UNIVERSITY of the WESTERN CAPE

SoPH BULLETIN

The UWC School of Public Health Newsletter May 2011

SOPH GRADUATES 2011

A. MASTER OF PUBLIC HEALTH

ADIE, Achinyang
Thesis: Knowledge of and attitudes towards HIV and risky sexual behaviour amongst adolescent secondary school students in Bekwarra, Nigeria.
Supervisor: Ms. S. Mohamed

AKPABIO, Alma
Thesis: Attitude, perceptions and behaviour towards family planning amongst women attending PMTCT services at Oshakati Intermediate Hospital, Namibia.
Supervisor: Dr. T. Mathole

BAGHAZAL, Anisa
Thesis: Factors influencing adherence to antiretroviral therapy at a general hospital in Mombasa, Kenya.
Supervisor: Dr. B. van Wyk

BAKUNDA, Kamaranzi
Thesis: Factors associated with late presentation of children under five and pregnant women with malaria for treatment at health units in Bungokho Health Sub District.
Supervisor: Ms. H. Bradley

CHIVONIVONI, Tamuka
Thesis : Antimycobacterial treatment among children at start of antiretroviral treatment and antimycobacterial treatment after starting antiretroviral treatment among those who started antiretroviral treatment without antimycobacterial treatment at a tertiary antiretroviral paediatric clinic in Johannesburg, South Africa.
Supervisor: Prof.H. Hausler
Co-Supervisors: Dr. T. Meyers & Prof. L. Kuhn

DANA, Pelisa
Thesis: Effects of peer counseling on feeding practices of HIV positive and HIV negative women in South Africa: a randomized control trial.
Supervisor: Prof. D. Jackson
Co – Supervisors: Dr B. van Wyk & Dr T. Doherty

EKEH, Peter
Thesis: Survey on nail discolouration and association with CD4 count among untreated HIV patients in APIN Centre, Jos, Nigeria.
Supervisor: Dr. E. U. Igumbor
Co-Supervisors: Dr. P. Agaba & Dr. A. Ani

KAKILI, Tuwilika
Thesis: Factors that contribute to treatment defaulting amongst Tuberculosis patients in Windhoek District, Namibia.
Supervisor: Ms. S. Mohamed

KIWANUKA, Suzanne
Thesis: The Ugandan Private Students Scheme *a*t Makerere University School of Medicine and its Effect on Increasing the Number of Medical Doctors Enrolled and Trained from 1993 to 2004
Supervisor: Ms. L. Alexander
Co-Supervisor: Dr. E.U.Igumbor

LLOYD, Bridget
Thesis: Stakeholder perceptions of human resource requirements for health services based on primary health care and implemented through a national health insurance scheme.
Supervisor: Prof. D. Sanders

LOMBARDO, Candice
Thesis: A matched case control study of the nutritional status of newly diagnosed Tuberculosis patients and Tuberculosis free contacts in Delft, Western Cape.
Supervisor: Prof. E.C. Swart
Co-Supervisor: Ms M. Visser

MMBANDO, Zebadia Paul
Thesis: Factors influencing men's involvement in reproductive health in Arusha and Arumeri Districts, Tanzania.
Supervisor: Dr. T. Mathole

MUSASA, Jean Paul
Thesis: Knowledge, attitude and practice with regard to tuberculosis and human immunodeficiency virus co-infection among patients with tuberculosis in Walvis Bay district, Namibia.
Supervisor: Ms. J. Uwimana
Co-Supervisor: Dr. E. U. Igumbor

MWANDA, Kalasa
Thesis: Impact of a family centered approach on uptake of HIV testing and antiretroviral therapy for exposed and infected children in Solwezi, Zambia.
Supervisor: Prof. C. Zarowsky

NGODJI, Terthu
Thesis: Knowledge, attitudes and practices of male circumcision for HIV prevention among voluntary counseling and testing clients in Onandjokwe District Hospital, Namibia.
Supervisor: Ms. J. Rebert
Co-Supervisor: Dr. E.U. Igumbor

NTOPI, Simon
Thesis: Impact of the expansion of the health surveillance assistants programme in Nkhatabay District of North Malawi.
Supervisor: Prof. U. Lehmann

OGWU, Anthony
Thesis: Adherence to antiretroviral therapy amongst women commenced on treatment during pregnancy at research clinics in Botswana.
Supervisor: Dr. G. Reagon

