Public-health icon Professor David Sanders was awarded an honorary Doctor of Science in Medicine by UCT on Friday 8 June 2012.

His work has contributed to the understanding of primary health care as a framework for health and development, and to improvements in child health through research, teaching and training, and policy advocacy and service development.

Born in 1945, David Sanders trained as a medical doctor in Zimbabwe. He qualified in paediatrics and public health in the UK and returned to Zimbabwe in 1980, working in paediatrics and district health and heading the Department of Community Medicine at the University of Zimbabwe.

Prof David Sanders

He later became the founding head of the School of Public Health at the University of the Western Cape, where he established the first multidisciplinary master's programme of its kind. He has pioneered thinking on the implementation of the World Health Organisation's model of primary health care.

The importance of his work has been recognised by policymakers and implementers, both internationally and locally. He is often called upon to contribute to analysis and policy development by a range of both state and civil society actors, including the World Health Organisation, UNICEF, Oxfam, Save the Children, the national and provincial departments of health, and labour organisations.
CITATION

Vice Chancellor, I have the honour to present, for the award of the degree of Doctor of Science in Medicine, honoris causa, David Mark Sanders.

Enter the four horsemen of the apocalypse. Pestilence, War, Famine and Death.

Pestilence carries a bow and wears a victor’s crown, War brandishes a sword, Famine bears the grain-weighing scales and Death, pallid as a corpse, is empty handed.

These four horsemen are mythical characters released as harbingers of the last judgement, inflicting their scourges onto the earth.

Most of the developed world lives as if immune to at least Pestilence and Famine, but in the least developed world, the four horsemen constantly ride over the land.

David Sanders would add a fifth horseman to the list: Social Injustice.

Why do 13 million children still die each year from preventable causes? Why is health care not available to every individual in the world? Why does Ethiopia import emergency rations to treat malnutrition whilst selling off prime land to food transnationals? Why has South Africa’s import of processed food products gone up exponentially?

David Sanders has spent his life challenging the horsemen at their very source – Greed and Official Complicity. He started a community clinic whilst he was still a fourth year medical student at Harare Hospital in the old Rhodesia. Later, whilst specialising in the UK, he became clearer about the bigger questions of politics and health. He started writing a pamphlet as a guide for health workers in developing countries. What he thought would take 3 weeks took 3 years and turned into his book, “The Struggle for Health”.

The book was published in 1985 and the key concepts are still relevant today: That social inequities are the cause of health inequities; that access to health is a basic human right and that Health for All can only be attained through a more equitable distribution of wealth, resources, opportunity, and ultimately, power.

He is a truth teller – forcing us to confront essential and difficult questions. He is resolute that medical solutions to illness are not solutions if people lack the power to determine their own destinies. He is radical, outspoken and tenacious.

His contribution has been as a pioneer thinker around the necessity for a political understanding of health. He has been a role model and a visionary leader in the People’s Health Movement, and, through the School of Public Health at the University of the Western Cape, he has helped to grow and develop entirely new paradigms of Public Health.

David Sanders is a challenger for the thundering hooves of the apocalyptic horses, doing so with Advocacy and Mobilisation as his weapons, and with Equity, Honour and Justice at his back.

Vice Chancellor, I have the honour to invite you to admit to the degree of Doctor of Science in Medicine, honoris causa, David Mark Sanders.
The University of the Western Cape (UWC), School of Public Health and School of Pharmacy are currently working on a research partnership project, “Accessing Medicines in Africa and South Asia (AMASA)”. This multi-country project aims to characterise the chief barriers in the pharmaceutical system hampering appropriate and affordable access to medicines, from both a demand and supply side. Partner institutions from the North include Edinburgh University (project co-ordinators), Swiss Tropic and Public Health Institute (STPH), Ghent University, and Queen Mary University of London. Our Southern partners, representing the study countries of which South Africa is one, include the Foundation for Research in Community Health (FRCH) in India and Makerere University and Mbarara University of Science and Technology in Uganda. This 3-year research project is supported by the European Union FP7 programme.

To advance the work of this project, the UWC team hosted a consortium workshop at the Breakwater Lodge, Waterfront from May, 7th to 9th, 2012. Two years into the project, the aim of the workshop was to assess the progress of the fieldwork and data analysis, to discuss the key preliminary findings and plan for the country-specific and cross-country publications that will occupy most of the researchers’ time until the end of the project in April 2013. The workshop was supplemented with one full day of MAXQDA software training at UWC on May, 10th.

On the first day, delegates were welcomed by the UWC Principal Investigator, Prof. David Sanders. He proceeded to introduce the UWC Acting Vice Chancellor, Prof. Ramashwar Bharuthram who provided the historical context of the university as a previously disadvantage institution, juxtaposed against the significant research strides made in recent years, including the seven recently awarded NRF-funded research chairs. Invited speaker, Mr Bada Pharasi, the president of the South African Pharmacy Council and Deputy Project Director for Strengthening Pharmaceutical Systems (SPS) at Management Sciences for Health (MSH) delivered a presentation on medicine utilisation in South African public health facilities. In the
past he formed part of a Ministerial Task Team to guide health policy decisions regarding
medicine procurement in South Africa. The results emanating from this research led to the
following recommendations: i) establishing a central authority within the NDoH – Central
Pharmaceutical Procurement Authority (CPPA), and ii) ensuring that functional Pharmacy
and Therapeutic Committees (PTCs) at facility level identify problems with medicine use and
institute appropriate interventions. He further alluded that improved access to medicines
will benefit immensely from collaborative projects such as AMASA.

