

## IN CONVERSATION WITH PROF. HELEN SCHNEIDER

*Shun Govender*



### **What brought you to Public Health?**

I've had a longstanding interest in the problem of transformation in South Africa's health system. I started my career more as a practitioner – as a public health activist – in trying to make a difference. I didn't start off as a researcher, but have always been interested in the thinking through of policy and policy implementation in the South African health system.

I encountered primary health care and district health systems very early on in my working life. These were the formative first years from where I gravitated towards public health. From around 1990 onwards I became very involved in the networks that were thinking about how to restructure things.

The issues and problems I've been interested in are broadly framed around the post-1994 transformation of the health system and are very much focused on the philosophy and set of principles around it. I am interested in the day-to-day movement of the health system and how to engage with it; a desire to make a difference as well as to reflect critically on it – to be a kind of critical mirror to what is happening and be able to make sense of it.

For many years I was based in the Centre for Health Policy at Wits University. We spent a lot of time thinking and reflecting particularly on the changing political dynamics. I saw

how things unfolded especially around the massive HIV epidemic which then became the centre of everyone's preoccupations. The Mbeki era was critical in forcing researchers to think about what their place is and to not take it for granted that they were on a kind of moral high ground.

***'Policy-responsive Research and Community Health Workers' What does that mean practically for your research endeavour?***

It would be not just about research. It would be about working with people. Universities work generally from the tripartite notion of teaching, research and service, particularly in an applied field such as ours. Schools of public health are oriented towards the major health needs of the country. They should be engaged in developing understanding of the country's problems.

The UWC School of Public Health happens to be a place that has that history of engagement and a very proud tradition of it. Its preoccupations have always been at the core of how to create a better health system in South Africa.

There are forms of research in schools of public health that may start with questions that are generated by the researchers themselves; you can have very high level conceptual work or complex methodological work; you can hone in on one particular phenomenon and investigate it in a huge amount of depth. Or you can have an agenda of research that starts out with the problems that are defined by the practitioner and the practitioner environment. There is a place for both kinds of research.

I suppose if you really want to stretch the boundaries of knowledge one shouldn't be too tied to the current problems – one must have a more long term vision. I think that there is a place for different kinds of approaches to research. My particular area of interest is in where knowledge communities, or people who sit in academic environments meet the practice environment and what happens at that intersection.

So for me work on community health workers has been a long engagement over a number of years. I was part of the post-1978 Alma Ata period. I was training as doctor then, graduating in the early 1980s and then working in a rural hospital where there was a real attempt by the people working there to implement some of the Alma Ata ideas: a programme around primary health care, training primary health care nurses, looking at questions of community participation quite seriously. It was part of a radical critique of the status quo and formed part of the network of other people who were involved in the anti-apartheid health movement such as the Progressive Primary Healthcare Network, NAMDA etc.