OMENKA, Charity
Thesis: Factors influencing access to antiretroviral treatment in Benue State, Nigeria.
Supervisor: Prof. C. Zarowsky

SAKALA, Morgan
Thesis: Assessment of the barriers to the utilization of antenatal care services in Kazungula district, Zambia.
Supervisor: Ms. L. Tsolekile
Co-Supervisor: Prof. U. Lehmann

SANGA, Erica
Thesis: Expectations and experiences of HIV vaccine trial participants at the Mbeya Medical Research programme in Mbeya, Tanzania 2006-2007.
Supervisor: Mr. S. Shamu
Co-supervisor: Dr. B. van Wyk

SISYA , Charity
Thesis: Identifying the potential barriers and facilitators that can contribute to the level of antiretroviral treatment adherence among people living with HIV/AIDS in the rural district of Chongwe, Zambia.
Supervisor: Ms. N. Schaay

ZINGWARI, Jebson
Thesis: Prevalence of malnutrition in HIV positive infants (age < 18 months) attending a clinic in Windhoek, Namibia.
Supervisor: Prof. C. Zarowsky
Co-supervisor: Dr. T. Achia

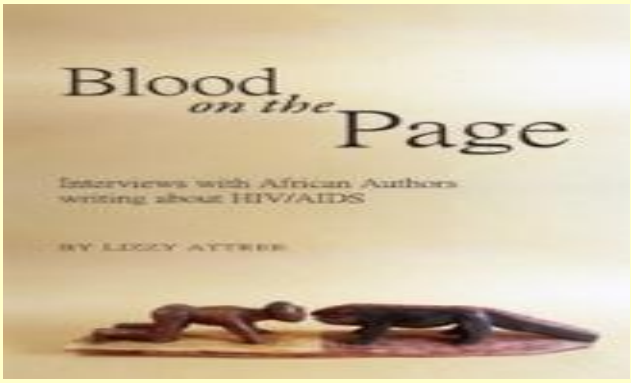
B. POST GRADUATE CERTIFICATE IN PUBLIC HEALTH

SEABE, Elizabeth

C. POST GRADUATE DIPLOMA IN PUBLIC HEALTH

CHANDIWANA, Precious
ELIPHAS, Hatutale
MOGAPI, Thato
MUTUNDA, Anne
KALANGU, Givas

Lizzy Attree, who recently held a Postdoctoral Fellowship in the UWC Centre for Humanities Research, has published a book entitled *Blood on the Page: Interviews with African Authors Writing about HIV/AIDS*



Jade Gibson, Lizzy Attree, Sean Christie

The fourteen interviews in this book form an unprecedented wealth of material on authors' responses to HIV/AIDS in South Africa and Zimbabwe. They comprise a valuable archive which documents and contextualises the variety of views and opinions of different authors on their often ground-breaking choices in writing about HIV/AIDS. Each author ranks among the first to publish fiction on HIV/AIDS in their respective countries. These interviews are of particular merit as these issues have not been discussed at length with any of the authors before. Collectively they offer a unique range of approaches and opinions in response to the HIV/AIDS pandemic in southern Africa. Their significance lies in their specific literary, as well as their broader social, cultural and political perspectives on a disease which continues to spread despite extensive NGO, medical and government intervention. In both South Africa and Zimbabwe, government responses have failed to address the urgent need for new political and economic solutions to the challenge of HIV infection. Responses among the population have varied from widespread silence, shame and fear to political activism and outspoken critiques of government inaction. Writers give voice to this silence and contextualise the disparate reactions amongst diverse peoples.

http://book.co.za/blog/2010/06/17/african-authors-discuss-hiv-in-lizzy-attrees-blood-on-the-page/

Saying goodbye will never be easy

Dr Thomas Achia

Leaving the nest hoping to fly, seeking a gentle thermal by which to soar on to encounter the surprising gust of a gale. That could be an understatement of the experience I feel as I leave UWC for UKZN. The School of Public Health, UWC, has for a year provided me a home away from home. Despite a short stint on the third floor of the magnificent SOPH building, I felt truly at home. In this one year I learnt to appreciate diversity in academic and intellectual endeavor and to more clearly realize that we all have a role to play in the *dynamics of building a better society*. I realized, more vividly, that there is indeed no silver bullet that can solve the immeasurable challenge, ranging from disease, poverty and societal rot that face this generation. Despite these apparently grim realities, we can, together, make a contribution and how true, *yes we can*, make this world a better place.