Status of our Research
All study countries have completed approximately 70% of their fieldwork (patient surveys,
key informant interviews and facility observations). The workshop gave an opportunity to
discuss data management activities, methodological challenges, key preliminary findings and
intended country and cross-country research outputs. All research outputs fall into either
one or more of the following thematic areas:

- Theme product 1 – regulatory capacity which includes GMP inspection/monitoring,
laboratory QC/samples, pharmacists, prescribing, pharmacovigilance;
- Theme product 2 – government procurement versus private national disease
programmes, donor agencies, distribution and storage as well as supply chain issues;
  - Theme product 3 – Rational use of medicines which includes clinical evidence, prescribing, essential drugs list, pharmacist/patient data and;
  - Theme product 4 – Community and User perspective (including civil society and advocacy groups’ roles in influencing health policies, and consumer interests).

Knowledge Management is also a key component of the AMASA project. At the workshop Kristina Pelikan from Swiss TPH provided an overview of the communication challenges over the past year and future plans for managing and disseminating the knowledge acquired through AMASA.

Uganda Group work

Next Steps...
This project will use MAXQDA and Epi-Info for data analysis. Initial training in the use of MAXQDA software was conducted online in recent months, and these sessions were supplemented with a one day session at UWC under the co-ordination of Roger Jeffery (Edinburgh University), Ashwin Budden and Kristina Pelikan (Swiss TPH)
AMASA envisages publishing 14 country-specific papers and 7 cross-country papers. Lead and support authors have been assigned and South Africa will be the main author on 5 papers. Countries are scheduled to complete field work over the next few months and this is running concurrently with initial data entry and analysis.

Overall, the team was very pleased with the progress made during the workshop and training. The next consortium workshop will be held in Edinburgh, Scotland in April 2013 to finalise the papers for journal publication and the country reports for submission to the EU.

I would like to thank the UWC research team viz., Prof. David Sanders, Prof. Henry Leng, Bvudzai Magadzire and our data manager, Patience Mahonah for their contributions in making this event a success, both in the organising and academic contributions. A special thanks also to Angela Fergusson from XL Millennium for professional service in helping to organise this event.
A range of different constituencies were represented at the one-day Symposium on Community Health Workers (CHWs) held at UWC’s School of Public Health (SOPH) on Thursday 7 June, 2012. The current context of major policy developments and growing research endeavours in the area of Community Health Worker highlighted the significance of the symposium.

The meeting was attended by representatives from the National Department of Health, Western Cape Department of Health, the Universities of Cape Town, Stellenbosch, Free State, Wits University, University of Kwa-Zulu Natal, including a wide range of NGOs such as Health Systems Trust, TB/HIV Care, Ke’impilo, MSF, Alma Philanthropies, Elgin Learning Foundation, Nacosa, Tatsa, Community Media Trust, SA Partners, and the Medical Research Council. International participants came from Malawi, Mozambique, the Netherlands and West Africa.

Prof. Uta Lehmann, Director of the SOPH, in her welcome said this was a clear indication of the interest and the relevance of the topic, its implications for the primary healthcare reengineering and the delivery of health services. It also indicated the need for such a forum to bring the different stakeholders together to discuss a topic that is very complex and very important. The topic of community health workers traces its roots back to Alma Ater and is resurfacing again as a major issue in the global primary healthcare discourse, the research on health systems, and how this impacts health policy and practice.

Prof. Helen Schneider pointed out that the SOPH has a long standing interest in research on Community Health Workers. This has developed into regional collaborations and engagement and global dialogues and action. Interest in this area of work and research is increasing in South Africa. Partly due to a vibrant policy environment, with the new initiatives such as Primary Healthcare Reengineering and Outreach Teams, this topic has assumed huge relevance. We have also seen increased donor funding for more research in this area as well as to facilitate meetings of stakeholders.

The programme included four plenary presentations that addressed the national policy frameworks (South Africa), CHW Revitalisation in Mozambique, an effectiveness study of an integrated community-based package for maternal, newborn, child and PMTCT care in South Africa, and the issue of Retention/Attrition and Time Use by CHWs. Panel discussants spoke on Primary Healthcare Reengineering in South Africa and parallel smaller sessions looked at Community Health Workers’ roles, the Social Dimensions of CHWs, Research on CHWs and the Health Systems dimensions of CHWs.

All fifteen presentations are available at http://www.uwc.ac.za/publichealth.
Introduction
Within ten years of implementing the national Prevention of Mother-to-Child Transmission of HIV (PMTCT) programme in South Africa interventions to prevent mother-to-child transmission (MTCT) of HIV are now offered in more than 95% of public antenatal and maternity facilities country-wide. However, this is the first national evaluation to determine the effectiveness of the National PMTCT programme. The 2010 South African PMTCT Evaluation (SAPMTCTE) will serve as a baseline to monitor the effectiveness of the antenatal and intrapartum aspects of the national PMTCT programme (i.e., early MTCT rates). The survey will be repeated in 2011 and 2012 (during which postnatal transmission at 6, 9, 12 and 18 months will also be measured) to track progress with reduction in MTCT rates during pregnancy, labour and delivery, and postpartum. This will provide a field-based, systematic approach to estimating the overall population-based transmission rate and the number of new paediatric infections at 4-8 weeks of infant age.

Aims and Objectives
The overall aim of this evaluation was to conduct a national facility-based survey to monitor the effectiveness of the South African National PMTCT programme. The primary objective was to measure rates of early MTCT of HIV at six weeks postpartum. The secondary objective was to periodically estimate coverage of key PMTCT interventions and services (e.g., HIV testing, CD4 cell count testing, infant antiretroviral (ARV) prophylaxis, infant feeding counselling).

