SOPH Winter School 2013
Addresses to Winter School 2013 Graduates

Prof Helen Schneider, Director of the UWC School of Public Health

“I’d like to thank all of you who participated in this year’s Winter School.

We ran a total of 15 courses. We’ve had more than 300 participants – including for the first time the participation of 29 Ward Councillors in our Community Participation Course - at our 2013 Winter School from all 9 provinces in South Africa, as well as 9 other countries.

For us the Winter School is much more than people coming for training and getting a certificate at the end of the week. Our Winter School has been running for 20 years. It is a core part of the School and who we are as a School of Public Health. It is a key aspect of fulfilling our mandate as an educational institution. But it is much more than that. For us it’s about learning as well. It’s about understanding the realities, the challenges and the inspiring work that people at the frontline of South Africa’s and other countries’ health systems.

It’s also about creating community, partnerships and networking, about building solidarity and rekindling our hope”.

Special Guest Speakers Address Graduating Classes

Dr Sharmila Mahtre
Head of Governance for Health
Equity and Health Systems,
International Development
Research Center

Dr Zandile Mahlangu-
Mathibela
Executive Director, City Health
Cape Town

I feel extremely privileged and honoured to be here today.

We are sitting in one of the largest continuing education programs in all of Africa. And that’s exciting! For me that’s especially exciting because I am with you, the 35th graduating class of the SOPH. Congratulations!

I see before me this incredible mix of cadre of health professionals – from managers to those of you out there in the front lines. I have had discussions with some of you in the course of this week and I am in admiration of you.

The message that I would like to convey to you is that all the opportunities that are offered to you are not just for the sake of adding to your resume. It’s something that you need to value and take to heart. Try to implement what you learn – at whatever level of management you may find yourself at.

What you have achieved so far is as a result of your own commitment and the support you received from higher management. Value it because in many instances there are managers who do not give this support and pass on such opportunities to staff for whatever reason.

The opportunity you have been given should inspire you to plant the seed for the
For taking time out of your extremely busy schedules to come here to get challenged, to take some risks, to go to places you haven't been to before - inside and out - and hopefully be inspired.

On a personal note it is really pleasing for me to be able to do this. I feel very touched to do this in South Africa. I first arrived in South Africa in 1997 and since then whenever I come here I have this sense and feeling of coming home every time I land here. For that I thank you!

My time here at the School of Public Health has primarily been with the Emerging Leaders of your Health Policy and Systems Research Programme that is run by Professor Uta Lehmann and Professor Lucy Gilson. I had the pleasure to engage and to listen and to learn with the future leaders of Africa. And I have had many learnings! From these engagements I have taken much. But because of time there is one idea – a theory - that I want to share with you today.

I want you to imagine a line above and below which you see things happening. There are people seeing, thinking and working above the line. We can call this ‘activities that are linked with management’. Below the line it is about relationships. It is about the heart and soul of what you do. This is where leadership comes from.

Yesterday in the Health Promotion class that is presented by Dr Stern and Professor Struthers I actually saw this above-and-below-the-line theory come into practice.

A ride in a bus to a community-based organisation was transformed into a discussion where Winter School students had to identify all of the positive and the negative things that they saw that affects the health of the communities. I was extremely impressed by the breadth of what they saw! From broken toilets, the smell, to people helping people. But I also saw that the participants went beyond identifying. They started to do an analysis and develop an understanding of what was affecting health.

And then they took it a step forward, which I found impressive. They talked as individuals about what they can and cannot do. I share what one of the participants said to me, ‘I have known some of these things but now I know how important they are. And I also know that I am important in improving the lives of people.’

It is a matter of conveying the message constantly as managers to our people with whom we work: that we appreciate them and value their contribution, and that they are doing what they do for a reason. As managers we are both employees as well as the agents representing the larger institution, in my case the City Council of Cape Town, and we have to be very mindful of the team that we are working with. They are doing very important work at the frontline of our service.

As managers we have to be able to pass on the feedback that we get from our clients. This is crucial to guide us to improve in those areas where we need to, and share good practice in those areas where we are doing well, both internally and with other colleagues in other departments or municipalities. As managers we are steering the vehicle, so we have to acknowledge those who are making the engine turn and work. Without the engine we cannot move ahead or forward.

Yes there are challenges that we as managers face and will face. It is certainly not a walk in the park - more so, the higher you go in management. There are responsibilities and you have to be accountable for each and every service that is delivered. And I have no doubt that this is also how you view your own position of responsibility and accountability as a manager. The fact that you are here having attended the Winter School is for a good reason. Be thankful for such opportunities as this. Whatever challenges you face are there for you to overcome and improve yourself. I have no doubt that when you leave here you will honour not only the theoretical empowerment that you have received but that you will go back and take it further. Implement what you have learned so that you too can say - together with your fellow participants here - ‘This time at the Winter School has added so much value to my career development’.

I wish you all well!
So as you go back to your emails and your meetings and your frontline service remember this: your importance as an individual lies in improving the lives of people. So for you class is not over yet!

The next session focused on groups doing a SWOT analysis on what participants actually saw when they went into this community-based organisation. Back to the above-and-below-the-line theory.

