Annual David Sanders Public Health and Social Justice Lecture

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#BlackLivesMatter

The 2015 Annual David Sanders Lecture, established by UWC and the School of Public Health in honour of Emeritus Prof David Sanders, Founder and first Director of the School, was delivered by Dr Mary Bassett, Commissioner of Health of New York City.

Dr Mary Bassett, moved by the recent attacks on Americans of African descent in the US, addressed the link between race and health in her lecture, entitled “#BlackLivesMatter”. Can such a link be made? Most definitely, argued Dr Bassett in an earlier editorial in the prestigious New England Journal of Medicine (NEJM, March, 2015). Her article provides statistics on health disparities as they affect people of colour and refers to the dearth of scholarly research on this link.

Race and health are critical issues that South Africans can relate to, both in terms of this country’s past injustices and its present challenges. With her long medical and research background of work in Africa, Dr Bassett was ideally placed to highlight the link between health disparities and inequities and race in the US and South African contexts.

Dr Bassett concludes her NEJM article with a plea:

“As a mother of black children, I feel a personal urgency for society to acknowledge racism’s impact on the everyday lives of millions of people in the United States and elsewhere and to act to end discrimination. As a doctor and New York City’s health commissioner, I believe that health professionals have much to contribute to that debate and process. Let’s not sit on the sidelines.”

#BlackLivesMatter is a social movement fighting for an end amongst others to racial profiling, police brutality, mass incarceration of African American, the militarisation of many US Police Departments and the structural racism embedded in American society.

Dr Bassett’s opinion piece in the NEJM speaks against the silence and denial of this structural violence in public health and medical communities...These are themes that resonate powerfully here. We were very keen to have Dr Bassett come and talk to us about this challenge and what it means for us”

Prof Helen Schneider
Excerpts from Dr Bassett’s Lecture...

It is wonderful to be in Cape Town to deliver the annual David Sanders Lecture in Public Health and Social Justice. The topic of my lecture is: 
#BlackLivesMatter: A Challenge to the Medical and Public Health Communities

Speaking about racial justice and population health in South Africa, as an outsider, is of course a huge challenge. So I want to first acknowledge that many, if not all of you in the room lived through apartheid and have powerful personal narratives. So although my talk will focus on the US, and primarily New York City – I plan to speak for 45mins to allow enough time for questions and dialogue, to discuss some of the similarities and differences in our struggles for racial justice.

While efforts to advance social justice are often local – taking place in the streets, in neighborhoods, in communities – injustice and oppression is reproduced through dynamics at a larger scale, so situating this discussion within the broader context of globalization and history, is important.

Our struggles are not independent.

As I am sure all of you are aware, there have been a number of widely publicized deaths of Black men at the hands of the police across the United States in recent months...

In response to these deaths, a powerful movement has emerged under the umbrella #BlackLivesMatter, led by three queer Black women.

While this movement was created in 2012 after George Zimmerman (not a policeman), was acquitted for the murder of 17yr old Trayvon Martin, the use of the hashtag became much more widespread in the last few years in response to police violence, and became a common slogan during demonstrations, with many groups using the language of “Black Lives Matter” to create a sense of urgency around addressing racism and police violence.

...But of course from a public health perspective, there may be unique health needs due to overlapping forms of exclusion and discrimination, as highlighted in the third infographic showing that the average life expectancy of a black transgender woman is 35years – a shocking statistic on health inequity.

Before continuing, let me be clear that while I am using the hashtag #BlackLivesMatter in the title of my talk, it is to acknowledge that at this point in history in the United States there is real momentum, a movement. I am not directly part of or affiliated with the movement, although of course stand in solidarity with efforts to advance racial justice.

So the question is how should we as health practitioners engage with this movement and seize the opportunity of public outcry to advocate for change?

If we fail to explicitly talk about racism and health, especially at this time of public dialogue about race relations, we may unintentionally bolster the status quo even as society is calling for reform.
...Is there something unique about the skills or values we have as a health community, that could contribute to this public conversation?

And are there ways to work with the artists, journalist, politicians who are already engaged in this dialogue and expand the boundaries of public health practice to help undo injustice and transform power structures which perpetuate poor health for some?