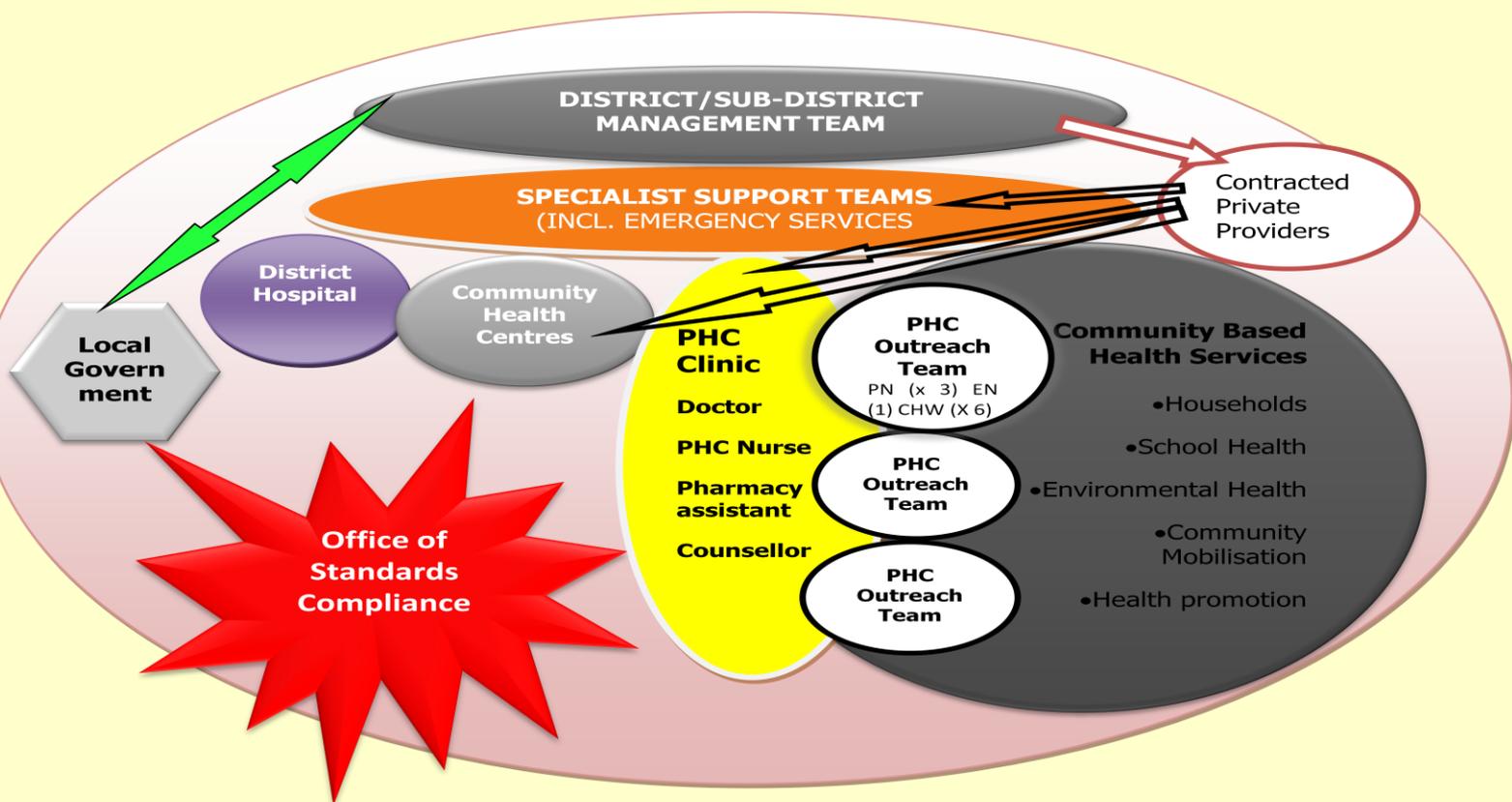
Most of the community health or lay workers in South Africa, emerged as an organic network of community caring largely around HIV and TB. It's been a massive growth; the formal policy positions in 1994 were not to have community workers. But with HIV we've had a huge number of lay workers emerging to fill gaps in service provision. And witnessing the AIDS activism and AIDS social rights movements as connected to all of this, I've come to see this as representing a potential space where I think transformation can happen. Which is why I have been very interested in it because it's been a complex organic development that represents a new kind of engagement of citizens in the health system. So if the health system from the top is struggling and can't change then this is a force potentially from the bottom that will shift things.

***You talk about the linkages between the researcher, the policy makers and the practitioners who face the day-to-day problems, and you have to exist at the interface where the need expresses itself most. How do you manage that?***

One of the enduring commentaries on the post-apartheid era has been the proliferation of good ideas and the failure to implement them. That's the central critique of what's

happened! Beautifully written documents by very clever people with puny implementation and the inability to translate ideas into practice

Around HIV one of the most successful policies in the country ironically has been antiretroviral therapy. There was such a battle to get it. But that battle mobilized a massive number of people on the ground. It created spaces of energy across the system that propelled it, and influenced what happened at the top as well as led to the emergence of partnerships in the NGO sector and the rights-based discourses. It is clear that it had a powerful impact at numerous levels in the macro-policy environment but also in the day-to-day interactions between patients and providers. What happens around HIV has in many ways forged spaces of exceptionalism within the health system. The question is how to extend that.