Above the line I heard people talking about access, security, HIV/AIDS, alcohol abuse, the violence, community involvement and partnerships. But below the line discussions were happening! I saw the collaboration, I heard people listening, I heard the passion and the compassion. And the discussion got heated! Then the voice from a manager from the North West Province broke: ‘Focus on what is here,’ she said. ‘Do not think on things that will destroy us. Focus on what we can do here, now and for the future.’ This manager was clearly a leader and leading from below the line - to change all of the structures, and processes and systems above the line.

I asked some of those participants if they would continue to have such discussions, to continue with this SWOT analysis when they got back to work. Some said yes, a few were not convinced that it would be possible. But there was a real declaration of the importance of this intersectoral engagement they were having. And as articulated by another participant: ‘One person alone does not see everything. So it is good to have many eyes!’

As you go back to your respective places of work I’d like to challenge all of you with your own words and the ideas that you have generated this week to work above the line to make a positive change. But make it transformative by leading from below the line with your heart and in collaboration with others. I know I’ll try my best because you have inspired me!

Congratulations for being the 35th Winter School graduating class of the School of Public Health!

What Course Participants Say about the Winter School 2013

Dr Victor Matabane

I am a medical doctor and Public Health Registrar based at Pietersburg Hospital.

On why I am here:

This is not my first time at the Winter School. I was here in 2011 which I also found very useful. The reason why I come to the Winter School is to fill the gaps that I see in my studies and in my place of work. This time I am taking three courses over three weeks on District Health Information Systems (DHIS) at the intermediate and advanced levels as well as work-based DHIS.

On the Benefits of attending Winter School:

The course is relevant for the work I am doing as a public health medicine registrar. I do mostly technical advisory work for hospital executives and also in the provincial office. So getting to know where to find data and how it is packed in the software is very important. I know people that I work with who complain about sourcing information from the hospitals. I advised one such person to teach the data capturers what she is expecting from them. This course especially will help me to take back to such a person techniques and methods, as well as training materials and tutorials in the information software which she can use to do a refresher course. She will then be able to show the data capturers what she wants and how useful it is.

Another thing that’s important after data capturing is to talk to the capturers. This is an important aspect that is missing. From a data capturer’s perspective, when you capture the data and do not get feedback, you think that you have done the capturing correctly. But in actual fact there are complaints on the other side, But you as data capturers do not know about it. If you are told how important your work is for your environment and information needs, you will capture correctly.

On how Winter School is run:

You are doing an excellent job. The food is alright. The peanut butter sandwiches do help! Now we understand the science behind
it and we have the energy to be alert for the whole day.

Just a comment on the graduation: It is okay, but there is something missing from what used to happen in the past. It should be less hurried and should have a little more ceremony.

Also in the past after the day’s classes there were speakers who would come in and speak on issues of public health matters. This I found very useful also.

**Dr Simon Mgqunyana**

I come from Limpopo Province and am based at Pietersburg Hospital. I am a registrar in public health medicine. In my training in public health we do rotational placements, and at present I am working in one of the National Health Insurance (NHI) project district sites at Vembe.

My project there deals with the burden of disease. One of the sources for data that I am going to use is the district health information system (DHIS). This made me realise that I need training in DHIS and based on my previous experience, I decided to get that training at the WS here at UWC.

**On the Benefits of the Course:**

I was clueless when I arrived. I heard people talking about health information systems. Now I can say that district health information will be a familiar animal to me and not something wild but a pet.

We have a good DHIS system, but the challenge lies at the level of data capturing. It is very difficult to control the human error. What I learned in the last weeks is that we also need to take responsibility to train our data capturers: to pay attention to what they are doing and giving them feedback on how important this work is. They think that the role they play is minute, and yet we know that it is so important. It is the same as having a cleaner in the facility: this role is one of the most important in the facility. Managers at the top cannot take proper decisions without getting information based on clean and verified data.

This is a skill that I need; this is the main reason why I came. Obviously I am not yet an expert on DHIS in two weeks, but what I learned is a very good starting point, a good foundation that I can build on.

But I am a sponsored participant at the WS and as such I am also expected to bring back my learning and share it with others within the province. It will become easier to learn forward when you take other people with you. In NHI my pilot site work in Vembe I will also have to train data capturers. Now I know that the DHIS software has got inbuilt material that one can use to train others as well.

From the point of the information needs for the implementation of the NHI one of the biggest issues that has been identified is in human resources, where a lot of capacity has to be built through training. I am involved in developing workload indicators for staffing needs (WISN). I know that we have human resource needs. DHIS can assist us by capturing the human resource needs in the different facilities. This week we are doing DHIS 2 which is internet based. If implemented we will be able to have immediate access to information.

**On Your Experiences of Winter School:**

One comes back if the first experience was good. I come back to Winter School because my first time was very useful. I did Waiting Times, Policy Development and Human Resource courses in 2011. I really appreciate the courses this time round. I have developed skills and now my hands are itching to go back and start using them.
Winter School through the Eyes of a Teacher and Course Leader
Interview with Dr Ruth Stern, SOPH Senior Researcher

Is the Winter School a useful event from a teaching point of view?

Very. As well as the content of the courses, there is always very good interaction between the course participants, bringing together people from different backgrounds, be it professional, geographical, SOPH students and people doing the courses as in-service training. They learn so much from each other. The evaluations we receive show that this is a very important component of the courses. It is also very useful for networking. Participants often take each other’s details to maintain contact after the courses have ended. For the SOPH students who come to the courses it enables them to get to know each other and other participants, often from different countries and contexts.