Methods
A cross-sectional facility-based survey was conducted at immunisation service points at public primary health care/community health centres (PHC/CHC) in all nine provinces. This methodology was chosen as immunisation uptake at 6 weeks is >99% in South Africa. The survey aimed to capture known and unknown HIV-exposed infants, as well as PMTCT participants and non-participants. A biomedical marker (HIV enzyme-linked Immunosorbent Assay (ELISA) tests to identify HIV antibody) was used to identify HIV-exposed infants from infant dried blood spot (DBS) specimens. All DBS specimens reactive on ELISA testing were sent for DNA-based polymerase chain reaction tests (DNA PCR) to determine infant HIV infection status.

Infants aged 4-8 weeks attending PHC/CHC facilities for their six week immunisation were included. Hospitals and mobile clinics, very sick infants or infants aged <4 weeks or >8 weeks were excluded.

The immunisation data from the 2007 District Health Information System (DHIS) were used to quantify the number of children that could be expected within facilities over a period of time and then stratify by size. Sample size was calculated so that valid national and provincial level estimates of MTCT could be ascertained. This resulted in between 34-79 facilities per province, 580 in total.
Facilities were randomly selected within strata with probability proportional to size (3 strata). Caregiver/infant pairs were consecutively or randomly selected from facilities (depending on facility size). Interviews were conducted and infant DBS drawn after receiving consent from caregivers for study participation. Mothers and infants were referred into HIV care, as appropriate. Data were collected using low cost cell phones and interview data were uploaded real time into a web-based database console. Analysis was weighted for sample realisation and at provincial level proportional to the live birth distribution of South Africa.

Results
A total of 10,820 eligible infants were identified from 572 facilities. Of these, 10,735 interviews were conducted and 10,178 (94%) DBS were drawn and analysed.

- The national weighted infant HIV-exposure prevalence was 32.0% (95% CI 30.7-33.3%).
- The national weighted MTCT rate measured at 4-8 weeks of infant age was 3.5% (95% CI 2.9-4.1%).
- The MTCT rate across provinces ranged from 1.4% to 5.9%.
- Among mothers who reported being HIV negative, 4.1% had HIV-exposed infants.
- Of all women participating 98.8 (95% CI 98.5-99.0%) received an HIV test during pregnancy and of these 98.6 (95% CI 98.4-98.9) got their HIV test results.
- Of the reported HIV-positive mothers 78.3% had a CD4 cell count done during pregnancy and 91.8% received either maternal highly active antiretroviral therapy (HAART) or mother/baby antiretroviral (ARV) prophylaxis.
- Only 35.1% intended to access early infant diagnosis services and 89% had received infant feeding counselling.
- Among HIV-positive women, 20% were exclusively breastfeeding, 62% formula feeding and 18% mixed feeding in the 8 days prior to the interview.

Conclusions and Recommendations
1. The national PMTCT survey found a 3.5% national MTCT rate in pregnancy and intrapartum with a greater than 4-fold differential range of rates across the nine provinces (1.4% to 5.9%).
2. Maternal HIV acquisition since the last HIV test was potentially high at 4.1% and therefore repeat HIV testing at 32 weeks pregnancy and couple testing is critical. Further data should collected to assess the contribution of false negative rapid test results to maternal potential HIV acquisition. In addition, more work is required to improve the quality of rapid HIV testing in the field.
3. Uptake of PMTCT services is high, with more than 98% of women getting HIV tested during pregnancy and 91.7% of HIV-positive mothers receiving ARV treatment or prophylaxis. However CD4 (78.3%) testing and early infant diagnosis (EID) (35.1%) uptake are lower and represent on-going missed opportunities in the PMTCT programme.
4. Early infant HIV testing uptake is high if offered to all infants (94%) at six-week immunisation visits, indicating that EID strategies that routinely offer infant HIV testing only to known HIV-exposed infants should be reviewed.xii
5. Given the measured MTCT rate in the early implementation phase of the revised 2010 South African PMTCT guidelines, virtual elimination of paediatric HIV infection is possible with intensified effort. However, postnatal transmission after 6 weeks also needs to be examined to assess achievement of <5% MTCT at 18 months of infant age.
6. Only 20% of HIV-positive women were exclusively breastfeeding, 62% were formula feeding and 18% were practicing high-risk mixed feeding, suggesting a need for increased attention to infant feeding.

Dr. Faustine Ndugulile received his Doctor of Medicine degree from the University of Dar Es Salaam, Tanzania in 1997, a Master of Medicine in Microbiology and Immunology in 2001 from the same university and a Master of Public Health degree from the University of Western Cape, South Africa in 2010.

Between 2004 and 2006, Dr. Ndugulile was the Head of Diagnostic Services of the Ministry of Health Tanzania and he was instrumental in building the capacity of the laboratory services to support the roll out of the HIV/AIDS Care and Treatment programme.

In addition, as part of the HIV/AIDS prevention strategy, Dr. Ndugulile was tasked with transforming the blood transfusion service from hospital based to a centrally coordinated system that is reliant on voluntary blood donors. Between July 2007 and September 2010, Dr. Ndugulile was contracted by the Centers for Diseases Control (CDC) to provide technical assistance to the South African Field Epidemiology and Laboratory Training Programme, aimed at building the capacity of South Africa in field epidemiology and diseases surveillance.

