Sub-Saharan Africa ranks lowest for Mothers
SOPH Researcher Kate Kerber contributes to Save the Children Study

Mail and Guardian Report by Ina Skosana
7 May 2013

A baby in sub-Saharan Africa is seven times more likely to die on its first day of life than anywhere else in the world, according to the latest State of the World’s Mothers report. The report, which is produced by the children’s rights organisation, Save the Children, says of the world’s one million babies dying on their first day, 400 000 are from sub-Saharan Africa. A baby’s birth day is considered the most dangerous for both the mother and her newborn child.

According to the report, the Democratic Republic of Congo is the worst place to be a mother, while Finland is the best. South Africa ranked as 77th on a list of 176 countries after the Ukraine, Algeria and El Salvador. Namibia ranked at 121, Botswana 116 and Swaziland at 119.

The reports states that 7 500 South African babies die on their first day of life every year and 20 200 by the first month. Almost 47 000 children don't live to their fifth birthday.

Though a change in calculation methods makes it difficult to compare this year's rankings to those of previous years, Kate Kerber from Save the Children said South Africa is slowly making progress with maternal and under five mortality rates. "Child mortality in South Africa has improved significantly over the past five years, but deaths..."
during the first month of life have not improved," said Kerber. "The day of birth is still dangerous and not much has changed over the past decade."

According to the University of Cape Town's Children's Institute, the country's under-five mortality was 80 per 1,000 births between 2003 and 2005. The latest health department figures show that this had improved to 56 per 1,000 births in 2011.

Kerber said most maternal and infant deaths can be prevented by improved access to quality healthcare for pregnant women and their babies. She said that increased attention to cost-effective, life-saving interventions such as antenatal steroid injections to help premature babies' lungs develop and resuscitation for babies who do not breathe at birth could help decrease the number of deaths during childbirth and the first week of life.

Inequalities

However, the organisation warned that the country figures published in the report may mask inequalities within countries. "There is a drastic difference in the care received in the private healthcare system as opposed to public healthcare," said Kerber.

Only eight million of the 52-million people in South Africa have access to private healthcare, leaving more than 80% of the country's population dependent on the state for basic healthcare.

Senior researcher with social justice organisation Section27 Sha'ista Goga said that government’s introduction of health reforms, such as the upgrading of health facilities and recruitment of health workers in preparation for the provision of universal healthcare through the National Health Insurance scheme, has the potential to bridge this inequality gap. "It [NHI] can address various inequalities, like funding and quality in underserved areas," said Goga.

She said the establishment of District Clinical Specialist Teams – roving medical teams with a nurse, a gynaecologist and advanced midwife, and other specialists, that service specific health districts – is a step in the right direction. The establishment of the Office of the Health Standards Compliance is also a "positive move towards ensuring that the medical care people receive is of a good quality because it will help government identify where the inequalities are, what form they take and therefore allow them to address them", Goga said.

According to Goga, the School Health Programme that the government introduced in October last year, where learners can access health services at school, will address the issue of parents failing to take their children to clinics due to a lack of transport.

However, Goga warned that quality healthcare depends on more than the health department and said that intergovernmental cooperation is still lacking. "Improved access to quality healthcare facilities will assist in increasing equity. But other government departments also play an important role in improving healthcare outcomes. We still have a long way to go," said Goga.
Health Systems Global Symposium

When: 30 Sept – 3 October 2014 Venue: Cape Town, South Africa

Health Systems Global board retreat – vision, mission, goals and the next symposium
A personal blog by Natalie Eggermont

The Board of the newborn society Health Systems Global met for two days at the London School of Hygiene and Tropical Medicine. The eleven elected board members were reinforced by Abdul Ghaffar and Kent Ranson from the Alliance, Jawara Lumumba from the USAID-funded Health Finance and Governance Project to facilitate the retreat and two invited ‘observers’, Martin McKee and Miguel Gonzalez-Block – the latter were invited to represent high income countries and Latin America respectively. Committed to building an energetic and sustainable society, we embarked on the ambitious agenda.

Our main goals for the two days were to agree on the Society’s mission and vision, to initiate the strategic planning process and to kickstart the organisation of the third symposium.

We’re almost there for the vision and mission, these documents will be finalized soon. It was challenging to find a balance between addressing all of the concerns that came from the members (through the online consultation and at the general assembly), incorporating our own ideas and still trying to avoid a WHO-style consensus outcome statement that would be too long for anyone to read aloud without getting lost. The vision will be short and ambitious; the mission will describe the core business of the Society.