And of course, not to overlook the important aspect that we, as course facilitators, learn so much from the participants, in particular about the realities on the ground that they face on a regular basis. So we are delighted when we see them return to take different other courses in subsequent years.

Is it a new experience every time? New challenges, new opportunities, new insights?

While many courses get repeated from year to year they are always different. This is because the participants and their portfolios vary and they naturally raise different issues. In addition, there are inevitably different dynamics in the group that we have to accommodate. We also change our courses from one year to the next on the basis of the participant evaluations. This could be adding some aspects or removing sessions that don’t work well. As noted above, we are constantly learning from our participants. Of course the feedback we receive can vary, within a course and from year to year, so we also have to use our own judgment on the success or problems on any particular course.

The backgrounds and experience of the participants can also shift. Over the years, the courses I teach, that is, Health Promotion, have had an increase in the numbers of environmental health practitioners attending. This has been particularly valuable as they have very good practical ‘on the ground’ experience which they share with others. For example, this year, the EHPs on our Community Participation in Health course brought in a ‘squeezy bottle’, a simple device for using water in informal settlements. This was given as an illustration of a solution to a problem developed by a community member - in this case, a local child.

Colin Abrahams (above left), Environmental Health Practitioner at City Health in Cape Town, explains the usefulness of the ‘Squeezy Bottle’.

We coordinate diarrhea awareness campaigns in the various sub-districts of the city, to lower the death rate and severity of the cases in our informal settlements and formal communities. There are various initiatives that we embark on, such as the ‘Sweezy Bottle’ and the Oral Rehydration Solution (ORS) or the Sugar-Salt-Solution (SSS), the latter initiatives being ways to get the minerals back into the body when you have diarrhea.

There are various remedies to prevent the spread of the disease through contributory factors such as water, sanitation and illegal dumping. The ‘Squeezy Bottle’ is one such preventative measure and a remedy that can be used. For instance people may be living too far from the communal tap. The regulation is to have one standpipe every 200 metres, or one standpipe for every 25 households. But if the pipe breaks where do people go to wash their hands?

A small boy from an informal settlement came up with the ‘Squeezy Bottle’ to resolve this challenge. We have adopted it as the City and promote its use! It consists of a two-litre bottle with two holes in the cap and a thin 4mm irrigation pipe inserted through one hole. Close the open hole, squeeze water out through the pipe and the suction creates a flow like a tap! It can be used by one person. It works in place of a hand-wash basin to clean the hands. This is a way to prevent cross-contamination, and it is used all over Khayalitsha.

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What are some of the lessons that we can take for future Winter School planning?

A key lesson is to listen to our participants when planning or revising our courses. This could relate to the development of new courses on topics that we have not given priority, as well as suggested changes in our existing courses. It is also important for us as a team to continually reflect on the overall balance of the courses, and to consider the currency of our existing courses. Questions we have to think about include whether our content is in line with the training needs of those working in public health; whether our courses are keeping up to date with changes in health policy and practice locally and within sub-Saharan Africa; and the impact of the wider socio-economic and environmental context. The relatively recent addition of the Globalisation and Health course illustrates this latter point.

The logistics of running the Winter School, both in terms of preparation and keeping it going during the three weeks, the responsibility of the administration team, are complicated. This is particularly difficult when there are large groups, as was the case this year. This too needs ongoing monitoring to see how it can run smoothly. Generally, given the extent of the flow of people, the team manages superbly. This behind the scenes activity is something that as a member of the academic team, I need and know I can rely on.

So a final comment – the SOPH Winter School can be hard work, but it is always very rewarding, stimulating and an amazing activity to be part of.

The Consortium for Health Policy and Systems Research in Africa (CHEPSAA)

CHEPSAA’s Emerging Leaders Programme: important capacity-building initiative takes off

SOPH-UWC hosted CHEPSAA’s Emerging Leaders in HPSR workshop

"Developing the practices of leadership" was the theme of the workshop organized by the Consortium for Health Policy and Systems Analysis in Africa (CHEPSAA) and held at SOPH- UWC during 1-7 July 2013. The event brought together 26 young professionals that are based in academic or research institutes in Nigeria, Ghana, Kenya, Tanzania, and South Africa. The workshop also marked the launch of CHEPSAA’s Emerging Leaders Programme, which is a pioneering initiative in the emerging field of Health Policy and Systems Research and Analysis (HPSR+A).

Two of UWC-SOPH staff namely, Verona Mathews (left) and Woldekidan Made (right), took part in the Emerging Leaders workshop. Reflecting on their experience, Wolde stated, “It was such an all-round exciting and empowering experience. I have gained so much insight as to how to further develop myself in the realms of management and leadership, and managed to establish a sense of comradeship with a group of very energetic and resourceful people. The sessions were far from prescriptive and were all geared to increasing/awakening our awareness to the diverse range of relevant and some long overdue questions that need to be asked about Health Policy and Systems in our respective contexts, being cognizant of the host of tacit assumptions we make that impact us on personal, interpersonal and professional levels”.

Twenty-six professionals, mostly educators and researchers, from five African countries gathered in Cape Town, for the launch of the Emerging Leaders Programme of the Consortium for Health Policy and Systems Analysis in Africa (CHEPSAA).

The Emerging Leaders Programme is a unique initiative that seeks to contribute to the goal of building a critical mass of future leaders in the field of health policy and systems research and analysis (HPSR+A) who are committed to working in this field in Africa and equipped with the necessary skills and capabilities.