I leave with a feeling of great academic satisfaction, having significantly grown in knowledge, slaying my hitherto Bayesian giant. With a loud hurray I can say I am able to use WinBUGS and R2WinBUGS to carry out my data analysis. It may seem a meager achievement but for me it means the whole world. I salute the VLIR-DBBS team for the opportunity given me to study, network and publish my ideas and for granting me a chance to stand alongside a great team at SOPH, albeit for a little while. I had a chance during my stint at SOPH to work with a brilliant mentor. Prof. Christina Zarowsky has been a great inspiration and the chance to work with her was a super experience.

Prof. Allyson M Pollock and David Price, senior research fellow at the Centre for Health Sciences, Barts and The London School of Medicine and Dentistry, Queen Mary's College, University of London write in the March 2011 British Medical Journal about the proposed statutory changes to the NHS and raise concerns that the government's role could be reduced to that of payer…

How the Secretary of State for Health Proposes to Abolish the National Health Service (NHS) in England

The coalition government's Health and Social Care Bill 2010-11 heralds the most controversial reform in the history of the NHS in England. The government plans to replace the NHS system of public funding and mainly public provision and public administration with a competitive market of corporate providers in which government finances but does not provide healthcare.

Primary care trusts and strategic health authorities are to be abolished and replaced by general practice commissioning consortiums, which all practices must join. As incorporated bodies, consortiums will not be directly controlled by the secretary of state for health and may enter into commercial contracts with "any willing provider" for all health services and will set terms and conditions of staff. They will have extraordinary discretionary powers to define entitlement to NHS provision and charge patients. Direct management and control of NHS providers will cease as foundation trust status becomes mandatory for all trusts. Provider regulation will be overseen by a market regulator, Monitor.

Since 1948 the government has had a duty to provide comprehensive healthcare free at the point of delivery. This duty is underpinned by structures, systems, and mechanisms that promote fairness and efficiency in resource allocation and facilitate planning of services according to geographical healthcare needs through risk pooling and service integration. These mechanisms have been eroded by a succession of major regulatory changes, including revision of funding and responsibility for provision of long term care; creation of an internal market; introduction of private providers and capital through the private finance initiative, independent treatment centres, foundation trusts, and the 2004 general practice contract; and creation of a tariff system of payment for providers. We examine the proposed statutory protections of the duty to promote and provide comprehensive care in the bill.

Duty to provide a comprehensive public service

Although the bill retains the secretary of state's duty to promote a comprehensive service, the duty to provide a comprehensive health service in England is abolished.[4] It is replaced with a duty to "act with a view to securing" comprehensive services. The health secretary's general powers of direction over NHS bodies and providers are also abolished, and the focus of his or her role will shift to public health functions, which become the responsibility of local authorities.

Section 9 abolishes the duty on the health secretary to "provide [certain health services] throughout England, to such extent as he considers necessary to meet all reasonable requirements." Commissioning consortiums will "arrange for" the services necessary "to meet all reasonable requirements" and determine which services are "appropriate as parts of the health service" (section 9, 2a). A consortium does not have a duty to provide a comprehensive range of services but only "such services or facilities as it considers appropriate" (section 10, 1). In making these arrangements, commissioning consortiums must ensure that their annual expenditure does not exceed their aggregate financial allocation (section 22, 223I-K). Consortiums may join together to form a single commissioning group for England (section 21, 14Q, 2b), but they are not required to cover all persons or provide comprehensive healthcare when doing so.

(…)**Regulating providers through commercial contracts**

The government proposes to regulate providers through commercial contracts:"The Government's approach is that where specific control mechanisms are needed for providers, these should in general take effect through regulatory licensing and clinically-led contracting, rather than hierarchical management by regions or the centre."