On strategic planning, we only started the process. We did some preliminary brainstorming at the retreat that will continue through email exchange in the coming weeks. Then we will seek input from the members, so they can expect an online survey in their inbox soon! The big headings in the strategic goals were convening (through the symposium, online CoPs, regional hubs, newsletter, …), advancing the field (capacity-building, methodology development, young researchers mentorship, …) and mobilizing for health systems research. Encouragingly, there was a lot of enthusiasm for providing space and building the capacity of young health systems researchers. A new mix of emerging voices will certainly be present at the next symposium, but there will be many other interesting options for young researchers through the work of the Society. On the topic of mobilizing many questions were raised regarding the advocacy role of the Society. Do we want to advocate for health systems research in general or will we issue advocacy statements for specific policies? I think personally that, if we want to transform health systems to achieve something – health and equity for all? – we might consider the second option. The challenge is then to foster debate within the Society about our position and hopefully find some consensus on principles and values we want to promote.

The planning for the third symposium has been initiated. It will be held in Cape Town, 30 Sept – 3 Oct 2014 (585 days to go!!). Because of the urgent work ahead we decided to postpone the nitty-gritty discussion on organisational structure and to convene an interim executive committee to get things going. The committee will include representatives from the board, the Alliance, the Cape Town consortium and possibly some sponsors. First of all we need to find a theme and some money – and we obviously need your help!

We already did some brainstorming on possible themes such as: people-centered health systems, democratizing health, social accountability, fragile states, sustainable health systems, health and economic growth. We agreed the theme should be attractive to diverse, multi-disciplinary audiences and relevant to local/regional contexts. Most
importantly, we want to get input from the members. So let us know what you think on Facebook, Twitter or via email (healthsystemsresearch@cphiv.dk) and spread the word!!

To conclude, a lot of good work was done and I hope we can continue in this spirit. I also hope we will succeed in involving our members in all our discussions, which means you need to raise your voice through all the online channels available to you!

However, we still have a large unfinished agenda, including a more in-depth look at our bylaws and board representation. We heard the comments received at the General Assembly and want the Society to be truly global, both in its membership and in members' representation at the Board. Inviting observers is a good immediate step but I hope we can also think about how we can avoid a similar situation in the future.

Let us apply the values we stand for in our own lives, work and research. With courage and ambition I believe the Society can contribute to a better and more just world. I’m looking forward to the work ahead and eager to contribute.


**Background on Health Systems Global...**

**Second Global Symposium on Health Systems Research**
- Inclusion and Innovation Towards Universal Health Coverage

Beijing, People’s Republic of China
Follow the discussion at [http://www.hsr-symposium.org](http://www.hsr-symposium.org)

Health Systems Global was officially launched at the Symposium on 3 Nov! And new Board chair Irene Agyepong spoke in the closing plenary.

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**First Global Symposium on Health Systems Research (Montreux, Nov 2012)**

Follow the discussion at: [http://www.healthsystemsresearch.org](http://www.healthsystemsresearch.org)

Health Systems Global welcomes applications from its members to establish thematic working groups (TWGs). TWGs will become an important part of HS Global’s operations. It is anticipated that they will provide a platform for membership interaction and the exchange of experiences around particular issues in health systems research.
Criteria for Thematic Working Groups

Prior to the Cape Town symposium HS Global envisages that it will give approval to no more than six TWGs. Proposed TWGs should:

- Represent a major health systems research issue, or methodological approach or capacity development challenge;
- Be led by current members of HS Global and have at least 15 HSG members who are potentially interested in participating in the TWG;
- Encompass diverse members of HS Global, for example including members from multiple countries or regions, or bring together researchers and policy-makers;
- Be of long term relevance (i.e. the society is unlikely to support short-term thematic working groups).

Benefits to the establishment of Thematic Working Groups

TWGs which are accepted by Health Systems Global will be offered the following benefits:

- A homepage on the Health Systems Global website;
- Access to HS Global member mailings/newsletter/social media (for example to announce events or activities);
- Dedicated time slot and meeting room during HS Global’s biennial global symposium;
- Priority access to meeting rooms for satellite sessions associated with the symposium;
- Use of the HS Global logo and name on their materials;

HS Global is considering ways in which TWGs may contribute or potentially manage different tracks within the Biennial Global Health Systems Research Symposium.