HPSR+A is an emerging field, the value of which is increasingly being recognised. However, African capacity to conduct and use HPSR+A is very limited. Challenges include relatively little funding for research in this field, few African scientists working in this area, the limited availability of relevant training programmes in African
universities and policy-makers who are often unaware of relevant research.

The Emerging Leaders Programme began with a capacity-building workshop this week (1-7 July 2013). This was followed by a period of peer support, which will lead into a second capacity-building workshop in mid-2014. The programme will culminate in a third and final event linked to the 3rd Global Symposium on Health Systems Research taking place in Cape Town in September 2014, where the participants will put into practice some of the core capabilities developed over the course of the programme.

For this first week of the programme, the participants have been asked to identify a health policy and systems research or leadership issue that they would like to work on during the week and beyond, with the intention of supporting them both to conceptualise the issue that concerns them and to plan for addressing that issue in future. In addition to this, they participated in various facilitated sessions seeking, among other things, to build their leadership capabilities and strengthen their leadership practices, improve their communication skills, and strengthen their project and time management skills.

Over the past year or so, CHEPSAA has, through a collaborative and consultative process, developed a set of core capabilities that it believes educators, researchers and analysts in the field of HPSR+A require to grow and be successful in the field. These have been organised into the themes (with more specific skills captured under each theme) of personal skills, writing skills, project management skills, networking skills, understanding and knowledge of HPSR+A, understanding of the health system, teaching skills, and research skills. These core capabilities underpin the design and activities of the Emerging Leaders Programme and the goal is to use the programme to realise them progressively over time according to the needs, strengths and weaknesses of each participant.

Using a screening process that collected information on issues such as work experiences, interests and career goals, the initial group of programme participants were selected from the CHEPSAA partner organisations in Nigeria, Ghana, Kenya, Tanzania and South Africa, as well as a broader group of nominees from organisations working closely with the CHEPSAA partners. In addition, a limited number of participants from other academic and research organisations and NGOs also participated.

CHEPSAA is a European Union-funded consortium of African and European universities which seeks to increase African capacity to produce and use high-quality HPSR+A. In addition to CHEPSAA’s own funding, this programme is also supported by a grant from the Rockefeller Foundation.


Ziyanda Mwanda

On Google Groups and Sites at SOPH

I am Ziyanda Mwanda (B.Sc. Biotechnology, UWC). I was introduced to Google apps by Ms Lucy Alexander. After spending time trying to understand their functions I became more familiar with each. I create and facilitate the Google Groups and Sites for the courses offered at School of Public Health, for the Postgraduate Diploma and Masters students. To be able to participate in the Groups and Site one is required to register their email address on Google accounts if it is not a Gmail email address.

Through the groups we aim to hold discussions related to the relevant module, send notifications and answer queries. The groups are restricted to students doing the module for security reasons.

The Google Sites are used as ePortfolio for students to showcase their best work pieces and reflective reports of the modules. I send out step by step instructions to assist students to create their Portfolios and help with technical problems they may come across while working with the two. I have also just recently introduced some to Dropbox for sharing large files that cannot be attached on email or google groups.
The School of Public Health and the Centre for Research in HIV and AIDS (CHRA) were well represented at the 6th South African AIDS conference in Durban, 18–21 June 2013 – convening and presenting papers in sessions and contributing to the extensive poster programme. The conference theme ‘Building on Successes: Integrating systems’ was realised through six tracks, with CRHA participating in Track 4 - ‘Social and economic sciences’ and Track 5 - ‘Health Systems, Programmes, Human Rights and Ethics’ which was convened by the School’s Director, Helen Schneider.

Prof Schneider convened and chaired a dynamic and up-to-the-minute symposium, ‘2+ million on treatment: What enabled this success in a troubled health system?’ Both the successes and shortcomings were debated by Yogan Pillay (Deputy-Director General, Strategic Health Programmes, National Department of Health); Sibongiseni Dhlomo (MEC for Health, KwaZulu-Natal); Francois Venter (Wits Reproductive Health and HIV Institute (WHRI)) and Bonginkosi Mthembu (Treatment Action Campaign).

**CRHA at the conference**

The Centre’s director, Christina Zarowsky, chaired and presented a paper in a panel on ‘Particularly vulnerable populations’. ‘What’s HIV got to do with it? Migrant perspectives on survival, stigma and HIV in SA’ discussed findings from ethnographic research underway with CRHA sabbaticant Prof Sally Guttmacher, from New York University, on migration, health and social support in the Cape Metropole. Post-doctoral fellow Joshua Aransiola also presented in this session. His paper ‘Stakeholder perspectives on human trafficking, health and HIV in SA’ reported on the baseline situation analysis he has done while in Cape Town as part of the project on irregular migration, human trafficking and HIV/AIDS in South Africa. Both Christina’s and Joshua’s work are part of the Centre’s HARICCI programme - HIV and AIDS Research in Complex Contexts of Inequality.

Project administrative co-ordinator and doctoral student Emma Chademana presented a poster on ‘Coping with HIV/AIDS in a fragile state: Structural factors affecting survival strategies of child-headed household in Zimbabwe’ in the Social and economic sciences track. She also worked as rapporteur for the track on ‘Health systems, programmes, human rights and ethics’, presenting the summary to the plenary on the final day of the conference.