Dr. Ndugulile has actively been involved in the HIV/AIDS field since 1993. He is a member of the Governing Council of the International Aids Society (IAS), a position he has held since 2008. In addition, he is a member of the American Society of Microbiologists (ASM), Tanzania AIDS Society (TAS), and Tanzania Public Health Association (TPHA).

Dr. Ndugulile is currently a Member of the Tanzanian Parliament and the Vice Chairman of the Parliamentary Social Services committee. He is also the Secretary of the Tanzania Parliamentarians AIDS Coalition (TAPAC).

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**Strategies to Overcome Poverty and Inequality: Towards Carnegie III**

3 - 7 September 2012

**A call for participation**

The University of Cape Town, with the support of the National Planning Commission, is coordinating a national conference to be held in the first week of September 2012, in order to stimulate deeper thinking about strategies to overcome poverty and inequality in South Africa. This is seen as the first stage of the third Carnegie inquiry in this country.

Anybody wishing to submit either an academic paper or some other presentation [such as a film or description of an NGO’s work in a particular place] is invited to submit a synopsis [300-500 words] outlining the proposed topic to the conference co-ordinators not later than 16 June 2012. Background to the conference as well as further details regarding dates for the submission of final papers are spelt out below and on the conference website [www.carnegie3.org.za](http://www.carnegie3.org.za)

**Purpose of the conference**

Inequality, like poverty, has many faces. The conference will seek to focus attention on understanding the lived experiences of inequality and the causes and dimensions of persistent inequality, and will consider policies and actions that are aimed at significantly reducing inequality.
and poverty in both the short- and long-term. This is a challenge that involves all South Africans, organised in many different ways. Taking seriously the President’s call for a ‘national dialogue’ about the future, and acknowledging the mandate of tertiary institutions to engage in socially responsive research, the purpose of the conference is to provide a platform for sharing and debate amongst academic researchers, government and practitioners. We look forward to welcoming participants from universities and NGOs; from Government at national, provincial and local levels; from trade unions, faith-based organisations and the business sector.

The conference will seek to move towards new ways of considering poverty and inequality, focusing less on describing the problems, and more on practical strategies to overcome them. This requires shifts in thinking, which the conference hopes to stimulate by combining a focus on academic and applied research with a set of demonstrations from the NGO, Business and Trade Union world.

**Towards a new paradigm for research and intervention**
The conference builds squarely on previous descriptive, analytical and policy work around the country by different institutions (including government), numerous individuals and at various conferences in recent years. It will seek to bring together multiple discourses in a way that allows cross-pollination of information and ideas. It will further debates by focusing on practical strategies to overcome poverty and inequality which mobilise the energies of people at all levels of society in creative and effective ways, and which address structural poverty and inequality and shifting power relations. Inter-disciplinary papers will be particularly welcome.

The NPC’s National Development Plan presents a future vision and begins to outline a path to eliminate poverty and reduce inequality by 2030. The Plan is a starting point, but as the NPC acknowledges, it requires extensive engagement to deepen and refine the strategies, and a collaborative effort to achieve its goals.

The conference will seek to provide a platform for serious and deep debate about difficult policy choices that must be made in tackling these issues of poverty, inequality and the underlying facts of massive unemployment. Thus, for example:

- Should the government promote further urbanisation or seek to stimulate growth in rural areas?
- What would be the consequences of a widespread subsidy to the youth wage?
- Is increased tariff protection a feasible way of generating more jobs in the country? At what cost?
- What practical steps can be taken in the short run to meet the challenges of literacy & numeracy in so many of the country’s primary schools?
- Plus a number of other difficult questions....

**Learning from experience**
The conference will combine formal presentations of new (including recently published) analytical research papers with panel discussions and presentations of on-the-ground innovation and interventions in practice. The aim is to ask questions about what works, what doesn’t work, and why. In particular, the conference will aim to stimulate thinking around the lessons that local-level initiatives have to offer. We will seek to show-case initiatives which may provide insight into:

- Ways of mobilising and supporting the energies of people at all levels of society to reduce poverty and inequality.
- Opportunities for establishing closer synergies between government, business, trade unions and the NGO sector
- Strategies for replicating and scaling up initiatives that work.

**Themes**
Whilst considering these practical innovations the conference will also seek to further debate and understanding about the structural underpinnings of both poverty and inequality in our society. The conference encompasses numerous and intersecting themes which are relevant to an understanding of inequality and ways to address it. Within each thematic area, we seek
to understand and benchmark the current debates, and to explore the critical ‘levers’ to addressing blockages that perpetuate inequality. Applied research and analysis will be interspersed with descriptions and demonstrations of practical innovations at micro level, drawing on the experience of civil society actors.

The conference will be designed as far as possible to promote integrated examination of the dynamics of poverty and inequality and to develop integrated responses. In this first stage of the Carnegie Inquiry the key purpose of the Conference will be to take stock of existing knowledge and debates and to stimulate cross-pollination of ideas across institutional, thematic and geographic barriers in order to provide feedback to the National Planning Commission. Further work of the conference in September 2012 will be to generate ideas and map out suggested priorities for research within the network of South African universities over the next two years as part of a longer Carnegie III process which, it is hoped, will culminate in a major conference two or three years from now.

For September 2012 major themes that need to be explored within the overarching framework of strategies to overcome poverty and inequality in South Africa include the following:

**Macro-economic policy:** with a hard look at the strengths and weaknesses of current policies from the perspective of poverty and inequality reduction. Plus debate about modifications and alternatives.