... I am proud to say that the American Public Health Association has been very vocal making the case the health equity is about social justice. And almost two decades ago, in 1998, APHA released a policy statement, recognizing the Impact of Police Violence on Public Health urging governmental entities to increase the involvement of public health professionals in data collection and monitoring of police violence.

But I am not aware of a more recent organized response in support of the Black Lives Matter Movement.

In March I published a paper in the New England Journal of Medicine to encourage critical dialogue and action around racism and health and for health professionals to engage in the larger social movement spreading across the United States under the banner #BlackLivesMatter.

In that piece I argued that ongoing exclusion and discrimination against people of African descent across the life-course, along with the historical legacies of bad policies, continue to shape patterns of disease distribution and mortality. I believe we must be brave to use the term racism. And recognizing that the intent of the #BlackLivesMatter movement is to speak out about injustice more broadly, not only related to police violence, I believe doctors and public health professionals have much to contribute to this conversation.

Unfortunately many health professionals recognize that what they witness daily in terms of the different health experiences and outcomes of their Black patients is unfair, but they stumble toward inaction because tackling racism is daunting and often viewed as divisive and requiring action outside our purview.

I would like to believe that there are at least three types of action through which we can make a difference: critical research, internal reform, and public advocacy. In this talk I will talk primarily on the role of research, data collection and visualization, and how that can be used for advocacy.

Of course, these ideas aren't new, and build on nearly two centuries of calls for critical thinking and action advanced by black U.S. physicians and their allies.

And it’s important to remember this history, good and bad, so that we can really talk about this moment as a movement with roots.

... Critical Research.

I use ‘critical’ as an adjective to describe research that is not simply a ‘technical’ exercise about using methods correctly, but research which is thoughtful, and grounded in theory.

Theory is essential to ensure that the right questions are being asked, and that the results and policy implications derived are meaningful and effectively communicated. For example, simply showing that people of African descent have poor health outcomes is not useful if there is no discussion/theorizing about responsibility and accountability – who is responsible for the conditions, how can we change them, and when?

... So where are we? I believe that we have come a long way to describe the social roots of disease – and the resurgence of social epidemiology is truly welcome, but we have done little to develop an antiracist model of disease causation – although there are some notable efforts underway.
In policy circles and among those responsible for action on health equity, the socio-ecological model (or a version of it) is the most commonly referenced model which incorporates the social determinants of health. This has also been embraced by the CDC in many of its prevention efforts, as you can see in this slide.

But I find the socio-ecological model misleading because it places the individual at the center of concentric circles and creates a visual distance between the outer circles, such as policy, and the individual. This implies that action at the individual level may be more immediate or more impactful, and that policy does not directly ‘touch’ the individual – since visually they do not touch - which we know is not true.

At the same time this is still a descriptive model. While it may be a useful model to categorize the social determinants of health, it says little about inequities in the distribution of power and resources, or time (blind to historical events) and place.

Even in the most equitable society, the social determinants of health would be important for public health to consider. But when disparities are as stark as they are in NYC, or South Africa, we must explicitly discuss class inequality, racial/ethnic inequality and gender inequality and talk about the social and political determinants of inequity.

... Models of determinants of population health are not the same as models of determinants of health inequities. This is important... I wanted to point out three things.

**First:** Population distribution health is at the center – not the individual. This helps us get away from victim-blaming ideologies

**Second:** Different forms of inequality are explicitly named. By studying ways in which racial inequality, alone and in combination with other forms of social inequality (such as those based on class, gender, or sexual preference), harms health, researchers can spur discussions about responsibility and accountability.

**Third:** There is a reminder that we must think about the lifecourse, as well as the broader historical and geographic context

... So let me give some examples of how this can be done.

In the mid-1960s there was a distinct convergence of Black infant death rates in the Jim Crow and non-Jim Crow states – but this was not the case for White infants.

In 1960-64, the Black infant death rate was 1.19 times higher in Jim Crow than in non-Jim Crow states. Between 1965-69, that relative risk declined to 1.07. And because nearly two thirds of all Black infants born in the 1960 to 1964 were born in Jim Crow states, this decline is particularly important.

Of course as you can see this convergence occurred against a general trend of declining infant death rates, and a persistent Black-White gap which continues to today.
And it is important to stress that the racial gap can stay constant and even increase, even when the overall trend is one of progress. This is what we are seeing in New York City. While the numbers are small and there is therefore some variation, as you can see there hasn’t been a significant narrowing of the racial gap, despite the fact that overall infant mortality rate has dropped to 4.6 per 1000 live births in 2013 as compared to 6.7 in 2000.