How the Thematic Working Groups will operate

Thematic working groups may have a variety of different objectives, from developing capacity for health systems research, to promoting and sharing research findings in a particular field. Accordingly, different TWGs may engage in different activities such as providing training opportunities for HS Global members through webinars or face-to-face training sessions; sharing announcements about relevant research funding opportunities; establishing mentoring schemes; developing advocacy tools; or providing awards to outstanding students or practitioners.

Each TWG should be led by a minimum of three HS Global members, who will take responsibility for developing the programme of work for the group and supporting its implementation. These “officers” of the TWG should be prepared to rotate periodically. The officers of the TWG will maintain an email list of the members and will organize section meetings at the global symposia. It is at the discretion of each group if they would like to plan interim meetings at events of their choice. These positions are non-remunerative and the TWGs should not expect additional support from HS Global beyond that outlined above.

Application to form a TWG

Health Systems Global is open to new proposals for TWGs, which must be submitted to the Secretariat (healthsystemsresearch@cphiv.dk), who will review the material and prepare it for Board consideration. Proposals should be submitted by existing members of Health Systems Global.

Application for Board consideration should be submitted by 1 June 2013, 1 December 2013 and 1 June 2014.

Proposals should consist of a 2-3 page expression of interest and must include the following:

- Name of the proposed TWG
- Clarification of the concept
- Detailed scope of the group’s focus area
- Objectives
- Proposed activities including examples
- Contact information of leaders and members of the group (name, affiliation, email, telephone)
- Names of at least 15 members who support the formation of the TWG and would like to participate in it.
Value of a mobile information system to improve quality of care by community health workers

Authors:
Mark Tomlinson, Mary Jane Rotheram-Borus, Tanya Doherty, Dallas Swendeman, Alexander C. Tsai, Petrida Ijumba, Ingrid le Roux, Debra Jackson, Jackie Stewart, Andi Friedman, Mark Colvin, Mickey Chopra

Background:
We will be unable to achieve sustained impact on health outcomes with community health worker (CHW)-based interventions unless we bridge the gap between small scale efficacy studies and large scale interventions. Effective strategies to support the management of CHWs are central to bridging the gap. Mobile phones are broadly available, particularly in low and middle income countries (LAMIC), where the penetration rate approaches 100%.

Objectives:
In this article, we describe how mobile phones and may be combined with mobile web-based technology to assist in the management of CHWs in two projects in South Africa.

Methods:
This article is a descriptive study, drawing lessons from two randomised controlled trials outlining how a mobile phone information system can be utilised to enhance the quality of health interventions. We organised our comprehensive management and supervision system around a previously published management framework. The system is composed of mobile phones utilised by CHWs and a web-based interface utilised by CHW supervisors. Computerised algorithms were designed with intervention and assessment protocols to aid in the real-time supervision and management of CHWs.

Results:
Community health workers used mobile phones to initiate intervention visits and trigger content to be delivered during the course of intervention visits. Supervisors used the web-based interface for real-time monitoring of the location, timing and content of intervention visits. Additional real-time support was provided through direct support calls in the event of crises in the field.

Conclusion:
Mobile phone-based information system platforms offer significant opportunities to improve CHW-delivered interventions. The extent to which these efficiency gains can be translated into realised health gains for communities is yet to be tested.

http://www.sajim.co.za doi:10.4102/sajim.v15i1.528
SOPH Professor Debra Jackson and Son make it to Mt Everest Base Camp! Congratulations!

And a New addition to the SOPH Family!
Leila Aviwe Kerber, born 29 January 2013

National Research Foundation (NRF) Interns at SOPH

Nokukhanya Tiyane
I am Nokukhanya Tiyane, 28 years of age. I am from Mthatha, Eastern Cape. I have an Honours degree in Psychology, passed the following Modules: Psychological assessment, Psychopathology, Counselling psychology, Developmental Psychology, Research Methods & Statistics, and Research Project. I am currently an NRF Intern working at the School of Public Health and South African Herbal Science and Medical Institute (SAHSMI) my Mentors is Professors T.Puoane and G Hughes. I will be focusing on obesity in men and the use of Traditional medicine to treat Non-communicable disease among the PURE study participants.
**Muhali Mulalo Kenneth**

Mr. Muhali Mulalo Kenneth is a young man born in Limpopo province in South Africa. He has been having interest in studying the environment since he was at the primary school. Mr. Muhali Studied Agriculture from primary school until he graduated at high school in 2006 where he received a Merit Certificate in Matric.

In 2007 he furthered his studies in the University of Venda where he studied Bachelor of Environmental Sciences and complete his degree in 2011. While Muhali was in his tertiary level he discovered that his passion was not only about the environmental studies but also the people that live environment.

