and infrastructure that facilitate population health

### *Critical uncertainties*

Future health systems will be influenced by a number of factors outside the control of health system leaders. Through over 100 interviews and workshops, six critical uncertainties that might significantly reshape the context in which health systems form and operate were identified:

- Attitudes towards solidarity: Will solidarity – the willingness of individuals to share the population's health risks – increase, decrease or be conditional upon certain factors?

- Origins of governance: Will power and authority be predominantly located at the national, supranational or local level?

- Organization of the health innovation system: Will innovation come from within or outside the existing system? What will be the level of funding? What will be the types of innovation produced?

- Access to health information: Who will take responsibility for collecting and analysing health data? Will people give their consent for their personal data to be used?

- Influence over lifestyles: To what degree will active influence over individual lifestyles be accepted and implemented?

- Health culture: Will healthy living be a minority choice, a civic duty or an aspiration?

### *Scenarios*

As the critical uncertainties demonstrate, health systems very different from those of today are highly plausible in the future. It will be important for policy-makers and industry leaders to be mindful of this when reflecting on strategies.

Scenarios are not forecasts or preferences, but plausible stories about the future. They depict relevant and divergent possibilities, providing a rich context for improving decision-making in the present.

Three scenarios were developed: Health Incorporated, New Social Contract and Super-empowered Individuals. The scenarios provided a key insight – efficiency gains are necessary to move health systems towards greater sustainability, but are insufficient alone.

In Health Incorporated, the boundaries of the health industry are redefined. Corporations provide new products and services as markets liberalize, governments cut back on public services and a new sense of conditional solidarity emerges.

In New Social Contract, governments are responsible for driving health system efficiency and for regulating organizations and individuals to pursue healthy living.

In Super-empowered Individuals, citizens use an array of products and services to manage their own health. Meanwhile, corporations compete for this lucrative market and governments try to address the consequences.

## ***Counselling and testing Children for HIV in South Africa***

On Jan 29, the South African Human Sciences Research Council issued the first national guidelines on counselling and testing children for HIV. These much-anticipated guidelines include manuals for HIV/AIDS practitioners on legal, ethical, and counselling issues related to HIV testing of children and adolescents. They were commissioned by the South African National AIDS Council to give technical support to the Department of Health.

In 2010, the South African Government launched a massive campaign to test 15 million people for HIV in 12 months. One element was to offer voluntary testing and counselling in schools, which raised concerns as to whether this delicate aspect would be handled appropriately. These new guidelines finally provide the information that was missing.

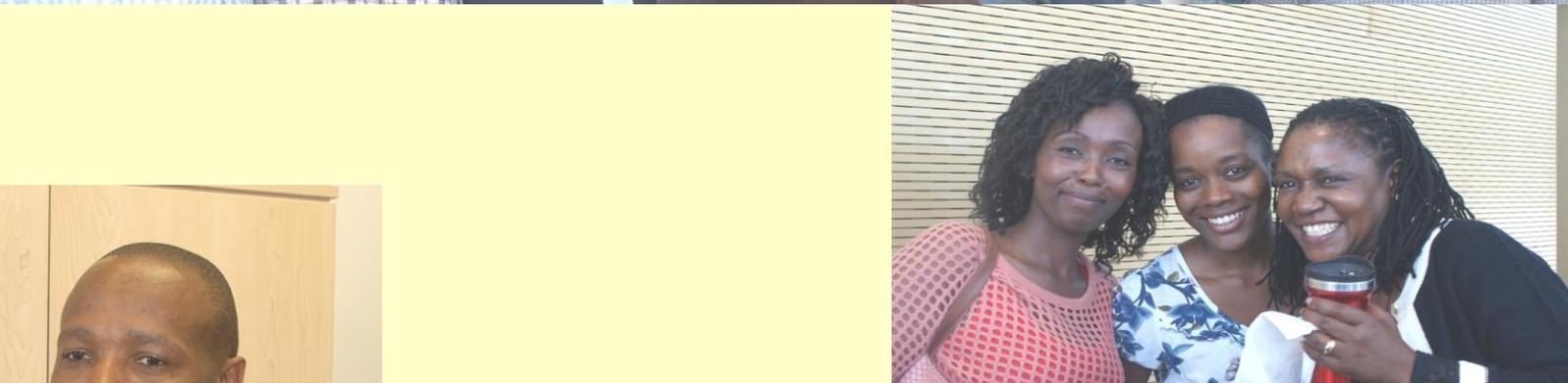
One controversial issue addressed in the guidelines is the assessment of the child's best interests and capacity to give informed consent. A child of 12 years or older can get tested without parental or guardian consent, providing that testing is in the child's best interests, they have been informed and show cognitive and emotional maturity to give consent (ie, knowledge, understanding, and appreciation of the risks and benefits of testing).