In 2013, the infant mortality rate among non-Hispanic blacks was 2.8 times higher than among non-Hispanic whites, down from 3.3 in 2004 and 3.1 in 2012, but worse than in 2000 when the gap stood at 2.5.

A similar persistent and unjust racial gap can be found in the rates of maternal mortality in NYC.

... I believe an area for further collaboration between academic institutions and departments of health, as well as graphic designers and communications folk, is around mapping inequality.

This has a dual purpose:

1) Maps make injustice visible to generate outrage and political will for action/change; and

2) Maps give us information to target interventions appropriately to places with highest need

... Almost a decade ago, as a Deputy Health Commissioner, I helped set up three District Public Health Offices in locations with the greatest need – namely the South Bronx, East and Central Harlem, and Central Brooklyn. When I became Commissioner last year we looked at the data again to see if the targeting was correct, and sadly, although there had been improvements in health in these areas, premature mortality is still concentrated in these same neighborhoods.

Because New York City is highly segregated residentially by race and poverty-level, neighborhood-based approaches and geographical targeting of resources are by default health equity strategies.

But rather than seeing our work at the Department as simply supporting the “neediest” communities, it is important to see this work as “undoing injustice” -- recognizing that the unequal distribution of resources is because political power is concentrated in the hands of too few (often as a result of racism). With this in mind, as Commissioner I have asked the Department to take community engagement seriously, building real partnerships with those who are at the forefront of social justice activism and supporting community organizing as a tool to effect change across the different sectors that affect a community’s health outcomes.

Access Dr Bassett’s Lecture Slides at:

http://www.uwc.ac.za/Faculties/CHS/soph/News/Pages/Dr-Mary-basset.aspx#.VaOWh7Wzlv4
Thank you for inviting me to officiate at your graduation ceremony. I am delighted to be here today to meet such an accomplished and dedicated group of professionals from throughout South Africa and our neighbouring countries.

For the past 23 years one of the major activities of the School of Public Health has been the providing pioneering short courses in Public Health/Primary Health Care during Winter Schools at the University of the Western Cape. This programme of continuing education is probably the largest and oldest continuing education programme in public health in Africa and possibly in the global south.

I am privileged to participate in this special occasion for two main reasons. First – The future well being of our communities will only be served by committed professionals working in partnership with our communities – listening and understanding their needs. Offering learning opportunities such as this Winter School is vital to enable professionals to share best practice – whatever their respective discipline - in a spirit of discovery whilst questioning current practices and unblocking challenges to meet the ever changing needs of our diverse communities.

Second - I appreciate the opportunity to renew old friendships and make new ones. My family and I have enjoyed a long and warm relationship with UWC and especially with the School of Public Health. This began in 1975 when we sponsored bursaries for dental students. Over the years our relationship with UWC broadened and strengthened. As a Director of the MFF, Prof Jakes Gerwel played an important part in our work as well as inspiring new generations of leaders in so many diverse fields including public health.

During Jakes’ time as rector of UWC, the MFF was honoured to be one of the first major donors along with the MRC of the School of Public Health in 1992. Jakes’ vision then challenged medical schools who had yet to build such schools – now all have such schools – and the impact has been profound and delivered on the promise. With Jake’s move to Madiba’s office, it was no surprise that he supported public health measures as part of the Mandela inaugural projects after his election in 1994. In 2013, we sponsored an award in public health in Jakes Gerwel’s to acknowledge his contribution to public health.

In conclusion, quoting the Consortium of Universities for Global Health “...the message is clear – it is time for greater ‘innovation’ and a greater focus on ‘implementation’ with an eye towards having a positive and long-lasting impact on health ‘outcomes’. However, I am sure we all acknowledge that the best intentions in any policy or major programme can go astray in the implementation. Therefore, constant, vigilant reality checking will always be necessary – particularly reality testing in terms of equity proofing to ensure the gaps in health experience are not inadvertently increased. Ongoing education is a real investment in growing future leaders in this important field. And most important, as you leave here today, I feel sure you will continue to be ambassadors and guardians of the UWC vision as a pioneer in promoting human rights, ethics, good governance and social justice in all aspects of your work.