Two extraordinary professors associated with the Centre participated in an important session on ‘Access’. Drawing on the ongoing work being undertaken in the Sisonke district of KZN, Harry Hausler’s paper was on ‘Community screening and GeneXpert for active TB case detection in a rural district in KwaZulu-Natal’ - while Debra Jackson presented on ‘Factors associated with client linkage to care following home-based HIV counselling and testing: A prospective cohort study in rural SA’. Complementing this, Debra and Tanya Doherty contributed to a poster on ‘Client experiences and perspectives on the linkage to care following home-based HIV counselling and testing: A qualitative study in rural South Africa’ presented by Reshma Naik, of the South African Medical Research Council (MRC).

Two contributions from the university’s School of Nursing were also linked to the CRHA’s work. Mary Modeste and Million Bimerew have both attended the Centre’s writing retreats – and Million has participated actively in the CRHA’s CDC-funded programme on human capacity building through the project on ‘Strengthening health system through training undergraduate midwifery students in community-based PMTCT competencies’.
Mary presented a paper on ‘Identified HIV- and AIDS-related essential competencies for nurses in SA’, while Million’s poster addressed ‘Nurse educators’ readiness to teach PMTCT competencies’. Petra de Koker – who has also attended the Centre’s writing retreats and was involved in our 2011 HIV-in-Context Research symposium focusing on gender and violence – presented a poster on ‘Sexual behavior among adolescent survivors and perpetrators of intimate partner violence in Cape Town’.

Through a range of printed media displayed at a table in the Exhibition hall, the Centre profiled some of its work, particularly the CDC projects. We were also often available to engage with people interested in our work and that of the School, handing out the SoPH’s annual report as well as a listing of all HIV and AIDS-related MPH theses over the last four years. 56 people signed up to receive the manuals from the Health Promoting Schools and ‘How to be a health activist’, a manual on TB developed with and for school learners during the CDC-funded project on ‘HIV/TB educational resources for South African school learners’.

**Collaborative research**

SOPH researchers participate extensively in collaborative research with other institutions, such as in the two following examples from the conference. Tabana Hanani from the MRC – working with SOPH on a project generating evidence to guide the policy process for the systematic formalisation and integration of community health workers into the primary health care system presented a poster on “Testing together challenges the relationship”. Consequences of HIV testing as a couple in a high HIV prevalent setting in rural SA’. Justus Hofmeyr, from the Effective Care Research Unit (ECRU) in the Eastern Cape - and long-standing collaborator with Prof Debra Jackson on a PROMISE-PEP (ANRS 12174) randomised controlled clinical trial on the efficacy and safety of prolonged infant PEP alongside breastfeeding - presented a paper on ‘Proposed HC-HIV RTS and feasibility of conducting an HC-HIV TRTS: Evidence on IUD to explain why IUD chosen as ‘comparator’ method’.

**Other UWC faculties and departments**

Staff from other faculties and departments at UWC also participated in the conference. Simon Travers from SANBI presented on ‘The role of M-linked glycosylation on structure and function’ and also offered a skills workshop on ‘The toils and troubles of deep sequencing analysis’ - while two posters were presented by the Physiotherapy and Pharmacy departments respectively. These were ‘Behaviours and protective factors contributing to the risk and vulnerability to HIV infection in rural youth’ by Adedepo Awotidebe and ‘Pharmacokinetics of kanamycin in patients with multi-drug resistant TB and in patients co-infected with multi-drug resistant TB and HIV’ by Pierre Mugabo.

**Overview / commentary**

The wide range of presentations and posters spanned the breadth of HIV issues – including the social and psycho-social - and also stretched from the micro/local level to high-level national and global policy. While stockouts of medicines was frequently mentioned as a systems crisis, the tone of the conference was largely consensual – or, at best, enquiring. This is very different to the earlier conferences held at the height of AIDS denialism with the attendant animosity between the state and civil society. If anything, the tension between these two major stakeholders, a fundamental agreement to a robust democracy, is not sufficiently taut. While this SA AIDS Conference featured much more attention to the structural drivers and social determinants of both ill-health in general and HIV in particular, the human rights and ethics foci were less visible.

Despite this, and the many comments of a health system in crisis, the tone was cautiously optimistic – exemplified in the session ‘2+million on treatment: what enabled this success in a troubled health system?’ chaired by the School’s director.

As the numbers of people on treatment increase, the incidence does not seem to decrease, however, and there was a notably renewed interest in prevention as well as in ‘key populations’ referring conventionally to sex workers, injecting drug users, men who have
sex with men, prisoners, migrant workers etc, all of whom are included in the list of 12 key populations in the current NSP. But in a final plenary presentation Dr Gita Ramjee (Director of the HIV Prevention Research Unit of the Durban-based MRC) asserted that the key populations of greatest concern were not these targeted sub-groups but rather all young women in KZN, among whom there is high incidence.

There is work to be done to reach our shared goals of Zero AIDS Related Deaths, Zero Stigma, and Zero New Infections. Understanding and responding to specific needs and contexts without fragmenting and exceptionalising these multiple AIDS responses will perhaps be the focus of the next SA AIDS conference.

**Insight on the Health Systems’ Track of the 6th SA AIDS Conference, 2013**

*Emma Chademana*

“As a country, we have made significant inroads in our response and have begun to see the impact of our policies and strategies” remarked Deputy President Kgalema Motlanthe at the closing session of the SA AIDS Conference in Durban.