Immediately after completing his degree in 2011 he formed alliance with some few young people (youth) and from a Non-Profit organization (Dzinaledzi Community Development Organization) with the aim of developing the community and Training them on Environmental/ Environment health issues through his awareness Campaigns that he was conducting.

He is currently a National Research Foundation (NRF) Intern based in the University of Western Cape, School of Public Health under the supervision of Professor Thandi Puoane and Dr. Gavin Reagon. He is involved in the Prospective Urban and Rural Epidemiology Study (PURE), mainly focusing on (EPOCH) Environmental Profile of a Community’s Health.

**SOPH Thesis Week for MPH Students**

**Karin Hasselman**

I am a nurse by profession and based in the Karasburg District in the far north of Namibia. I am currently working in the special diseases programme and involved with HIV/AIDS, TB Malaria and STIs in the district. I have a supervisory role and oversee the implementation of the guidelines for the programme.

My area of study has to do with the uptake in the use of the female condom in the district where I work and live. It may be a less complex study in terms of methodology, but I want to know why uptake in the facilities is so small - to the point where our district pharmacist does not order them anymore. So why do people not take up this service despite that fact that women know of its benefits and that it will give women more bargaining power? In that sense it is a relevant. I have not come across many previous studies in Namibia.

Since I began the MPH programme my eyes really opened in terms of public health problems. When you’re a nurse you don’t necessarily study public health. My study is adding great value to my perception not only of public health but also how I perceive things now in the area where I work and the value I can add to patients. Even though I obviously cannot change their circumstances or the social determinants of health but I can try and add to their own understanding also. The public health background that I am gaining is also helping me when I am in meetings with people at a higher level within the health system because I can contribute more from what I know, even though it’s not always that they will listen t what you’re saying. This can be challenging when the people you are speaking to do not have the same understanding of public health issues.
In terms of this SOPH Thesis Week I am so happy that I am attending. With distance learning and being at home there are so many other commitments that come in between your study and you are alone. And it is often difficult to understand and grasp some things. It was very beneficial in terms of clarification of many terms and aspects of the protocol of my study which I am now busy working on. I can say that it is of great value and an investment worth making. I am much clearer in terms of where I am with my proposal writing at the moment, and I know that I will reap the fruit of being here over the next months.

The teaching and support staff at SOPH are very helpful and friendly. I really feel safe being at SOPH. The feedback I receive is so helpful. I am happy that I made the decision to do the MPH here at UWC. As far as my future is concerned I definitely want to be in the public health field. I see myself in one or other programme implementation or management role, either within government or the private sector.

Kululwa Ndayi

I am Kululwa Ndayi from Eastern Cape Umtata. I have a health promotion background. I completed my undergraduate (BSc Health Promotion) and Post Graduate diploma in Health Promotion at Walter Sisulu University. I joined the School of Public Health in 2010 working as a research assistant in the Prospective Urban and Rural Epidemiology (PURE) Study which is a multi-country cohort study. I am mainly focusing on the collection of nutrition data using Food Frequencies Questionnaire (FFQ). I have been cleaning data, formatting questionnaires and developing a food photo manual. In 2011 I was offered an internship by the Medical Research Council (MRC) under the Research Capacity Development Unit, and have worked in the Health Kick project in line with PURE. This year I am under the National Research Foundation (NRF) internship program working under the supervision of Professor Thandi Puoane and Dr Gavin Reagon. Through working on these two major projects as an MRC intern and PURE research assistant, I began to see areas of interest in research which drove me to enroll for MPH degree at the University of the Western Cape.

James Kruger

I am a medical technologist by profession. I moved away from laboratory services and looked for an opportunity to get more involved in public health. I am currently working as a programme manager with the Department of Health in the Cape Winelands District based in District Health Office in Worcester. My responsibilities are for the HIV/AIDS, TB, STI Programme for the district, charged with the task of implementing national and provincial policies on HIV/AIDS, TB and STIs at all health facilities which includes all the district hospitals and specialised hospitals. I work with a team that goes down from the district to the sub-districts.

Through this job I wanted to study public health and looked at the public health programmes at the different universities. UWC enticed me for two reasons, one in terms
of this university’s historic connection with our past struggle, and secondly the MPH programme is more linked to communities. For me this is very important because I do not just want a masters degree but a practical MPH.