***What then is the message to the policy makers? I know that it's not an either-or. How does one engage with them?***

There's a very big ongoing tension particularly because of the federal nature of the political system. The national level feels that it is compelled to deliver – it has the money – meaning that central government retains quite a lot of responsibility. But a lot of decision making happens at lower levels of the system.

So the big challenge is how to create enabling policy environments at a national level, and how one gets conversations of cooperative governance between national and provincial governments and between provincial and local governments, and between provinces and district health systems. I don't think that we've managed to create a coherent national vision of what the health system is trying to do across all these divides. A major challenge for the reengineering of primary health care is to communicate it and get people to buy into it. If it is going to be a renaissance period and we are going back to some of the original founding ideas, a very large number of people have to be brought on board, as managers at every level but also the hundreds of thousands of providers at the coalface who in a sense are 'the moment of truth' of the system.

***In terms of the role that an institution like SOPH can play where – in terms of your experience and insights into how the system works – do you think this School can and should be asserting itself as a research institution, as a place where we are also trying to assist policy makers and provide training.***

The SOPH runs wonderful educational programmes, and particularly the Summer and Winter Schools that attract a South African audience at middle management levels. There are some other Universities that do this but the UWC summer and winter schools are quite special in this regard and provide a mechanism to tailor courses to the practitioner environment and the need for practical skills. But also to work at a Masters and PhD level to build institutional intelligence oriented to the South African health system.

Then there are a large number of research questions that can be tackled and many possibilities for getting involved in helping to implement, although over the years I've come to understand that universities have a limited role in that. When you are inside the system you have a lot more tacit knowledge about how to go about doing things which we just don't have.

We have the formal knowledge, so the issue is what we bring to bear in that respect. I think it is a kind of principled approach based on our understanding of international best practice, our understanding of history and what health systems have done elsewhere, our conceptual and theoretical understanding and engaging in international debate around what is health systems and policy research and how to work with some of the cutting edge stuff around notions of complexity and how to bring that to bear on health systems as organizations. We do need to have some of that as well as the much more applied, pragmatic research.

And I think partnerships is the name of the game, such as the partnerships that Prof. Uta Lehmann and others have been forging with UCT on a number of projects building a platform of collaborative endeavour; such as the DIAHLS project we are doing with UCT where practitioners are being brought more and more into a discussion. There is a real exchange there as well as a reflective space.

***How are we faring with regard to the Millennium Development Goals (MDGs)? Why is that we not doing so well or are going to miss the targets?***

I think that if we did not have HIV we would have been on target. When I started my public health career in the late eighties it was clear that our infant mortality rates, particularly in the urban areas, were going quite rapidly into decline. In areas like Soweto, for example, the notion of young children dying disappeared for almost a generation and then started coming back again with HIV.

One cannot underestimate what the HIV/AIDS epidemic has done to shape health in this country; it's been completely devastating. It's changed the practice of health care at every level. It's also influenced politics, and we'd probably be doing much better as a country on poverty and in equality if we did not have it.

But having said that, HIV has come on the top of all the other legacies. What we have in South Africa is a health system that spends more than 8% of GDP and produces very little for that. That's because 15% of the population consumes half of that 8%. That is what the National Health Insurance (NHI) is supposed to address. There is a massive maldistribution of resources.

The political space also hasn't been able to work sufficiently to address that legacy. There have been moments of success, but how to prioritise what is needed, how to create the systems that do that, how to build the capacity in and across sectors and working with a complex array of stakeholders, has not been adequately achieved. Stakeholders include public and private providers, drug manufacturers, insurance companies, governmental

systems, professionals and professional interests. It is about how to navigate this complex environment.