The importance of counselling before testing is also rightly emphasised: this stage permits the counsellor to encourage the involvement of parents or guardians, or to identify an alternative carer for the child. Counselling after testing enables the child to be informed about the implications of the result and referred for treatment and mental health services when needed. Other aspects such as disclosure, confidentiality, follow-up, or mandatory reporting of abuse are clearly explained.

South Africa's tremendous efforts in fighting HIV have resulted in about 1.9 million people taking antiretroviral therapy in 2012. The National Strategic Plan for 2011–16 shows increased attention to HIV prevention. The guidelines provide legal clarity and allow South Africa to continue on the right track, emphasising prevention, further reductions in mother-to-child transmission, and addressing stigma.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60229-9/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=E24A35F](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60229-9/fulltext?elsca1=ETOC-LANCET&elsca2=email&elsca3=E24A35F)

## ***Summer School 2013 Participants***



### ***Mlungisi Mbanjwa shares his Experience of Summer School 2013***

My name is Mlungisi Mbanjwa. I am a nuclear medicine technologist. I am from the Eastern Cape near Cofimvaba. I came to Cape Town in 1996 to do a BA in Dietetics here at UWC but I did not complete the degree. I worked for a few years and then did a course on radiography at Pentech. I qualified in 2003.

I completed my one-year community service in Durban at Addington Hospital. I also worked in Pretoria Academic hospital for a short while and thereafter was employed in a private practice in Rustenburg as a radiation control officer and manager.

I see a lot of patients from the public health system who are referred to us by one of the district hospitals. The state of these patients is one of the reasons that prompted me to go into public health. When you look at these patients you see that something needs to be done and I want to become an agent for change. What I noticed was the state of the illnesses of these patients. The state of the pathologies in public health is nothing that you see in private practice. They are very ill. They struggle with ambulances and transport. So for example, you have a booking for a patient at 8 o'clock in the morning but the patient arrives at 3 o'clock in the afternoon. There is no coordination within the hospitals. Patients come in dirty linen, their drips are blocked. It's sad.

This changed me and is why I have decided to study public health. At first I did not know much about public health. In 2009 I registered with Unisa for a post graduate degree in health sciences and social services management which I completed in 2012. I then applied and was accepted for the post graduate diploma in public health at the School of Public Health at UWC.

The Summer School is helping me. I didn't have an idea of the structure of the course other than what I saw in the modules. Now at Summer School one meets with and hears the lecturers and I have an idea what they expect from me. I did not have such contact classes when I studied at Unisa. This is very nice for me as a distance student. As a distance learner one has the time and the deadlines for the assignments but there is the temptation is to procrastinate, so one has to be able to manage one's time and pace yourself. There are also other challenges with distance study. Sometimes there are questions that one has which need to be discussed with the lecturer. If you send an email and maybe it takes weeks before you get an answer or sometimes you get no response.