I think that the SOPH MPH is a fantastic course. I do think that distance learning is difficult. The programme so far has been very helpful. One of the first things I learned is that most of us have been trained in the biomedical model. When I started to learn about the social determinants of health and comprehensive primary healthcare I realised that there is a bigger world.

But I must also add that having this knowledge and wider perspective has brought me into conflict with other colleagues because many of them are stuck to the biomedical model and are not prepared to change. One of the first pillars for me in this regard is the role of communities in health. The SOPH course is community focused but government is not community driven. Government is a big bureaucracy and the way that government provides services is not community driven. And that is the big disjuncture for someone like me. We make decisions for communities assuming that because we are educated they will agree with us and that we are doing them a favour. That is a problem because many of these decisions are not always beneficial to them as the recipients of our services. We stick to the biomedical model which is an expensive model, whereas if for example we implemented comprehensive primary healthcare we could broaden the base and provide more services and also include other stakeholders which is the focus of my study.

The focus of my study is around circular migration, and the effects of the circular migrant system on our health system in the De Doorns area. We have circular migrants from Lesotho and Zimbabwe who work seasonally on the farms. They touch our health system intermittently. But our health system seems not to be ready to pick these people up. Last year we had nineteen children dying of diahorrea which is a preventable childhood death. If we can figure out what are these people’s needs and priorities and try to understand them. So the reasoning behind my study is about why and how we should prepare better to provide health services. Given that we know when and for how long they come we should be able to provide a better service to them, in terms of health, but also in terms of all the services government provides.

This Thesis Week has been very beneficial for me. A lot of the theories and methods and designs that I had in my head as a scholar I have now realised needs more clarification and sharpening - which is what Thesis Week has done for me. The lecturers of the SOPH are of a very high caliber; they know their field of study and can assist you. I found them really refreshing. I also see SOPH as an intellectual home. They helped me clear up things that I took for granted and made me realise that it is not as simple as it sounds. They are very critical and make you think. They have made me more analytical. This is what we will take back into the health system, to ask more critical questions and not take things for granted. They have assisted me with my study design and sharpened what I actually want to achieve through the mini thesis. I certainly want to make a difference in the health department push the social determinants of health higher up on the agenda and affect policy in doing that. Coming from a rural area (Beaufort West) the rural impact of health has always been important. I have chosen as my focus an area of study that is going to either, address some aspect of health and thus be beneficial to the work I am doing or set the scene for a larger study in a PhD programme.

What has also been very rewarding is the engagement with students from elsewhere in Africa – from Namibia, Nigeria, Zimbabwe - who are studying here at SOPH. We have spoken during this week about ways in which we can keep this kind of contact alive, beyond Thesis Week. We know one another and we have developed a relationship from our visits at Summer and Winter School and Thesis Week, so for example, we could start a Study Group among ourselves as tightly knit group doing the same course. We can be critical of each other and assist one another. We could take turns to moderate such a group and even research some aspect of health challenges as a group. And because this will be a group of
peers at a similar level of academic development we can feel comfortable and do this without feelings of inadequacy or intimidation. This can become an alumni activity and a great help for new students who come onto the programme.

**My PhD study....**

Kufre Joseph Okop obtained a Master’s degree in Public Health from the University of Ibadan, after studying for his B.Sc (Human Anatomy) in the University of Calabar, Nigeria.

He has worked as a monitoring and evaluation specialist for over 8 years with International and indigenous public health NGOs supported by USAID, DFID, Gates & Melinda and Global Fund providing technical support in monitoring and evaluation of HIV/AIDS, malaria and reproductive health programmes and research.

Mr Okop is currently studying for his PhD in the School of Public Health, UWC, under the supervision of Professor Thandi Puoane. His research focus is in the area of social and environmental determinants of healthy lifestyle behaviours and cardiovascular risks among individuals living in poor-resource settings.

He is one of the PhD Research Students supported by the Centre of Excellence, CDIA (Chronic Diseases Initiative in Africa) of the University of Cape Town.

**The Academy for Leadership and Management in Health Care**

*Speaking notes by the Minister of Health Dr Aaron Motsoaledi on the launch of the Academy for Leadership and Management in Health Care 6 November 2012*

First of all I would like to thank all colleagues who have put in long hours and have worked tirelessly in making sure that the launch of the Academy for Leadership and Management in Health Care is a success. Your contribution in the build-up of this launch is extremely appreciated.