Most economists agree health services cannot be sufficiently controlled through market regulation because the complexity and unpredictability of treatment makes it impossible to set

out all eventualities in a contract. This problem of incomplete contracts was first described by the founding father of health economics and Nobel laureate, Kenneth Arrow. He argued in 1963 that producers of healthcare services will always have more information than purchasers, who will never be able fully to evaluate the likely consequences of different services and so will never be completely certain that they have chosen the best provider or that the outcome is optimal.
When market contracts are used to regulate providers and commissioners, managers have an incentive to exploit the information deficit on the part of patients and government by reducing service quality in order to maximise profits. According to Arrow, incomplete contracts can explain why "the association of profit-making with the supply of medical services arouses antagonism and suspicion on the part of patients and referring physicians."

Section 52 of the bill proposes new competition duties that will allow remaining public controls over health services to be challenged by multinational companies and investors anywhere in the world. Trade rules outlaw public policies that prevent, restrict, or distort competition in trade within the UK or the European Union such as setting prices, public subsidies for teaching and research, and controls designed to ensure fair distribution of resources. Rules on free movement of capital could undermine powers that the government proposes to reserve for protection of service continuity. One company, Circle, the first to take over a foundation trust, is already using competition rules to challenge a primary care trust's decision to restrict the volume and range of services under the commercial contracts for NHS elective surgery.

(…) **Freedom to create surpluses from care budget**
The bill explicitly authorises the creation of surpluses from the patient care budget and their distribution to staff and shareholders as part of financial incentive or bonus schemes (section 23). Surpluses can be generated by selecting patients or services, denial of care, or reductions in staff terms and conditions, responsibility for which will be transferred to corporate bodies. The secretary of state cannot be held to account for diversion of NHS funds from patient care to staff or investors.

(…)**The end of the NHS?**
The government proposes a commercial system in which the NHS is reduced to the role of government payer, equivalent to Medicare and Medicaid schemes in the US. However, government belief that cost efficiency, improved quality, and greater equity flow from competition in healthcare markets is not supported by evidence, the Office of Fair Trading, the government's impact assessment, or its experience of independent treatment centres and private finance initiatives.
In order to create a commercial market the government has repealed the health secretary's duty to provide or secure the provision of comprehensive care and has abolished the structures and mechanisms which follow from this duty. It has granted new powers and financial incentives to corporate commissioners and investors to redefine eligibility and entitlement for NHS funded care, select out profitable patients and services, and introduce regressive funding through patient charges and private healthcare.

(We) list some key amendments to ensure continuation of NHS comprehensive healthcare throughout England. The stark alternative is exposure of NHS funds and provision to international competition laws that will further limit the ways in which governments can intervene in markets to off-set unwanted effects for public health. Unless the amendments are made, the bill as drafted amounts to the abolition of the English NHS as a universal, comprehensive, publicly accountable, tax funded service, free at the point of delivery.

Amendments to ensure continuation of NHS comprehensive healthcare

- Restore the duty of the secretary of state for health to provide or secure the provision of comprehensive healthcare throughout England to such extent as he or she considers necessary to meet all reasonable requirements
- Impose a duty on general practice commissioning consortiums to provide comprehensive healthcare for all residents in geographically defined areas and fund them accordingly and on the basis of need
- Impose a duty on the NHS Commissioning Board to retain and further develop a system of resource allocation based on the healthcare needs of all residents of geographically coterminous areas
- Withdraw the power granted to commissioners to charge for healthcare services and reserve the power to the health secretary

- Remove health services from jurisdiction of competition law
- Require the health secretary to ensure continuity of patient care through administrative and financial integration of provider services under the jurisdiction of geographically defined consortiums (as in Scotland and Wales)
- Impose a duty on the health secretary to protect professional autonomy and increase direct public accountability
- Impose a duty on the health secretary to abolish financial incentives to create and distribute surpluses by underspending patient care budgets

Cite this as: *BMJ* 2011;342:d1695; *BMJ* 2011; 342:d1695 doi: 10.1136/bmj.d1695 (Published 22 March 2011)

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA
UNODC ILO UNESCO WHO WORLD BANK
UNDP
World Health Organization

PRESS RELEASE

UNAIDS/UNDP/WHO concerned over sustainability and scale up of HIV treatment

UNAIDS, UNDP and WHO encourage countries to use the flexibilities as set out in the TRIPS agreement to lower costs and improve access to HIV treatment

Geneva, 15 March 2011—The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP) and the World Health Organization (WHO), are deeply concerned about the long-term sustainability of access to affordable HIV treatment.