The 6th SA AIDS Conference took place 18-21 June 2013 in Durban South Africa and the theme of the conference was “Building on the Successes: Integrating Systems”. The theme resonated throughout the track on Health Systems, Programmes, Human Rights and Ethics as the overall tone was largely positive, acknowledging the successes achieved in the fight against HIV/AIDS. This article will give a brief synopsis of the Health Systems’ track. The track was chaired by Professor Jerome Singh from the Centre for the AIDS Programme of Research in South Africa (CAPRISA), University of KwaZulu-Natal and Professor Helen Schneider, the Director of the School of Public Health, University of the Western Cape.

The efficient response to HIV/AIDS in South Africa can be largely attributed to an integrated response, focused leadership and dedicated funding, through conditional grants and donor programs. Dr Yogan Pillay Deputy Director General, Strategic Health Programmes National Department of Health, Dr Sibongiseni Dlomo, MEC for Health, KwaZulu-Natal and Professor Francois Venter, Wits Reproductive Health & HIV Institute discussed factors enabling South Africa’s efficient response to the HIV/AIDS epidemic.

Across the sessions, there was a broad range of interventions presented, some specific to HIV/AIDS and others more general to Health System Strengthening. Some of the presentations looked at the effective Innovations in service organisations such as how the decentralisation of care has helped the health system to cope with the increased patient load. Currently South Africa has over 2 million people on antiretroviral treatment and the National Strategic Plan 2012-2016 targets to have 80% of all people eligible to be placed on ART by 2016, which is estimated to be more than 3 million people; this growing number places increasing pressure on the already stretched human resource capacity. ART adherence clubs offer the potential to reduce pressure on facilities by reducing patient load thereby reducing waiting times which all contribute to increasing long term patient retention. ART adherence clubs are a long term retention model of care catering for stable ART patients (MSF, 2013). The Hannan Crusaid Clinic’s Anti-retroviral Therapy (ART) delivery model presented at the conference uses this decentralized approach of adherence clubs working with Community Care Workers (CCW) to provide ART in Gugulethu, Cape Town. Further decentralization is planned as the clubs will be shifted to community centres within walking distance from members’ homes.

A number of presentations highlighted the important roles of traditional health practitioners (THP) in the health system. The concern was that the traditional sector has been formally recognized yet committed action towards working together is still lacking. The need to understand the importance of working symbiotically to cater for patients’ best interests was stressed. Recommendations on how to bridge the gap between Western and Traditional models of care include creating opportunities for dialogue; integrating
allopathic interventions into traditional prevention practices and ensuring allocation of resources to Traditional Health Practitioners.

In line with the WHO Health Systems Framework which advocates the use of new technologies as a building block for a well-functioning health system, presentations showed how the use of technology has helped strengthen system performance, namely the use of GeneXpert for active TB case detection that has significantly increased TB case findings and decreased time to treatment in Sisonke district, KwaZulu-Natal. The GeneXpert MTB/RIF test diagnoses both TB and rifampicin-resistance in under two hours. This means people presenting with cases of multiple drug resistance (MDR) TB can be put on treatment much earlier. In the TB Reach project, the average time from sputum collection to treatment for drug resistant TB decreased from 136 days to 15 days. This project also used mobile phone technology to link patients to Community Health Facilitators (CHFs) as the CHFs use cell phones to contact patients directly once results from the lab arrive.

The implementation of a CD4 results reporting system in Malawi has also shown to increase HIV testing. mHealth technology has been shown to be a viable option in increasing entry and retention in care; it provides a promising solution for ensuring Health System strengthening. Discussions on mHealth centred on its sustainability as it requires IT infrastructure and governmental resourcing.

A guiding principle of the Ouagadougou declaration on Primary Health Care and Health Systems in Africa is intersectoral collaboration. It recognizes the need for coordinated intersectoral action in order to improve health determinants. This principle was echoed at the conference in a discussion of the new Integrated School Health Programme (ISHP) where the Departments of Health (DOH), Basic Education (DBE) and Social Development (DSD) have taken joint responsibility for ensuring that health services reach all learners across the education system. The programme aims to build on and strengthen existing school health services for learners by offering a comprehensive package of health education and promotion, learner assessment and screening, on site health care services and environmental assessments. The ISHP is rooted within the primary healthcare re-engineering in the department of Health and the Care and Support Learning Programme in the Department of Basic Education.

Discussions on Quality improvements approaches echoed the benefits of simple models and flexible approaches that adapt plans to respond to contexts in comparison to rigid approaches. Lessons learnt from the studies presented were: sharing experiences between facilities improves quality of services; health facility staff in the study was empowered by new ideas like process analysis as a result of the quality improvement sessions; and engaging people from the frontline contributed to buy in to the quality improvement approaches and reduced resistance to change.