### ***HIV/AIDS Conferences and Important Dates for 2013***

<b><i>Conference</i></b>	<b><i>Web Link</i></b>	<b><i>City</i></b>	<b><i>Dates</i></b>	<b><i>Abstracts due</i></b>
<b><i>5<sup>th</sup> Annual HIV In Context Research Symposium</i></b>	<a href="http://www.hivaids-uwc.org.za"><u>www.hivaids-uwc.org.za</u></a>	<b><i>Cape Town</i></b>	<b><i>13-15 March</i></b>	<b><i>08 February</i></b>
<b><i>6<sup>th</sup> SA AIDS Conference</i></b>	<a href="http://www.saaid.co.za/"><u>http://www.saaid.co.za/</u></a>	<b><i>Durban</i></b>	<b><i>18-21 June</i></b>	<b><i>30 January</i></b>
<b><i>2<sup>nd</sup> International HIV Social Sciences &amp; Humanities Conference</i></b>	<a href="http://www.asshhconference.org/"><u>http://www.asshhconference.org/</u></a>	<b><i>Paris, France</i></b>	<b><i>7-10 July</i></b>	<b><i>01 February</i></b>
<b><i>5th In Sickness and In Health International Conference</i></b>	<a href="http://www.isihconference.com"><u>http://www.isihconference.com</u></a>	<b><i>Montreal, Canada</i></b>	<b><i>18-20 July</i></b>	<b><i>31 January</i></b>
<b><i>9<sup>th</sup> International Association For the Study of Sexuality, Culture &amp; Society</i></b>	<a href="http://www.iascscs.org/2013conference/"><u>http://www.iascscs.org/2013conference/</u></a>	<b><i>Buenos Aires, Argentina</i></b>	<b><i>28-31 August</i></b>	<b><i>01 March</i></b>
<b><i>PHASA</i></b>	<a href="http://www.phasa.org.za/conference"><u>http://www.phasa.org.za/conference</u></a>	<b><i>Cape Town</i></b>	<b><i>25-27 September</i></b>	
<b><i>AIDS Impact</i></b>	<a href="http://www.aidsbarcelona2013.net/eng/"><u>http://www.aidsbarcelona2013.net/eng/</u></a>	<b><i>Barcelona, Spain</i></b>	<b><i>29 Sept-02 October</i></b>	<b><i>01 May</i></b>
<b><i>7<sup>th</sup> SAHARA Conference</i></b>	<a href="http://www.sahara.org.za/conferences/2013"><u>http://www.sahara.org.za/conferences/2013</u></a>	<b><i>Dakar, Senegal</i></b>	<b><i>7-10 October</i></b>	<b><i>28 February</i></b>
<b><i>ICASA</i></b>	<a href="http://www.icasa2013southafrica.org/"><u>http://www.icasa2013southafrica.org/</u></a>	<b><i>Cape Town/Durban</i></b>	<b><i>7-11 December</i></b>	<b><i>13 June</i></b>



## Call for Applications 2013-2014 CARTA PhD Fellowships

### *Background*

The Consortium for Advanced Research Training in Africa (CARTA) is an initiative of nine African universities, four African research institutes, and selected northern partners. CARTA offers an innovative model for doctoral training in sub-Saharan Africa to strengthen the capacity of participating institutions to conduct and lead internationally-competitive research.

The multi-disciplinary CARTA program is open to staff members from participating institutions who are interested in conducting their PhD research on topics relevant to the broad fields of public and population health. We welcome applications from disciplines, such as public health, demography, anthropology, economics, among others, as long as the research question aims to contribute to public and population health issues.

Over the medium-term, CARTA aims to produce a critical mass of high-quality graduates trained to address the complex issues surrounding health and development in Africa, retain them in the region, and provide them a vibrant intellectual environment, as well as viable and challenging research and growth opportunities. CARTA aims to achieve reforms in higher education by:

- 1) Assisting universities to develop enriching and vibrant academic and research environments; and
- 2) Supporting promising African scholars who teach at affiliated universities to obtain high-quality doctoral training in public and population health-related fields.