***What you are saying is fascinating! In our struggle for a better society some people came in on a vision of what they wanted to implement and inherited all of the challenges that come with turning vision into reality. What I'm hearing you say is that you've gone through a baptism of reality (in terms of health care in this country), encountering the problems, being a practitioner and struggling through some of the research questions. My question to you is: how do you keep your vision, how do you keep going? Do you have hope and is SOPH that place for you?***

We had hope, and it could have been different, as we know from other experiences in the world! But this is also the privilege of being in an academic environment: that you are removed from the day-to-day trauma of it. Our job is to reflect. It's about always discovering within a very chaotic and unsatisfactory aggregate picture, spaces of achievement. The West Coast District, for example, has civil servants who are doing an amazing job, really implementing and providing good health services and continuity of care. There is an integrity in the way the system is functioning. You see that a lot in health facilities where there is a good manager. At the coal face of the health system there is still space to do things well.

The current minister of health is deeply committed to making a difference. There are still principled people around which makes it worth fighting for. It may not last, so one has a much more acute sense of windows of opportunity. We have become much more strategic in the way we do things, despite the scepticism. It helps also that globally public health has come up on the agenda with a lot more money and global initiatives going into it. There is a reinvestment in health and with the money there is the realisation that if you want to implement all the interventions like malaria, TB, HIV and other programmes, that you need a functioning health system as the vehicle for that. Health systems are now becoming an area of academic interest also.

## **Prof. Oldenburg speaks about his research on Diabetes at SOPH**

***Lungiswa Tsolekile***



Prof Brian Oldenburg's presentation focused on ***strengthening the global evidence base for effective prevention of diabetes and its complications***. He summarised several randomised trials that were undertaken in Finland, USA, India, Japan and China and have been reported to be effective in preventing the development of Type 2 diabetes mellitus. He however pointed out that these intervention trails were too costly and intensive to be implemented in a real world setting. This poses a challenge to scaling up such interventions. He also shared how he and colleagues from India have scaled up these trials taking into consideration the socio behavioral model; enviromental and other factors that may influence lifestyle modification. His current interventions include the use of peers supporters and technologies to improve the control of diabetes. Brian's talk was very interesting and stimulated discussions about the relevance of these interventions in countries such as South Africa where there are many challenges to change behaviour towards healthy lifestyles.

Brian Oldenburg (Ph.D) is Professor of International Public Health and Associate Dean (Global Health and International Campuses) at Monash University in Australia and Director of the International Public Health Unit. His research program focuses on health policy, global health and the primary and secondary prevention of chronic conditions, such as diabetes and their associated social and behavioural risk factors across the life-course. He has conducted research in health care settings, work organisations, schools and other community settings in Australia and other countries that include China, Malaysia, India, South Africa and Finland. Over the past 15 years, he has increasingly focused on the development of the academic public health capabilities of LMICs both through his own research and through his extensive involvement with a number of capacity building networks. His research productivity is evidenced by almost 300 publications, including more than 150 peer-reviewed journal articles. He has co-authored many major (inter)national reports and monographs examining aspects of health trends, socioeconomic determinants of health and building public health capabilities of Australia and other countries. He has held senior appointments in many (inter)national organizations related to health, behavioral medicine and public health. He serves on the editorial board of several journals, including *Translational Behavioral Medicine*. In 2006 he has awarded a Lifetime Fellowship membership of the US Society for Behavioral Medicine for his contribution "to building evidence-based population health interventions that can guide practice and change policy globally". He holds current Honorary Professorships at University of Queensland and Beijing CDC.

## Accessing Medicines in Africa and South Asia

*Kim Ward, Caroline Kinyua*

Accessing Medicines in Africa and South Asia (AMASA) is a comparative research study investigating how the complex interplay of patent regimes, pharmaceutical regulation, engagement by foreign donors, local production capacity and supply chain efficiency influences appropriate and affordable access to medicines in India, South Africa and Uganda. The project examines the production, distribution, supply and consumption of medicines through the lens of 7 tracer drugs which are commonly used in various national health programmes, including HIV and TB, Malaria, Reproductive Health, Mental Health, Pain Management and Diabetes.

AMASA is a 3 year research project funded under the European Union's Framework Programme 7. South Africa's involvement in this project is through the University of the Western Cape, School of Public Health (Principal Investigator: Prof. David Sanders), in collaboration with the School of Pharmacy. Academic leadership and technical support is provided by partners from the North, including

### ***Dr Kim Ward***

Queen Mary University of London, University of Edinburgh, Ghent University and the Swiss Tropical and Public Health Institute.