**Unemployment and labour issues:** the challenge of unemployment and strategies for creating work – including industrial and formal sector strategies, wage subsidies, EPWP & CWP; the dynamics of the informal sector and ways of extending rights and protection to informal workers. Informed debate about the role of labour regulations.

**Education:** The challenge of achieving meaningful access to education – including patterns of educational mobility, issues of pedagogy and support for teaching and learning, school resources and the role of schools as centres of community development. (The education stream will focus on five aspects of education: early learning; primary schooling; secondary schooling; FET & vocational skills training; with a fifth particular consideration of the transition from school, including access to tertiary education.)

**Legal frameworks:** the Constitution as a bedrock for addressing poverty and inequality; issues surrounding access to justice; implications of the Traditional Authorities Bill; & other pertinent legal considerations.

**Entrepreneurship and livelihood strategies:** challenges and constraints to entrepreneurship and to sustaining livelihoods and ways to overcome them; examples of innovation and implications for unemployment and inequality; opportunities for collaboration, and the role of finance institutions and corporate investors, government and institutions of learning.

**Social protection and welfare:** the role of social grants in addressing poverty and inequality; gaps in the social security system and their implications for inequality; the role of social welfare in mitigating the effects of poverty and inequality; constraints and innovative approaches to the provision of social welfare services.

**The family:** the effects of inequality on the shape of families and dynamics of household life, and ways of coping; the structural production of unequal childhoods; consequences of a changing world for families, households, neighbourhoods and communities (including issues of migration, work, marriage and care arrangements); family violence; critical services and interventions for young children and their caregivers.

**Public space, safety and violence:** geographies of apartheid and public space as both manifestation and cause of inequality; strategies to improve public space; spatial planning – urban upgrade and rural development; safe parks and places for children & youth; dynamics of crime and violence. [This theme might be divided into two: Public space; Safety & violence]

**Land & agriculture:** with a particular focus on new models of agriculture. There will also be space for consideration of key debate around land reform as part of the preparation for the major conferences on the Land Act being planned for 2013.

**Towns and cities:** issues of urban planning and service delivery; urban migration and its implications for urban inequalities; food security in the urban context; policy, planning and implementation – and the scope for innovative collaboration between public, private and civil society sectors, including the role of research institutions.
Environment and resources: from extractive to sustainable approaches to water and energy; innovative methods of waste management; the impact of resource management on human wellbeing; the dynamics of inequality in relation to climate change.

Health issues: intersecting burdens of disease and poverty; health services that meet the needs of the poor; how the NHI can address inequalities and benefit the poor; addressing inequality in the burden of TB, HIV/AIDS and maternal and child mortality.

Migration: the impact of immigration into South Africa as well as the consequences of internal regional flows (particularly urbanisation) is another area of focus in assessing strategies to overcome poverty and inequality.

Other: Whilst the above themes are central to the development of strategies to overcome poverty and inequality consideration will be given to other topics relevant to the overall theme.

Numbers will be limited due to space constraints, and priority will be given to those who write papers or prepare presentations about practical initiatives.

Requirements for participation
- Synopses of proposed papers or presentations should be submitted no later than Saturday 16 June, via the conference website: www.carnegie3.org.za
- These synopses will be assessed for overall “fit” into the conference as quickly as possible and contributors will be informed of provisional acceptance by Monday 25 June.
- The first complete draft of papers must be submitted electronically not later than Tuesday 31 July when a multi-disciplinary team will work hard to read the papers within the following week in order to confirm final acceptance not later than 7 August.
- There will be opportunity for further revision, but final draft of the papers must be submitted electronically not later than midnight on Tuesday 21 August.
- There will be no registration fee, but attendance will be conditional upon final acceptance of a paper, or another appropriate format of presentation in the case of Government, NGOs, and other non-academic participants.

South Africa scores poorly on 'Saving Mothers'

Almost 5 000 women died while pregnant or within 42 days of giving birth in South Africa between 2008 and 2010, more than in any of the previous years.

This is according to the Saving Mothers report that summarises findings on the confidential enquiries into maternal deaths in South Africa between 2008 to 2010.

The “big 5” accounted for 86.5% of maternal deaths – Non Pregnancy Related Infections (NPRI) at 40.5% was by far the biggest factor. The majority of these NPRI conditions were diagnosed before birth (59.7%), but the majority of deaths occurred after the births (60.6%). Respiratory tract infections (tuberculosis, pneumocystis pneumonia and other pneumonias) contributed to almost three quarters (67%) of the NPRI deaths followed by meningitis (12.9%) and gastroenteritis (5.2%).

Researchers noted that complications of antiretroviral therapy, although fairly rare, increased significantly in 2010 when compared with 2008 and 2009 with liver complications and Stevens - Johnson syndrome the most common. Respiratory failure (64%) and cerebral complications (17.9%) were the most common final NPRI causes of maternal deaths. HIV infection was the most common contributory condition with 87.3% of the women being HIV infected, 5.2% HIV negative, 0.7% declined testing and in 6.8% the status was unknown. In this group 69% had AIDS (defined as a CD4 immunity count below 200).
The report identified the delay in accessing medical help and poor or no antenatal care attendance as further patient-related factors. The most common administrative avoidable factor was lack of appropriately trained staff doctors and nurses (6.2%) and lack of intensive care unit facilities (3.7%).

Obstetric haemorrhage was the second most common cause of maternal death, accounting for 688 deaths or 14.1% of the total. This is considered to be an avoidable cause of death involving bleeding during and after caesarean section.