I’m delighted to see so many of my colleagues here today to recognise the official birth of this Academy which is a concerted effort to ensure excellence and the successful implementation of the goals set in the Human Resources for Health Strategy for the health sector. Today is also a fitting tribute to those who have worked so hard to make this day a reality – both those within the department and those across the healthcare science profession and professional bodies especially the people who were part of the transitional arrangements.
The main purpose of the Academy is to address skills gaps at all levels, including clinical and hospital management.

From my time as a medical practitioner and subsequently as Minister of Health in the public service, together executive leadership of the National Department of Health, I have seen and recognised the need for an overarching human resource in the health sector workforce – and on professional education, training and regulatory matters.


From now on, new hospital CEOs and other high-level managers responsible for health care delivery in South Africa will undergo specialised training in health care management.

Khopotso Bodibe

The national Health Department launched the Academy for Leadership and Management in Health Care, whose aim is to equip health managers with the know-how of navigating through situations that can compromise health care delivery.

Many of the appalling conditions of South Africa’s public health care service, such as hospitals running out of drugs or crucial equipment not working, are directly linked to the quality of managers that lead our public health institutions. The Academy for Leadership and Management particularly aims to empower hospital CEOs with practical knowledge about the day-to-day running of hospitals. Health Director-General, Precious Matsoso, says the Academy seeks to fill the gap between current health education and practice, thus giving health care workers class-based as well as on-the-job training on crucial aspects of health care delivery, particularly towards the implementation of the National Health Insurance scheme.

“Most of them would be trained as mainly post-graduates. There are quite a number of training programmes within the country, some at Masters level, others at post-graduate diploma level. But these have not been specifically designed to prepare CEOs of hospitals and neither have they been specifically designed to prepare district managers, as you know, the thrust of service delivery for NHI is at district level. We’ve done an analysis of all the training programmes in the country that are provided by various institutions. The academy is actually supposed to pull all of those together to ensure that we can produce a certain cadre of health managers as well as CEOs of hospitals, which will be a combination of not only class-room training, but also on the job training on-site”, says Matsoso.

The Academy will start operating in January and the first learners will be the new CEOs of the 97 hospitals located in eight provinces, with the exception of the Western Cape, that the national Health Department has decided need competent CEOs. Health Minister, Dr Aaron Motsoaledi, says the interviewing process for the appointment of the CEOs will be finalised before the end of the year. Motsoaledi said two of the eight provinces have already completed the interviews, but he declined to name them. He said no new hospital CEO will start work before they are taken through the necessary paces at the Academy for Leadership and Management in Health Care.

“In my thinking, nobody should ever be interviewed, win an interview and enter a hospital as a CEO without having gone through some form of training through this academy... even if (it is) just for induction, and they will continue doing in-service training over a long period of time”, he says.

The Academy is modelled on the College of Medicine in South Africa. It will train health care workers who have an interest in health care management in practical skills needed for the smooth functioning of health services at hospital, district,
provincial and national level.

“Those who know how the College of Medicine in South Africa functions, whereby people do their different degrees in different medical universities, but when they do a senior a degree - a particular qualification - they must be accredited or write their exams through the College of Medicine, which encompasses all medical universities (in) South Africa. We are doing more or less the same thing. We need a central Academy of Health Leadership and Management which will standardise and accredit people who must manage health care institutions, and we’d like to start with CEOs. They will do custom-made courses. In other words, if you must be a CEO of a hospital, what do you do every day when you arrive? What do you do before you knock off? What do you do on a weekly basis? What do you do on a monthly basis? The various sectors of the hospital... what do you do for them? Many people don’t necessarily know that. That’s what the institution will do.

But, further than that, what about people who must manage health districts? What must they know? But, lastly, at head office... to be a DG for Health or a DDG or a chief director, what form of skill must you have acquired apart from your first degree or your primary qualification?”, Motsoaledi explains.

He says the Academy has been in the pipeline for the last two years and has described it as a gigantic step towards the implementation of the National Health Insurance scheme.

“It has to develop education, training and professional standards to drive towards scientific practice and evidence-based, patient-orientated services suitable for NHI. We, in the Department of Health, see this Academy as a gigantic step towards the implementation of NHI”.

An advisory committee comprising 12 senior local and international experts in health care delivery will lead and provide guidance to the Academy. Professor Noddy Jinabhai, a retired professor from the University of KwaZulu-Natal and a member of the advisory committee says the launch of the Academy seeks to address problems in the public health care sector over time.

“The aim of this academy is to improve service delivery, and the Minister hopes, through the launch of this unique innovative academy, to address and overcome those deficiencies of the past 18 years”, says Professor Jinabhai.


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