Congratulations on your achievements and very best wishes for a successful future.
Good day colleagues and students. Thank you for this opportunity. I feel truly honoured to be standing here today to address you.

Someone once said that a good speech is like a mini skirt – long enough to cover everything, but short enough to be interesting. I will try and keep mine short.

Today is about you. And as we celebrate the giant in you; the indomitable spirit that looms splendidly I’d like you to take a moment to bask in your own glory.

It takes moments like this to remind me of why I work at a university, and why I love events like these. It is about the constant sense of amazement I feel when people realise their dreams or the dreams of their loved ones. It is about appreciating the impact each and every student who leaves our gates with a certificate in their hand will have on society. It is about the feeling of victory and hope over the dark past that I know education can achieve. It is about sharing a special moment with those who chose to shine, and being able to celebrate your success with you. Yes, you chose to shine. Be proud and stand tall.

Marianne Williamson said: “Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us. We ask ourselves, Who am I to be brilliant, gorgeous, talented, fabulous? Actually, who are you not to be? You are a child of God. Your playing small does not serve the world. There is nothing enlightened about shrinking so that other people won’t feel insecure around you. We are all meant to shine, as children do. And as we let our own light shine, we unconsciously give other people permission to do the same.”

Life is about choices. You chose to shine. You chose to enrol for this course. You chose to make certain adjustments in your life to be available each day in class. You chose to further your education, training, and awareness. Because you knew that this choice will not only benefit you in perhaps getting that increase, or that promotion. But it will also benefit society. It will benefit a healthcare system in our country and continent which is under threat. Your family and friends will see you as role models. You may inspire someone to follow in your footsteps. You are contributing to a better society. And an educated society is a liberated society.

We are confronted with choices every moment of every day. Should I study for that test or watch tennis on TV? Should I have that slice of cake? Take the elevator or stairs? You chose to make certain sacrifices to be here. You worked hard. You decided that you wanted to learn. To grow. To shine. And you did! Congratulations!

But you could not have done it on your own. A number of factors worked together to make this possible. The University and the School of Public Health which saw the need to offer these courses; your family and friends who encouraged and supported you and made certain sacrifices with you; your employers who gave you the space and opportunity; and the gaping needs in the health system all collectively made this moment possible. But while they were enablers you were responsible for its successful execution.
There may have been moments in your studies when you wanted to give up. You may have questioned yourself about what you were doing; about where it would take you; how will it change what sometimes appears to be beyond your control; is it worth the effort, you may have asked? Trust me every effort is worth it. Before I leave I want to share a special story with you.

It's called the Starfish story.

Once upon a time, there was an old man who used to go to the ocean to do his writing. He had a habit of walking on the beach every morning before he began his work. Early one morning, he was walking along the shore after a big storm had passed and found the vast beach littered with starfish as far as the eye could see, stretching in both directions.

Off in the distance, the old man noticed a small boy approaching. As the boy walked, he paused every so often and as he grew closer, the man could see that he was occasionally bending down to pick up an object and throw it into the sea. The boy came closer still and the man called out, “Good morning! May I ask what it is that you are doing?”

The young boy paused, looked up, and replied “Throwing starfish into the ocean. The tide has washed them up onto the beach and they can’t return to the sea by themselves,” the youth replied. “When the sun gets high, they will die, unless I throw them back into the water.”

The old man replied, “But there must be tens of thousands of starfish on this beach. I’m afraid you won’t really be able to make much of a difference.”

The boy bent down, picked up yet another starfish and threw it as far as he could into the ocean. Then he turned, smiled and said, “It made a difference to that one.”

Congratulations and continue to shine!

Rational Medicines Use

One of the new courses offered at Winter School 2015 was the Rational Medicines Use Course. Chris Nobles reports on the week-long offering and Shun Govender interviewed Tinne Gils, a pharmacist with MSF, on her experience of the course.

Report BY Chris Noble

This last week the University of Western Cape SOPH led by Dr. Hazel Bradley teamed up with the UWC School of Pharmacy, SIAPS/MSH and the Boston University School of Public Health [BUSPH] to offer the second Rational Medicine Use [RMU] course for the 2015 Winter Session. As a part of an ongoing collaboration project between UWC SOPH and BUSPH, Chris Noble, a masters student from BU and intern at UWC for the winter sessions, helped support the course and facilitate future collaborations between both school's access to medicine programs. The class consisted of 17 participants from pharmacists and medical professionals from several regions including the Western Cape, Swaziland, and Medicine San Frontier.