The latest figure compared with 491 deaths in the 2005-2007 period. The haemorrhage related maternal mortality ratio (MMR) was 24.9 deaths per 100,000 live births, which is an increase from 18.8 in 2005-2007 and 20.7 in 2002-2004. There was considerable provincial variation with the greatest numbers of haemorrhage deaths occurring in Eastern Cape, Gauteng and Limpopo and lowest in the Western Cape.

Complications of hypertension in pregnancy (14%), pregnancy related sepsis (9.1%) and medical and surgical disorders were the other major contributors to death.

The Saving Mother committee summarised its recommendations as the “5 H’s” that could have a major impact on the escalating maternal mortality rates – HIV/AIDS, haemorrhage, hypertension, health worker training and health system strengthening. The interventions include addressing HIV/AIDS through early testing and access to antiretrovirals, preventing severe haemorrhage by making it a major alert requiring immediate attention, recognising hypertension as life threatening, training all health care workers in maternity care and ensuring 24 hour access to functioning emergency obstetric care.


65th World Health Assembly closes with New Global Health Measures

The Sixty-fifth World Health Assembly concluded Saturday after adopting 21 resolutions and three decisions on a broad range of health issues. The six days of discussions involved nearly 3000 delegates, including health ministers and senior health officials from amongst the 194 WHO Member States, as well as representatives from civil society and other stakeholders. The agenda covered some of the biggest challenges and opportunities facing public health today.

“As challenges, let me mention noncommunicable diseases and ageing, maternal and child health, under- and over- nutrition, the eradication of polio and health demands during humanitarian emergencies,” said Dr Margaret Chan, WHO Director-General. “As opportunities, let me mention immunization, and the decade of vaccines, and the new multisectoral strategies made possible when we take a social determinants approach.”

The Health Assembly opened with delegates noting the tremendous achievements in health in recent decades and the emergence of global solidarity around health. Multiple Member States supported the concept of universal health coverage. “Universal health coverage is the single most powerful concept that public health has to offer,” added Dr Chan.
“Public health should be one of the top priorities in our development projects, because without health, no development is possible,” says Professor Thérèse N’Dri-Yoman, Minister of Health of Côte d’Ivoire and the elected President of the Health Assembly. “It was clear from all the presentations that the best and safest way to reduce inequalities in health-care delivery in our countries, either poor or rich, is by implementing universal health coverage.”

Reappointment of Dr Margaret Chan: At the World Health Assembly, Dr Margaret Chan was appointed for a second five-year term as Director-General of WHO with 98% of the Member States’ votes. Dr Chan’s new term will begin on 1 July 2012 and continue until 30 June 2017. In her acceptance speech, Dr Chan pledged her continued commitment to improve the health of the most vulnerable. In addition, she said that the biggest challenge over the next five years will be to lead WHO in ways that will help maintain the unprecedented momentum for better health that marked the start of this century.

WHO reform: Member States discussed reform proposals in three areas: programmes and priority setting, governance and management. Delegates reaffirmed support for the Director-General’s reform agenda, reiterating the need for comprehensive reform, for WHO to become more effective in its normative and technical assistance role and to improve accountability and transparency. They encouraged greater focus on results and enhanced governance. Proposals around improving monitoring of WHO’s work were welcomed.

Delegates expressed broad acceptance of the proposed five categories: communicable diseases, noncommunicable diseases, health through the life-course, health systems, and preparedness, surveillance and response. Member States emphasized that WHO should increase the focus on the social, economic and environmental determinants of health. The delegates requested the Secretariat to show how health determinants will be given priority in the next draft of the Organization’s General Programme of Work, which will be reviewed at the year’s Regional Committee meetings.

The resolutions and decisions adopted by the Member States include:

Early marriages and young pregnancies: More than 30% of girls in developing countries are married before the age of 18, and 14% before the age of 15. Many delegates requested that WHO continues raising awareness of the problem of early marriage and adolescent pregnancy and its consequences for young women and their infants. Several Member States noted the importance of implementing laws and policies and strengthening sexuality education. Some countries said that “one size does not fit all” and that family and community social norms must be considered. The Secretariat confirmed that it will work with Regional Offices to adapt the guidelines to public health realities country-by-country.

Humanitarian emergencies: The World Health Assembly adopted a resolution reaffirming the central role of health in humanitarian response and strongly endorsing WHO’s role as Health Cluster Lead Agency. It calls on Member States and donors to allocate sufficient resources for health sector activities during humanitarian emergencies and for strengthening WHO’s capacity to exercise its role as Lead Agency both at global and country levels. The resolution also calls on WHO to provide Member States and humanitarian partners with predictable support during emergencies, by coordinating rapid assessments, the development of strategies and action plans, and monitoring the health situation.

International Health Regulations: The Health Assembly reviewed the annual report on the implementation of the International Health Regulations (2005). State Parties were making fair progress in 2011 for a number of core capacities, notably surveillance, response, laboratory and zoonotic events. Most regions reported relatively low capacities in human resources and preparedness for chemical and radiological events. Many State Parties have requested or will request a two-year extension to the mid-2012 deadline for establishing core capacities under IHR. The delegates referred to difficulties in implementing measures related to points of entry and in engaging stakeholders outside the health sector.

Mass gatherings: The Health Assembly received the report by the Secretariat on “Global mass gatherings: implications and opportunities for global health security”. The discussions were led by delegates from areas which have hosted mass gatherings recently or on a regular
basis. Delegates expressed the need to exchange lessons learned on preparedness and management and Member States also stressed the need for efficient preventive measures and interventions.