CARTA is currently offering a collaborative doctoral training program in public and population health. This program has been developed in response to the great challenges faced by Africa's institutions of higher education in addressing the training and retention of the next generation of academics in the region. Women are particularly encouraged to apply. CARTA has also reserved a small number of scholarships specifically for doctoral students conducting research on issues of sexuality and reproductive health and rights.

Specifically, CARTA seeks to fund candidates who will be future leaders in their institutions; that is, young, capable, and committed individuals who, in time, will ensure that their universities will be the institutions of choice for future generations of academics and university administrators wishing to make a positive impact on public and population health in Africa.

CARTA hosts a series of Joint Advanced Seminars (JAS) for cohorts of doctoral students admitted and registered in the participating African universities. Both the development and delivery of these courses are jointly-led by regional and international experts. The seminars consist of didactic sessions, discussions, demonstrations, and practice labs. These activities collectively serve to:

- 1) Expose students to key theories and concepts, seminal readings, and research methods of disciplines relevant to public and population health;
- 2) Train students in critical research skills; and
- 3) Build and maintain a network of researchers for scientific collaborations, professional support, and mutually beneficial exchange of scientific resources.

The advanced seminars are offered once annually for four years to each cohort and build skills and conceptual depth from year to year. Each JAS runs for 3 to 4 weeks. Specific topics covered in each JAS include the following:

- JAS-1 builds critical thinking, technical skills, and other core research competencies, and introduce students to the essential concepts and seminal articles of the disciplines brought together under CARTA
- JAS-2 focuses on data management and analysis. Fellows learn to use software packages for qualitative and quantitative data management and analyses. Practice sessions use real research data and current software packages for hands-on training
- JAS-3 focuses on data presentation, the doctoral dissertation, and scientific writing and communication skills to facilitate results dissemination and policy engagement

- JAS-4 addresses professional development including skills necessary to manage and teach large class sizes, raise and manage research funds, grant writing and research management. JAS-4 is also designed to serve as an opportunity for senior fellows to practice mentoring of junior fellows through discussions and laboratory sessions, software training, and general information sharing

During the 2013/2014 academic year, the CARTA program is planning to offer up to 25 PhD fellowships. The Fellowship, which is tenable at one of the participating African universities, includes the cost of fellows' participation in the advanced seminars; a modest monthly stipend; small grants for research activities; a laptop loaded with relevant software; funds for travel to conferences, as well as costs for participating in joint program activities. The fellowship runs for a maximum of four years. Fellowships cover tuition fees, medical insurance, and other university fees in special circumstances only. Partner institutions have committed to continue paying Fellows' salaries (or equivalent) and to modify workloads for the fellows to enable them to fully participate in CARTA organized activities pertaining to their PhD programme and also to concentrate on their PhD studies. Fellows are encouraged to seek supplemental funding to cover additional costs of their doctoral program.

For more information, visit the CARTA website [www.cartafrica.org](http://www.cartafrica.org)

## **SA committed to curbing maternal mortality**

President Jacob Zuma says despite South Africa being the last country to launch the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the country was set on using every opportunity to achieve the targets set out by the strategy.

"South Africa is committed to doing everything we can to decrease maternal and child mortality and to improve the lives of women and children, both in our country and on the continent," he said.

Speaking at a high level meeting of the CARMMA on the sidelines of the African Union Summit underway in Addis Ababa, Ethiopia, Zuma said government had developed a national dashboard to monitor progress in the implementation of the strategy.

With the aid of government's development partners, the country's provinces have been supported to strengthen their plans to achieve the goals of CARMMA.

CARMMA aims to reduce the number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, among others.

Part of South Africa's intervention would include strengthening family planning, especially teenage pregnancies as they contribute up to 36% of maternal deaths, despite only constituting 8% of the total number of pregnancies.