The project commenced in May 2010 and we are currently in the second year of research. At an induction workshop in July, 2010, seven technical working groups were selected to focus on various research topics, inter alia, medicine regulatory systems and policies, the local production capacity and sustainability and supply/distribution chains within respective study countries. To date, the chief deliverable generated by the 7 technical working groups is the extensive literature review conducted in the three study countries which identified information gaps and set priorities to be addressed by each country in field work activities. Data collection tools are in the process of being developed and are on course to be completed in time for submission of country research plans to the respective Institutional Review Boards at the end of June 2011. Fieldwork is scheduled to commence in August 2011.

A brief synopsis of the undertakings within two of the seven working groups is provided by two of the project research assistants below.

### ***Donors and Patent & Trade Regulations Working Groups***

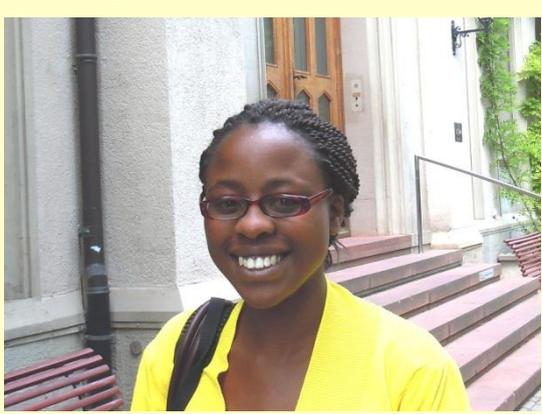
A key component of the research is mapping our donor fund flows to key health areas in the country. External funding accounts for just under 1% of the total expenditure on health in South Africa. With a substantial amount of this external revenue channelled to financing HIV/AIDS programs and TB treatment care, the project aims to determine how these funds enhance or impede access to essential medicines. Secondly, the research aims to determine if the activities of these external funders contribute towards strengthening the health system.

In addition, through this research we would like to determine the impact of patents and trade regulations on access to medicines, particularly, patent infringement and cross-border trading in pharmaceuticals. South Africa has a progressive regulatory

### ***Caroline Kinyua***

framework with Trade and Related Aspects of Intellectual Property Rights (TRIPS) flexibilities incorporated in three forms of legislation: the Patent Act, the Medicines Control and Related Substances Act and the Competition Act. These three pieces of legislation have been utilized in different occasions to ensure access to medicines. Key research priorities for AMASA are: identifying barriers to cross-border distribution of drugs and evaluating patent status and price

for off-patent and patented combinations of selected medicines (selection criteria unique to the project).



### ***Consumer and Community Interests Working group***

This Working Group examines consumer and community interests in accessing and using essential medicines in India, South Africa, and Uganda. It situates this focus within contextual factors that shape consumptive behaviour, including cultural beliefs about illness, normative help-seeking patterns, patient perceptions of health care and medicines, and extant structural barriers and healthcare interventions. Whereas other AMASA working groups address questions about the

***Bvudzai Magadzire*** production, regulation, financing, and distribution of essential medicines, this working group investigates the factors that contribute to care-seekers' ability or inability to obtain these commodities and that influence the appropriate or inappropriate use of them. As such, it focuses on the critical endpoints in the supply of medicines to communities in developing countries represented in this study.

There are a few specific objectives that guide the examination of research pertaining to consumer and community interests. The first is to determine availability, access, and costs of medicines to consumers in urban and rural areas. The second and related objective is to assess consumer perceptions about need, availability, accessibility, affordability, value, safety, and efficacy of medicines and how these attitudes affect both the decision to obtain medicines and to use them appropriately. Describing these subjective factors also demands attention to how they articulate with broader cultural beliefs about illness and treatment and normative help-seeking strategies and treatment experiences. Another objective is to examine the mutual relationships of accessibility and affordability of medicines with livelihood, gender and social dynamics, poverty, and local-level resilience strategies. A final objective is to compare these community level factors across the study countries and across tracer medicines where possible. To gain this information, we intent to conduct fieldwork in at least 2 provinces in South Africa and conduct interviews and focus group discussions with patients, staff at health facilities, members of support and advocacy groups and community members in general.