**Millennium Development Goals:** Member States endorsed the report on the progress and achievements of the health-related Millennium Development Goals and health goals after 2015. While the pace of progress has accelerated in many Member States, it was also acknowledged that more still needs to be done in the remaining three years to achieve the goals.

A second report on The Commission on Information and Accountability for Women’s and Children’s Health, established at the request of the United Nations Secretary-General’s in the context of the Global Strategy for Women’s and Children’s Health, presented 10 recommendations to improve accountability in countries and globally. The focus is on the 75 countries which together account for more than 95% of all maternal and child deaths in the world. Many countries and global partners have made specific commitments to accelerate action towards the achievement of MDG 4 (reduce child mortality) and 5 (improve maternal health).

**Noncommunicable diseases:** The Health Assembly adopted several resolutions and decisions on noncommunicable diseases (NCDs):

- Delegates approved the development of a global monitoring framework for the prevention and control of NCDs, including indicators and a set of global targets. Member States agreed to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases such as cardiovascular disease, cancer, diabetes and chronic respiratory diseases by 2025.

- Another resolution focuses on strengthening NCD policies to promote active ageing. The resolution urges Member States to encourage the active participation of older people in society, increase healthy ageing and promote the highest standard of health and well-being for older persons by addressing their needs.

- The building of partnerships at national and global levels are essential components of multisectoral action against NCDs. Member States discussed ways to prevent NCDs through action involving other sectors than health to prevent premature deaths and to reduce exposure to risk factors for NCDs, mainly tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity.

- Delegates also received a report on the progress of the implementation of the global action plan for the prevention of avoidable blindness and visual impairment.

- Member States acknowledged the need for a comprehensive, coordinated response to addressing mental disorders from health and social sectors at the country level. The delegates recognized this includes approaches such as programmes to reduce stigma and discrimination, reintegration of patients into workplace and society, support for care providers and families, and investment in mental health from the health budget.

**Occupied Palestinian territory:** The World Health Assembly adopted a resolution on the health conditions in the occupied Palestinian territory including east Jerusalem, and in the occupied Syrian Golan. The need for full coverage of health services was reaffirmed while recognizing that the acute shortage of financial and medical resources is jeopardizing access of the population to curative and preventive services.

**Pandemic influenza preparedness:** Member States acknowledged that the pandemic influenza preparedness (PIP) framework is a crucial development for global health security, based on the lessons from the 2009 influenza pandemic. Delegates recognized that industry and other partners play important roles in the development of vaccines to counter outbreaks. Delegates agreed on a 70% and 30% share of resources between preparedness and response respectively, but that this would be regularly reviewed. They welcomed the role of the framework’s advisory group, but stressed the need for extra resources – both human and financial – to support WHO capacity and leadership.

**Intensification of the global polio eradication initiative:** The delegates acknowledged that polio eradication is at a tipping point between success and failure and
necessary funding is essential to ensure success. In this regard, Member States declared the completion of polio eradication a programmatic emergency for global health.

**Research and development**: The Health Assembly welcomed the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination containing recommendations for securing new funds for health research and development on diseases that affect people in developing countries. It adopted a resolution to hold Member States’ consultations at national, regional and global levels to analyze the report and the feasibility of the recommendations.

**Schistosomiasis**: Delegates adopted a resolution to support countries in evaluating interruption of transmission and preventing its re-emergence during the post-elimination phase. They also discussed the need for a health-systems approach, involving public-private partnerships, to ensure availability of drugs and their development.

**Social determinants of health**: The Health Assembly endorsed the Rio Political Declaration and its recommendations. It approved measures to support the five priority actions recommended in the declaration to address social determinants of health. The measures will lead to, among other things, greater collaboration between UN and partner agencies and more support for Member States to adopt an inclusive ‘health-for-all’ approach.

**Substandard/spurious/falsely-labelled/falsified/counterfeit medical products**: Delegates approved a draft resolution on a new Member State mechanism proposing international cooperation on substandard, spurious, falsely-labelled, falsified or counterfeit (SSFFC) medical products. Many countries stressed the need for strengthening regulatory authorities and the critically important role that WHO plays in enhancing regional and international networking among the regulators. Emerging channels of distribution such as Internet sales pose a significant threat and require specific solutions. Representatives of NGOs and the pharmaceutical sector expressed their support for the mechanism.

**Progress reports**: The delegates also received progress reports in six areas: strengthening of health systems; disease eradication, prevention and control; reproductive health; food safety initiatives; climate change and health; partnerships and multilingualism.

The World Health Assembly is held annually in Geneva, Switzerland and is the decision-making body of the WHO. It is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the Director-General in election years, supervise financial policies, and review and approve the proposed programme budget.

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Phelophepa, the mobile health train, brings primary healthcare to a different rural village in South Africa each week. Roche has supplied funding for the Phelophepa Health Care Train for the entire fifteen plus years of its existence. This mobile clinic delivers medical care to remote parts of South Africa; in some of the country’s rural areas, there is just one doctor for every 4,000 patients. [http://react.roche.com/react_overview.htm](http://react.roche.com/react_overview.htm)

**Phelophepa to reach 10 000 patients**

*By Mandla Khoza*

Six thousand more people in Mpumalanga are expected to be checked or treated for illnesses on the Phelophepa health train. Transnet Phelophepa Clinic train manager, Thabisile Makhaye, said more than 4 000 people had already been treated since the train stopped in the province last month.

"The train is now in Mpumalanga; we have already passed Acornhoek and we are now in Mbombela and in the three weeks that we have been here, we have treated 4 602 people. We believe before we leave here we will reach more than 10 000 people," said Makhaye. She said the professionals on board the train checked or treated patients for different illnesses including high blood pressure, diabetes and cancer. Some have also received dental and eye care.