After starting with an informational and engaging presentation by Professor Richard Laing on the benefits of RMU and the potential costs of irrational use, the class were presented real life scenarios to relate back to their respected colleagues stressing the importance of critical pharmaceutical use.
Next, Dr. Janine Jugathpal from the National Department of Health gave a presentation on the Essential Medicine List and Standard Treatment Guidelines that provided a critical look at the tender and procurement process in South Africa. Many students actively participated in the various topics including the costs and benefits of incorporating DALY vs economic justifications for tender decisions and the importance of sufficient procurement agents and a transparent selection process to increase accountability with the public.

Later in the week, Nondumiso Ncube from SOPH and Reneir Coetzee from the School of Pharmacy walked the class through the process of analyzing a new drug through primary literature so the participants can apply these lessons to what would be expected in the field. For example, if you encounter a new antihypertensive drug and you want to incorporate it's use into your formulary, what steps can one take to ensure the drug's benefits outweigh the potential harms of treatment for my patient? What elements of the paper should you take most into consideration?

We were glad to have some local professionals sharing their practical experiences with the participants. These included Yasmina Johnson from the Western Cape Provincial Department of Health on Pharmacy and Therapeutic Committees and Professor Andrew Whiteclaw regarding antimicrobial stewardship.

Percy Daames, from UWC SOPH, presented the ABC analysis, a way of analyzing medicine costs, which was highly valued as participants felt capable of sharing their experiences and teachings to their respective groups and organizations. Others valued the big picture element of the ABC and VEN analysis. People can begin to see the big picture of the health system in connection to their individual components to improve their management and stewardship practices. One participant said that she "had gained clarity in many concepts that were once misconstrued."

To close out the week, Percy Daames presented on the Medicine Use Evaluation [MUE] steps and closed the session with this unifying quote:

"ABC and VEN models say what and how many medicines are used. DDD and MUE say where and it what context are they used. Qualitative analysis says why certain medicine responses happen and the combination of these strategies of evaluation results in the Rational Use of Medicines to improve patient health outcomes."

With the conclusion of our second year of hosting the RMU course, the team here will use the participants evaluations to generate ideas for improvements in future sessions. We hope our participants can bring what they learned during this session back to their professions and begin incorporating their Rational Medicine Use skills in the field.
Interview with Tinne Gils

Shun
How did you find our new course on Rational Medicines Use (RMU)?

Tinne
I found it very helpful. It has given me an insight in the general framework of rational medicines use and which aspects of it can be relevant to target to improve. We went into some very useful applicable tools on first of all monitoring and evaluation and explored some specific interventions and strategies to optimise the rational use of medicines.

Shun
So what is Rational Medicines Use?

Tinne
RMU encompasses everything that is related to the appropriate use of the most appropriate medicines at a cost that is most acceptable for the setting. This rationalisation of RMU comes from a WHO definition where in a given setting where resources are limited, you will try to find the optimal strategy to treat the most people by use of medicines in a cost-effective way.

Shun
Given the South and Southern African situation why is this issue of RMU important?

Tinne
I work in Southern Africa and it is extremely important in this setting, because of the fact that resources are by definition limited. So it is essential from a public health perspective to be able to treat the highest number of people in the most appropriate way. You balance the resources you have with the best treatment available. So RMU touches on pricing, selection, availability, on policy like standardization of treatment regimens – and making tools guiding RMU available and applied at all levels of the supply chain. Which is not an easy task!

Shun
There is definitely a great need for such a course to be offered by the School of Public Health. Do you think that there will be a vigorous uptake of this training from government?

Tinne
Well actually, there is a very good uptake from government stakeholders for this course! Most of the people on the course are working in government settings, with a few (including myself) from the non-government sector and some private sector actors. There are mostly health care workers from the department of health, with a medical or pharmacy background.

Shun
As someone from Doctors Without Borders (MSF), how will you find the course relevant for your work?