The drug supply challenge was a very prominent topic at the conference as the Eastern Cape has been experiencing on-going interruptions of ARV and TB drug supply. This drug supply crisis extends beyond Eastern Cape stretching across South Africa for ARVs and various chronic medications. A coalition consisting of the Rural Health Advocacy Project (RHAP), Doctors Without Borders (MSF), the Treatment Action Campaign (TAC) and SECTION 27 released a report on the catastrophic drug supply crisis in the Eastern Cape and other provinces in the country at the conference. The report, “The Chronic Crisis: Essential drug stock-outs risk unnecessary death and drug resistance in South Africa” is a follow up report from the first report released in January 2013 that outlines the history of the Mthatha Medical Depot crisis and the intervention by TAC and MSF. The follow up report discusses results from their survey where 40% of 70 facilities in Eastern Cape experienced HIV and TB drug stock out in May 2013 with stock outs lasting an average of 45 days at a time forcing thousands of people to interrupt their treatment. The Mthatha crisis dates back to October 2012 and, to date, has not been addressed. In response to the problem, the coalition has set up a civil society monitoring group that will focus on solving the drug supply problems and continue monitoring drug supply across the country. The
coalition called for urgent action from the National Department of Health and the Eastern Cape Department of Health and stresses that “any durable solution to the supply problems in the Mthatha region must make the Depot and health system as a whole more accountable to the patients that it serves.”

Overall, the key theme emerging from the presentations and discussions was that health system strengthening involves reinforcing many complex and interlinked systems. There is no magic bullet! Recommendations and lessons include

- building health workforce capacity requires a combination of approaches such as training, mentoring, increasing staff numbers and building positive attitudes;
- intersectoral collaboration is vital for a well-functioning health system;
- sharing and distilling health system strengthening experience and innovations is required for more systematic scaling up and
- there is need to strengthen community systems and civil society engagement.

http://www.wpro.who.int/health_services/health_systems_framework/en/index.html


Interns at SOPH

Marya Jaleel

My name is Marya Jaleel and I am from Ottawa, Canada. I graduated in May of 2013 from the University of Ottawa with an Honours Bachelor in Health Sciences (BHSc). I am one of the four interns brought here through the Canadian International Development Agency’s International Youth Internship Program in partnership with the Human Rights Internet, a Canadian NGO. This is the first time I have participated in such a program, but I have experience working with the Public Health Agency of Canada, evaluating national public health programs and with the Canadian Cochrane Centre, assisting with educating researchers on how to conduct systematic reviews in health research. I also have experience volunteering in Kenya and India working on development and health related projects. I have been interested in global public health for many years now and hope to pursue a Master of Public Health next year. I will be assisting with the PURE study over the next six months under the supervision of Dr. Gavin Reagon and Professor Thandi Puoane. I’m greatly looking forward to my time in Cape Town and with my new colleagues at the School of Public Health!

Sarah Wilmer

My name is Sarah Wilmer and I am from Guelph, Ontario, Canada. For the upcoming six months I will be working in an internship position funded through the Canadian International Development Agency (CIDA) and administered through the Canadian NGO, Human Rights Internet. Prior to arriving at the School of Public Health I recently completed my Master of Public Health (MPH) degree at the University of Guelph. My final practicum paper and presentation was focused on obesity status of elementary school aged children in Turks and Caicos Islands. While completing this project I was able to work alongside the National Epidemiology Research Unit (NERU) to analyse data and generate a health promotion campaign to encourage healthy eating and increase physical activity among youth. Before completion of my MPH I received my undergraduate degree at the University of Ottawa and earned an
Honours degree in International Development and Globalization with a minor in Public Administration. I look forward to my internship at the School of Public Health where the majority of my time will be dedicated to the WOTRO maternal health project under the guidance of Dr. Thubelihle Mathole. I welcome the opportunity to increase my knowledge and learn about all the important and interesting projects taking place at the School of Public Health!

**Kulsum Khan**

My name is Kulsum Khan and I am from Toronto, Ontario, Canada. I was selected as an Intern by the NGO Human Rights Internet, funded through the Canadian International Development Agency. For the next six months I will be working with the School of Public Health with Professors Nikki Schaay and Thubelihle Mathole. I will be assisting with the CHESAI and DIAHLS Projects. I have recently graduated with a Bachelor in Social Work from Ryerson University. I enjoy working on health focused research projects. My recent research projects consist of: "Aging in place" for elders with intellectual disabilities; The Ethics of Care in Working with Immigrant Families; Students Learning in the Field and There is a method to this madness: Critical discourse analysis and mental health recovery submitted to Qualitative Sociological Journal. I hope this experience will deepen my understanding of the health system and health issues in South Africa. In the near future I hope to use my learning's towards attaining my Master in Social Work with a focus on health and mental health. I look forward to learning more about the SOPH and the brilliant minds that work here.

The Lancet

**AIDS governance: best practices for a post-2015 world**

_Michel Sidibé, Kent Buse_

On May 30, 2013, the UN Secretary-General’s High-Level Panel of Eminent Persons on the Post-2015 Development Agenda published its eagerly anticipated report.1 The unequivocal conclusion of the report is that the “unfinished business” of the Millennium Development Goals (MDGs) cannot be swept aside, and that the goals set 13 years ago are ripe for renewal and remodelling.1 In a similar process of critical self-reflection, the global AIDS community is identifying features of the AIDS response that we wish to protect, enhance, and extend as we move into a different era of global health and development.

The AIDS response is among the most successful public health initiatives of the past 50 years. People living with HIV, affected communities, scientists, and policy makers joined in common cause, driven by the urgency and scale of the pandemic. Governance—the ways we organise ourselves within countries and at the international level to tackle such challenges—is the glue that has held the response together; and it ushered in many innovations.