She said check-ups were done for free while medicines were sold at only R5. "We also clean teeth and remove them for free. If someone needs specific treatment, we only charge R10," said Makhaye.

The Phelophepa health train is an initiative of Transnet which started in 1994 to give affordable primary health care to the poor. Whenever the train pulls into a station, 40 health lifestyle volunteers are there to help the community in health awareness.

"Each week we train 40 volunteers to teach the local community... we also employ 70 people for different things like interpreting for the doctors who might not speak the patient's language, cleaning and other work," said Makhaye.

Makhaye said among the doctors and nurses on board were fourth-year students specialising in certain health professions and doing their internships.

"The students are working under the supervision of doctors. As we also test for cancer and HIV. We work with the Department of Health in each province. This ensures that these patients get help even when we are gone," said Makhaye.

Makhaye added that Transnet had introduced a second train. "The other one is now in the Northern Cape and this one is going to leave Mbombela on June 18 for Kinross near Secunda," said Makhaye.

Constance Sehlabela, 53, said she had come for a check-up because she could not see well.

"I do not have money to go to a special doctor, but here they checked me for free and gave me spectacles for only R30. Now I can see properly and can even see when it’s dark," said Sehlabela.

The shortage of health workers around the world is estimated at over 4 million, and 57 countries are experiencing a critical shortage, defined as having fewer than 2.3 doctors, nurses or midwives per 1,000 population. This translates to nearly a billion people who have no health worker to turn to when they or a loved one becomes ill or needs medical attention.

How is the sustained development of healthy and prosperous communities possible in such an environment?

At the United Nations Conference on Sustainable Development, Rio+20, leaders of governments, civil society, NGOs, donors and the private sector will convene to consider the future of development and humanitarian assistance. I urge us all to consider how our approach must change. U.S. Agency for International Development Administrator Raj Shah’s blog talks about U.S. investments and a shift in thinking from relief to resilience. I applaud this idea and challenge us to think about the roles health workers play in resilient communities.

For millions of families, a frontline health worker is their only source of critical care. She may also be their primary source of health information on issues like HIV prevention and family planning. Are these same health workers prepared to counsel families on lifestyle choices to prevent chronic disease? To support mental health? To promote green development, education, or women as entrepreneurs? In Rio and beyond, we must seriously discuss the roles that health workers are playing or could play within their communities. If not, we may fail to tap into the potential of a wide-reaching network of change agents.

The health workforce shortage has received increased attention over the past few years, starting with the World Health Organization’s 2006 World Health Report on the crisis. Many countries have invested in strengthening national health systems and creating a policy environment that supports human resources for health. I salute the increased investments and attention that have come from the donor community, but we are not there yet.

Health systems are still weak or failing in many countries, and health workers are witnessing how every little failure touches someone’s life. This may include having the skills to treat a child suffering from pneumonia, but no drugs due to a stockout. Or knowing that a woman needs urgent care during labor and delivery, but lacking the means to transport her to a hospital. Health workers can also help to fix these failures, given the right support and innovative thinking.

A healthy community, though, is more than a community with access to a health worker. It’s more than an absence of acute illness. Climate change, social inequities, poverty, armed conflict and other humanitarian crises, and pollution are just some of the factors affecting health and the ability of health workers to do their jobs. We need more intersectoral
approaches and systems thinking to address development challenges. We cannot make these factors disappear, but together we can work to address them.

Individuals and communities around the globe are increasingly interconnected. Health workers are links within communities; they are influential, and they can be powerful. They know their community members intimately, and are with them during times of joy as well as times of sorrow. They are trusted by their friends and neighbors. Health workers can truly be change agents in helping their communities come together to address a myriad of challenges with local solutions and bringing the voice and needs of their communities forward. I have seen this happen in communities around the world, from India, to Kenya, to Senegal.

IntraHealth is a global champion for health workers, and we use a comprehensive framework to guide our investment in health workers. We are committed to making sure that more health workers are present, ready, connected, and safe. I urge the broader development community to consider everything this framework encompasses and how your work fits in, because I guarantee that it does.

Health workers need to be present — on the job where they are most needed, including serving rural and remote populations. They need to be ready, with the right skills, supplies, and support. They need to be connected to technology, information and each other. And finally, health workers deserve to be safe. They should be able to work free from occupational hazards, gender and other forms of discrimination, and they should be protected during armed and social conflict under the principle of medical neutrality.

A dramatic shift is necessary to solve some of the most pressing global health problems, and as hard as producing 4 million more health workers may be — it’s not the only solution, because the problem is not one of sheer numbers alone. Countries need more health workers, and they need to better prepare them to operate in a more integrated world.

By the end of Rio+20, I hope to see strategies and resources dedicated to better preparing health workers to operate in this increasingly connected world. If this does not happen, we will miss an opportunity to leverage the unique role and position of health workers not only in addressing health, but in addressing the overall development of their communities and countries.

Pape Amadou Gaye is the president and CEO of IntraHealth International. He serves on the board or in an advisory capacity for the Center for African Family Studies, Development in Gardening (DIG), Duke University’s Global Health Institute, InterAction, Management Strategies for Africa International, Nourish International at the University of North Carolina, and the Triangle Global Health Consortium. Prior to IntraHealth International, Gaye was a trainer of Peace Corps volunteers in Senegal and Benin.


Second Global Symposium on Health Systems Research
When: 31 October-3 November 2012
Where: Beijing, People’s Republic of China
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