Tinne
In the last few years we have an increased presence of pharmacists in the organisation, which is historically very medically driven. There is a realisation of the importance of pharmacists in MSF for the benefit of the medical supply chain, to give pharmacological expertise, work on access issues (which is very important in MSF through the MSF Access Campaign), and ensure medicines quality and pharmacovigilance. But there is also a growing interest to look at rational drug use, especially the good use of antibiotics and antiviral medicines in order to avoid resistance. There have been a few research projects in MSF settings where rational drug use is being monitored and evaluated.
**Shun**

*What is your background?*

**Tinne**

I am a Belgian-trained pharmacist. I also have a Masters in Industrial Pharmacy, which basically is private-sector pharmaceutical production, but never worked in this sector. I also did a Post-graduate Diploma in Biomedical and Tropical Sciences in Health at the Institute of Tropical Medicine (ITM). After a few years of work in private retail pharmacy in Belgium, I have been working in MSF for the last five years. I started my MSF work in Lesotho, then in South Sudan in emergency refugee crisis, in Mozambique, in South Africa on specific projects, and in Malawi. I am currently in a multidisciplinary team in MSF called the Southern African Medical Unity (SAMU) working to support HIV and TB projects across the region of Southern Africa and beyond.

**Shun**

*Has there been any discussion on the course on the issue of the illegal trade in medicines and the clandestine routes used to do this kind of illegal work?*

**Tinne**

We touched on it briefly but did not go into debt. Although illegal trade in mostly falsified and substandard medicines are a big problem in many Southern African countries, in South Africa this is probably less of an issue because there is a quite stringent quality assurance policy. The course is very interesting for me to understand the South African situation well and compare this to other contexts in which I work.

It would of interest to discuss how to balance limiting falsified or substandard medicines from entering a country without losing efficiency in registration procedures. We did talk about what can be done to monitor quality at end-user level, such as effective feedback mechanisms to report quality problems.

**Shun**

*What is your view on stockouts?*

**Tinne**

MSF and other civil society actors have been very much engaged especially in South Africa, but more and more across the region, on the problems surrounding supply chains and medicines availability and the impact that that has on patients. South Africa is a very good example. A survey that was done by the Stop Stockout Project at the end of last year focusing mostly on HIV and TB drugs but also including vaccines and some other essential medicines. We discovered that one in four facilities in South Africa had a stockout of HIV and/or TB drugs, which is a worrying situation for a country with a very large HIV programme. It should be a priority to be tackled by the government. That being said some countries are not doing better or even worse, while countries like Malawi and Zimbabwe have quite well structured supply chains so they are limiting their stockouts quite effectively.

We in MSF see it as a priority for governments, and donors to not only put the medicine in place but also to ensure that the route is assured to get them to patients, and even to get them into the community. We are supporting community models of care, exploring how patients access medicine better, faster, closer to their home, with extended refill intervals – ways of accessing treatment that are as patient friendly as possible. Fixing the supply chain is a high priority in order to make this happen and to be able to treat ever growing cohorts, and earlier initiation of treatment. Better and easier to take drugs are now available, so let’s get them to patients and let’s put the necessary structures and strategies in place to make that happen.

**Shun**

*Say a little more about community models of getting medicines to patients.*

**Tinne**

There are a lot of different models that could work for different settings. For example, where there are very long geographical distances, you might want one patient to come a pick up drugs for other patients who are already stable on the ARVs. So they would go into the
community, discuss in groups about adherence issues, their side effects and while providing medicines for their peers.

Another models that has been tested in South Africa is the club model where a group of twenty or more patients comes to the facility or to a community point and access their ARVs at the same time so it reduces workload in the health facilities, it’s easier for patients, and its beneficial for retention in care.

A model like the Chronic Dispensing Unit (CDU) in the Western Cape, where you have chronic medicines being prepacked at a private sector factory and delivered by patient name to facilities could be used to deliver to the community directly, because its already been dispensed and labeled for a specific patient. We need to make it as easy as possible for patients to access their medicines. There is no reason why a patient who has been stable on treatment for years should not have access to this kind of flexibility.

Another intervention is to just increase the medicines refill interval. In South Africa there’s still the need legally to have a clinical visit every six months. Patients who have to do a viral load test only once a year shouldn’t have to come every six months.

Easier access, closer to home: that’s the way to go

*Shun*
*And you are hopeful that this will happen?*

*Tinne*
I’m hopeful! There are a lot of great things that are being done. What we see as one of the critical barriers is sometimes legislation that doesn’t allow task shifting, of medicines dispensing and supply chain issues.