### ***Renata and Cassie from Canada intern at SOPH***



Renata E Mares is completing a 6 months internship at the School of Public Health, University of Western Cape. She is representing the Human Rights Internet, an agency funded through the Canadian International Development Agency. Previously, Renata completed her undergraduate studies in BSc Nursing and BA Honors in Kinesiology at the University of Western Ontario, Canada. She then started her career as a Public Health Nurse in Sexual Health Clinical Services and Vaccine Preventable Diseases Program at Wellington-Dufferin-Guelph Public Health Unit. After 2 years of work experience, Renata continued her academic achievements at the School of Population Health, University of Queensland, Australia finishing her Masters of International Public Health. Currently, Renata is part of the Global Health Initiatives research group at the SOPH as a research analyst.

***Renata Mares***

Cassie Schwarz will be interning at the School of Public Health for the next six months. She recently completed my MSc in Human Rights and International Politics from the University of Glasgow following the completion of the BA (Honours) Development Studies program at the University of Calgary. Before coming to UWC, Cassie worked as a Research Assistant for the Faculty of Nursing at the University of Calgary. She has also conducted an independent research project in Ghana, concerning the state of maternal health care. Additionally, Cassie has been active in the voluntary sector. She established the Calgary branch of Oxfam Canada and aided in policy research for the British Columbia Green Party. Currently, she is excited to be working with the PURE research team.



*Cassie Schwarz*

## Medical Schools in Sub-Saharan Africa

Prof Fitzhugh Mullan MD, Seble Frehywot MD, Francis Omaswa FRCS, Prof Eric Buch FFCH(CM)(SA), Candice Chen MD, S Ryan Greysen MD, Travis Wassermann MPH, Prof Daa ElDin ElGaili Abubakr MD, Magda Awases PhD, Charles Boelen MD, Prof Mohenou Jean-Marie Isidore Diomande MD, Delanyo Dovlo MWACP, Prof Josefo Ferro MD, Prof Abraham Haileamlak MD, Prof Jehu Iputo MBChB, Prof Marian Jacobs MBChB, Prof Abdel Karim Koumaré MD, Prof Mwapatsa Mipando PhD, Prof Gottleib Lobe Monekosso MD, Emiola Oluwabunmi Olapade-Olaopa MD, Prof Paschalis Rugarabamu DDS, Prof Nelson K Sewankambo MBChB, Heather Ross MPH, Huda Ayas EdD, Selam Bedada Chale BA, Soeurette Cyprien BA, Prof Jordan Cohen MD, Tenagne Haile-Mariam MD, Ellen Hamburger MD, Laura Jolley MPH, Joseph C Kolars MD, Gilbert Kombe MD, Andre-Jacques Neusy MD

### Summary

Small numbers of graduates from few medical schools, and emigration of graduates to other countries, contribute to low physician presence in sub-Saharan Africa. The Sub-Saharan African Medical School Study examined the challenges, innovations, and emerging trends in medical education in the region. We identified 168 medical schools; of the 146 surveyed, 105 (72%) responded. Findings from the study showed that countries are prioritising medical education scale-up as part of health-system strengthening, and we identified many innovations in premedical preparation, team-based education, and creative use of scarce research support. The study also drew attention to ubiquitous faculty shortages in basic and clinical sciences, weak physical infrastructure, and little use of external accreditation. Patterns recorded include the growth of private medical schools, community-based education, and international partnerships, and the benefit of research for faculty development. Ten recommendations provide guidance for efforts to strengthen medical education in sub-Saharan Africa.

Source: *The Lancet*, Volume 377, Issue 9771, Pages 1113 - 1121, 26 March 2011 Published Online: 11 November 2010  
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61961-7/abstract#aff1](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61961-7/abstract#aff1)

***All work and no play will make SOPH an unhealthy place!  
SOPH in action at the UWC Cricket Day March 2011***