Others measures include eliminating mother to child transmission of HIV; strengthening maternity services by deploying dedicated obstetric ambulances to transport women in labour to the nearest appropriate health facility; training doctors and nurses who work in maternity units in the essential steps in the management of child birth emergencies; training more midwives and advanced midwives, and the expansion of immunisation coverage.

"Unfortunately, despite progress in dealing with HIV since 2009, HIV still contributes to about 40% of maternal and child deaths in South Africa. This means that unless we deal decisively with HIV, we will not be able to reduce maternal and child mortality to any significant extent," said Zuma.

In order to address this, he said the country's HIV programme -- where citizens are encouraged to get tested for HIV at least once a year -- was imperative in extinguishing the epidemic.

According to the World Health Organisation, as many as 1 500 women die every day globally due to complications related to pregnancy or childbirth.

**From the...**



## **Academic and Peer Reviewed Articles**

### **Policy implementation and financial incentives for nurses in South Africa: a case study on the occupation specific dispensation**

Prudence Ditlopo, Duane Blaauw, Laetitia C. Rispel, Steve Thomas, Posy Bidwell. *Glob Health Action* 2013, 6: 19289. Published: 24 January 2013.

In 2007, the South African government introduced the occupation-specific dispensation (OSD), a financial incentive strategy, to attract, motivate, and retain health professionals in the public sector...

Source: <http://www.globalhealthaction.net/>

[Accessed: 8 February 2013]

### **Restructuring brain drain: strengthening governance and financing for health worker migration**

Tim K. Mackey, Bryan A. Liang. *Glob Health Action* 2013, 6: 19923. Published: 15 January 2013.

Health worker migration from resource-poor countries to developed countries, also known as "brain drain", represents a serious global health crisis and a significant barrier to achieving global health equity...

Source: <http://www.globalhealthaction.net/> [Accessed: 8 February 2013]

### **Outreach services to improve access to health care in South Africa: lessons from three community health worker programmes**

Nonhlanhla Nxumalo, Jane Goudge, Liz Thomas. *Glob Health Action* 2013, 6: 19283. Published: 24 January 2013.

This article examines three South African CHW programmes, a small local non-governmental organisation (NGO), a local satellite of a national NGO, and a government-initiated service, that provide a range of services from home-based care, childcare, and health promotion to assist clients in overcoming poverty-related barriers to health care...

Source: <http://www.globalhealthaction.net/> [Accessed: 8 February 2013]

### **Moving towards universal coverage in South Africa? Lessons from a voluntary government insurance scheme**

Veloshnee Govender, Matthew F. Chersich, Bronwyn Harris, Olufunke Alaba, John E. Ataguba, Nonhlanhla Nxumalo, Jane Goudge. *Glob Health Action* 2013, 6: 19253. Published: 24 January 2013.

In light of the global emphasis on universal coverage, empirical evidence is needed to understand the relationship between new health financing strategies and health care access thereby improving global understanding of these issues...

Source: <http://www.globalhealthaction.net/> [Accessed: 8 February 2013]

### **WHO and the future of disease control programmes**

Christopher Dye, Thierry Mertens, Gottfried Hirnschall, Winnie Mpanju-Shumbusho, Robert D Newman, Mario C Raviglione, Lorenzo Savioli, Hiroki Nakatani. *The Lancet*, Volume 381, Issue 9864, Pages 413 - 418. Published: 2 February 2013.

Huge increases in funding for international health over the past two decades have led to a proliferation of donors, partnerships, and health organisations...

Source: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2961812-1/fulltext>

[Accessed: 8 February 2013]

## **Training and Resources**

### **African Partnerships for Patient Safety**

World Health Organization

WHO released a resource package of practical tools specifically aimed at improving patient safety in hospitals in developing countries. African Partnerships for Patient Safety (APPS) is a WHO Patient Safety Programme building sustainable patient safety partnerships between hospitals in countries of the WHO African Region and hospitals in other regions.

### **Call for Proposals: HIV and AIDS Response Fund**

CIDA

Closing Date: 15 February 2013.