In a new policy brief launched today, UNAIDS, UNDP and WHO urge countries, where appropriate, to use the intellectual property and trade flexibilities set out in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), and the Doha Declaration on the TRIPS agreement and public health, in order to reduce the price of HIV medicines and expand access to people most in need.

“We are seriously concerned about the future of HIV treatment programmes,” said Paul De Lay, Deputy Executive Director, Programme, UNAIDS. “Only about one third of people in need have access to treatment. In the current economic climate even sustaining that over the long-term will be a challenge. Countries must use all the means at their disposal, including the TRIPS flexibilities, to ensure sustainability and the significant scale up of HIV services to reach people most in need.”

At the end of 2009, nearly 15 million people were estimated to be in need of antiretroviral treatment for HIV and 5.2 million people had access to the life-saving therapy.

Over the last 10 years the annual cost of a first-line antiretroviral regimen for low-income countries decreased by almost 99%––from more than US$ 10 000 per person in 2000 to less than US$ 116 for the least expensive WHO-recommended first-line regimen in 2010. However, prices are still too high for many low- and middle-income countries, especially for second-line regimens.

"Millions of people in developing countries now depend on a steady supply of affordable first-line treatment for HIV. If their treatment is interrupted, which can lead to drug resistance, these patients will have to switch to a second-line regimen. That can be at least six times more expensive than the first-line regimen," said Dr Gottfried Hirnschall, WHO's Director of HIV/AIDS Department. "Making full use of trade flexibilities and other cost reduction strategies for quality medicines is now more important than ever."

The challenge is further exacerbated by an uncertain economic climate. In 2009 funding for HIV was lower than in 2008. This is putting current treatment programmes under increased strain because of reduced budgets and competing priorities. In addition, proposed bilateral and regional

free trade agreements could limit the ability of developing countries to use the TRIPS flexibilities. Governments in both developed and developing countries should ensure that any free trade agreements comply with the Principles of the Doha Declaration.

Jeffrey O'Malley, Director of UNDP's HIV Practice said, "Using TRIPS flexibilities will allow countries to issue compulsory licences and to use other mechanisms provided by the TRIPS Agreement and Doha Declaration to obtain access to affordable generic antiretroviral medicines. This means a country could produce generic medicines at a lower cost or, if it does not have manufacturing capacity, import lower-cost, generic medicines from another country."

Brazil issued a compulsory license for efavirenz through the TRIPS flexibilities which brought the price down by more than two-thirds, from US$ 1.60 per dose to US$ 0.45 for the generic version. Such price differences have enormous implications for the ability of national authorities and other service providers to deliver antiretroviral treatment to people in need.

Despite the opportunities provided by the TRIPS flexibilities, many countries have yet to amend their laws to incorporate them. UNAIDS, UNDP and WHO will continue to support countries, on their request, to increase access to treatment and provide technical assistance to implement the TRIPS flexibilities to scale up access to life-saving antiretroviral medicine.

UNAIDS and WHO launched the Treatment 2.0 initiative in 2010 to accelerate access to cheaper, more effective and tolerable drug combinations and diagnostics. Efforts must be maintained to spur much-needed innovation in developing new medicines and to support new intellectual property approaches. Incorporating and using the available TRIPS flexibilities will also be key to expanding access to HIV treatment in the coming years.

Contact
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HIV IN CONTEXT SEMINAR SERIES

PROMOTING RESEARCH ON MIGRATION & HEALTH IN EAST AND SOUTHERN AFRICA:
Opportunities and challenges

DATE: Monday 16 May 2011
TIME: 12H00 - 14H00
VENUE: 2A, School of Public Health Building, UWCDr Johannes John-Langba (PhD, MPH) is the co-ordinator of the Migration Health Research Department at the International Organization for Migration (IOM).

RSVP: Tamlin Petersen, SOPH by 13th May 2011, Tel: 959-3545/2809 Email:hivcentre@uwc.ac.za

Thato Ramela

SOPH PhD Student Thato Ramela wins ADDRF Scholarship

From the ADDRF Selection Committee...

Dear Thato
The African Doctoral Dissertation Research Fellowship Selection Committee has finalized the selection of fellowship awardees.

We received about 170 applications from candidates representing 25 sub-Saharan African countries and will make about 15 awards. The Selection Committee is very pleased to inform you that you have been selected as one of the award recipients.

Congratulations on being chosen for this highly competitive award!