New global, regional, and national institutions were created to ensure HIV prevention and treatment. Pioneering mechanisms of inclusion and accountability enabled affected communities to participate meaningfully in governance processes. Citizen activism spurred unprecedented political leadership, new global compacts, debates in the Security Council and UN General Assembly, and a series of instrumental UN political declarations. In a spirit of global responsibility, western governments and the private sector played vital parts in scaling up HIV treatment worldwide.

But we must recognise that the old ways of doing business are obsolete. The financial crisis has created funding constraints. Multilateralism is under pressure. Critical development issues contend for attention. A more ambitious global health agenda is increasingly focused on health rather than disease.2 In forging a transformative
governance architecture that will serve people best in 2020 and 2030, the principles that are fundamental to the success of the AIDS response must remain at the heart of the new agenda.

First is the centrality of justice, human rights, and gender equality—hallmarks of the AIDS movement and the catalyst for real progress in countries. Yet much more remains to be done. Discrimination, stigma, and criminalisation of people living with, and at increased risk of, HIV remain the main barriers to services in many societies. We must continue to promote human rights as both an entitlement and engine of development.

Second, people and communities most affected by AIDS should have a central place in governance arrangements. The participation of people living with HIV was crucial to the legitimacy of AIDS initiatives, and directly improved the acceptability and effectiveness of programmes. The same is true of civil society organisations that are hardwired into AIDS governance arrangements—from board membership to reporting mechanisms. Integration is a third principle. The recognition that AIDS requires multisectoral action was key to the creation of national AIDS councils and UNAIDS as a joint programme of several UN entities. But we need to exploit further synergies across health and development. The post-2015 agenda should be designed to build better linkages throughout the new development architecture—and the place of AIDS within it—in a more holistic way.

Finally, the AIDS response is underpinned by the principle that action should be data-driven, evidence-informed, and results-oriented. Gathering good data is challenging, but it is essential to measure progress, target resources, and discover and document what works in real time; it is also the keystone of transparency and accountability. The Global AIDS Response Progress Reporting system represents an unparalleled governance achievement: in 2012, 96% of all countries reported on their epidemics and responses, and often on challenging issues. We can and must continue to make our actions ever more evidence-informed. Data is a governance input and output: it drives what we do and shows what we have achieved.

In confronting dysfunctional systems, the AIDS movement might have only created “good enough” governance, but it drove a revolution in governance nonetheless. As discussions on the future of sustainable development continue in the wake of the report by the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda, we must protect AIDS governance innovations, and the principles behind them, because they deliver results. It is encouraging to see that the report by the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda identified many of these principles: the importance of inclusiveness; the interconnected nature of development challenges; the need for global partnerships; and the importance of effective, open, and accountable institutions. These principles must remain prominent as the discussion now shifts from “what” to “how”.

Whilst the AIDS community has a crucial part to play in forging the post-2015 agenda, we also need to listen, learn, and identify areas for improvement. Although AIDS has been a catalyst for many innovations in governance, much of the AIDS governance architecture was created on a reactive, ad-hoc basis. Current arrangements are unwieldy and inefficient, do not deliver enough accountability, do not give sufficient prominence to the voices of the global South, and are not progressive or ambitious enough in their agendas. These arrangements need a shake-up. We must not, however, fall into the traps that lead to a new round of institution creation. We must aim instead for radical simplification. The global health architecture needs no more than three agencies: one to handle financing; one to set norms and standards; and one for advocacy and accountability. An effective apex mechanism could bring different actors together, including the private sector. That is all the complexity needed.
However, we should not impose particular models on countries—their needs will vary according to local epidemics and broader governance arrangements. Governance should evolve to become truly multisectoral and inclusive, avoid duplication, and wield the necessary political clout to deliver health-in-all-policies. Further, governments and other institutions must move from a model of mutual accountability to one of people-centred accountability, with greater independence and real sanctions to discourage non-performance.9 Governance is by and for the people—and they are best placed to hold us to account. This would represent a true democratisation of global health.

The post-2015 development agenda should empower those affected to become active agents of change. This demands that people should be supported to know their rights, are given the political space to mobilise around them, and are enabled to articulate them as concrete demands. Human rights literacy is “demand creation”. These efforts must include young people, enabling them to mine the data revolution and use social media and other forms of activism to demand justice.

We must also continue to look critically at ourselves while daring to pursue an alternative future. The UNAIDS and Lancet Commission: From AIDS to Sustainable Health,10 co-chaired by Joyce Banda, Nkosazana Dlamini Zuma, and Peter Piot, will have a critical role as we move forward and build on the proposals of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda. But ultimately, enhanced governance needs to come from within—from the trust generated within systems and society, between people and leaders.11

The AIDS movement is at a risky juncture. Any disinvestment in the response endangers the health MDGs and jeopardises returns on past investments. Greater country ownership and integration between health and development issues, although desirable, could challenge some of the central principles of the AIDS response. But these challenges bring opportunities to reignite and fight for the global sense of purpose we had at the start of the MDG period. We have an unprecedented opportunity to sow the seeds of a broad-based movement for change rooted in principles of solidarity and global justice. Transforming global governance for health will require continued investment—but it will be an investment in results.

MS is Executive Director of UNAIDS. KB is Chief, Political Affairs and Strategy, UNAIDS. We declare that we have no conflicts of interest. We thank the participants of the Thanda Dialogue on AIDS Governance, May 29—30, 2013, where these ideas were presented and discussed, particularly Per Strand of Star for Life and Simon Rushton of Sheffield University, UK.

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