The Canadian International Development Agency wishes to invite eligible civil society organizations to apply for funding under Round 4 of the HIV and AIDS Response Fund.

### **Human resources for universal health coverage: a call for papers**

Bulletin of the World Health Organization

Closing Date: 10 March 2013.

The WHO Bulletin welcomes submissions that will be published in a themed issue on HRH and universal health coverage to provide an opportunity to identify the changes in HRH investment, production, deployment and retention required to achieve UHC. Its publication will coincide with the Third Global Forum on Human Resources for Health, to be held in Recife, Brazil, on 10–13 November 2013..

## Reports and Publications

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### **Research Snapshot: Public health and management competency requirements for Primary Health Care facility managers at sub-district level in the District Health System in South Africa**

*Health Systems Trust. Published: 2013.*

The South African Department of Health (DoH) has initiated an overhaul of the country's health system to improve health outcomes and progress towards attaining the Millennium Development Goals (MDGs). The Primary Health Care (PHC) re-engineering strategy forms a significant part of this overhaul.

### **New guidelines for counselling and testing children for HIV**

*Human Sciences Research Council (HSRC). Published: 2013.*

A new set of guidelines and training tools dealing with the legal, ethical and counselling issues related to HIV testing of children is now available for HIV/AIDS practitioners working with children.

### **Promoting Access to Medical Technologies and Innovation: Intersections between public health, intellectual property and trade**

*World Trade Organization (WTO). Published: 2013.*

This publication examines the interplay between public health, trade and intellectual property, and how these policy domains affect medical innovation and access to medical technologies.

### **World Report 2013**

*Human Rights Watch. Published: 2013.*

This 23rd annual World Report summarizes human rights conditions in more than 90 countries and territories worldwide in 2012. It reflects extensive investigative work that Human Rights Watch staff has undertaken during the year, often in close partnership with domestic human rights activists.

## Conferences

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### **5th Annual HIV-in-Context Research Symposium: Urbanisation, Inequality and HIV**

*When: 13 March 2013 - 15 March 2013*

*Venue: Cape Town, South Africa*

*URL: <http://www.hst.org.za/events/>*

This 5th Annual Symposium examines 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.

### **HIV Capacity Building Partners Summit**

*When: 19 -21 March 2013*

*Venue: Johannesburg, South Africa*

*URL: <http://hivcapacityforum.org/>*

The Second HIV Capacity Building Summit will build on the emerging consensus that there is need to turn the tide to ensure capacity building interventions effectively addresses the existing skills and capacity gaps that have continued to constrain the attainment of the HIV and health targets towards achieving the MDGs in the Eastern and Southern Africa region.

### **TB Vaccines Third Global Forum**

*When: 25-27 March 2013*

*Venue: Cape Town, South Africa*

*URL: <http://www.tbvaccines2013.org/>*

The Third Global Forum on TB Vaccines will bring together researchers, policymakers, donors, civil society and other stakeholders interested in the development of new TB vaccines that will contribute to global efforts to eliminate TB.

### **6th South African AIDS Conference**

*When: 18-21 June 2013*

*Venue: ICC Durban, South Africa*

*URL: <http://www.sa aids.co.za/>*

The 6th South African AIDS Conference will be held in Durban from 18-21 June 2013 and the conference theme is "Building on our successes: Integrating responses".

### **7th SAHARA Conference 2013**

*When: 7-10 October 2013*

*Venue: Dakar, Senegal*

*URL: <http://sahara.org.za/conferences/2013>*

The Social Aspects of HIV and AIDS Research Alliance (SAHARA), established in 2001 by the Human Sciences Research Council (HSRC), is an alliance of partners established to conduct, support and use social sciences research to prevent the further spread of HIV and mitigate the impact of its devastation in sub-Saharan Africa. The SAHARA 7 conference theme is "Translating evidence into action: Engaging with communities, policies, human rights, gender, service delivery".

*Go to: <http://www.hst.org.za/>*