*Shun*
*What is your view on the way in which this Course has been delivered, on the facilitation and teaching, and the course material?*

*Tinne*
I think there a few really strong evidence-based sessions where studies were being shown, with results of interventions, suggesting best practices. There were many very interesting speakers with a lot of experience, like Dr Richard Laing. So there is a lot of expertise available and very valuable for the Course.

There were a few sessions that could have been a bit more practical or more specific on how can this knowledge now be used in a practical setting.

Overall I’m very happy that I took the Course and I think most of the participants are, Now it’s a matter of putting it into practice!

*Shun*
*Thank you very much for sharing!*
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Missed Opportunities along the Prevention of Mother-to-Child Transmission Services Cascade in South Africa: Uptake, Determinants, and Attributable Risk (the SAPMTCTE)

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Abstract

Objectives
We examined uptake of prevention of mother-to-child HIV transmission (PMTCT) services, predictors of missed opportunities, and infant HIV transmission attributable to missed opportunities along the PMTCT cascade across South Africa.

Methods
A cross-sectional survey was conducted among 4–8 week old infants receiving first immunisations in 580 nationally representative public health facilities in 2010. This included maternal interviews and testing infants’ dried blood spots for HIV. A weighted analysis was performed to assess uptake of antenatal and perinatal PMTCT services along the PMTCT cascade (namely: maternal HIV testing, CD4 count test/result, and receiving maternal and infant antiretroviral treatment) and predictors of dropout. The population attributable fraction associated with dropouts at each service point are estimated.

Results
Of 9,803 mothers included, 31.7% were HIV-positive as identified by reactive infant antibody tests. Of these 80.4% received some form of maternal and infant antiretroviral treatment. More than a third (34.9%) of mothers dropped out from one or more steps in the PMTCT service cascade. In a multivariable analysis, the following characteristics were associated with increased dropout from the PMTCT cascade: adolescent (<20 years) mothers, low socioeconomic score, low education level, primiparous mothers, delayed first antenatal visit, homebirth, and non-disclosure of HIV status. Adolescent mothers were twice (adjusted odds ratio: 2.2, 95% confidence interval: 1.5–3.3) as likely to be unaware of their HIV-positive status and had a significantly higher rate (85.2%) of unplanned pregnancies compared to adults aged ≥20 years (55.5%, p = 0.0001). A third (33.8%) of infant HIV infections were attributable to dropout in one or more steps in the cascade.

Conclusion
A third of transmissions attributable to missed opportunities of PMTCT services can be prevented by optimizing the uptake of PMTCT services. Identified risk factors for low PMTCT service uptake should be addressed through health facility and community-level interventions, including raising awareness, promoting women education, adolescent focused interventions, and strengthening linkages/referral-system between communities and health facilities.

Exploring Corruption in the South African Health Sector

Abstract
Recent scholarly attention has focused on weak governance and the negative effects of corruption on the provision of health services. Employing agency theory, this article discusses corruption in the South African health sector. We used a combination of research methods and triangulated data from three sources: Auditor-General of South Africa reports for each province covering a 9-year period; 13 semi-structured interviews with health sector key informants.
and a content analysis of print media reports covering a 3-year period. Findings from the Auditor-General reports showed a worsening trend in audit outcomes with marked variation across the nine provinces. Key-informants indicated that corruption has a negative effect on patient care and the morale of healthcare workers. The majority of the print media reports on corruption concerned the public health sector (63%) and involved provincial health departments (45%). Characteristics and complexity of the public health sector may increase its vulnerability to corruption, but the private-public binary constitutes a false dichotomy as corruption often involves agents from both sectors. Notwithstanding the lack of global validated indicators to measure corruption, our findings suggest that corruption is a problem in the South African healthcare sector. Corruption is influenced by adverse agent selection, lack of mechanisms to detect corruption and a failure to sanction those involved in corrupt activities. We conclude that appropriate legislation is a necessary, but not sufficient intervention to reduce corruption. We propose that mechanisms to reduce corruption must include the political will to run corruption-free health services, effective government to enforce laws, appropriate systems, and citizen involvement and advocacy to hold public officials accountable. Importantly, the institutionalization of a functional bureaucracy and public servants with the right skills, competencies, ethics and value systems and whose interests are aligned with health system goals are critical interventions in the fight against corruption.

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