Uta Lehmann promoted to Full Professor in the School of Public Health

Congratulations Uta!

Prof. Uta Lehmann, Director of SOPH
This Brief for the WC Provincial Public Health Research Committee (WCPHRC) was compiled by Prof. Helen Schneider of the School of Public Health, University of Western Cape, with inputs from Profs. Rodney Ehrlich and Lucy Gilson, Dr. Tracey Naledi and other members of the WCPHRC.

**WHY THIS DOCUMENT?**

Health systems research (HSR) focuses on the performance and problems of health systems. A health system is the sum of the structures, people and processes that together provide the vehicle for the delivery of health care and achievement of better health. The Western Cape Provincial Health Research Committee has set as one of its goals the promotion of HSR in the province.

**WHY HEALTH SYSTEMS RESEARCH?**

Interest in how to design, fund and manage health systems in the most efficient, equitable and sustainable fashion is not new. However, the ‘scaling up’ of new HIV, TB and other interventions and slow progress towards the Millennium Development Goals has exposed health systems as the weak link in the chain of implementation, particularly in developing countries. In South Africa, addressing system wide weaknesses are at the heart of new health sector policy initiatives such as National Health Insurance (NHI) and PHC re-engineering. As policy makers and practitioners across the globe grapple with the challenges of strengthening health systems, a community of health systems and policy researchers has emerged to provide insight into and knowledge of how best to do this. However, health systems research does not exist solely to resolve implementation ‘bottlenecks’, but is a field of research in its own right focusing on a complex array of system structures and processes.

Although few would disagree with the importance of health systems research, it is still a relatively new area of scholarship. In November 2010, the first Global Symposium on Health Systems Research was held in Montreux, Switzerland (see: http://www.hsr-symposium.org). Preceding this were a number of international meetings, the establishment of the Alliance for Health Policy and Systems Research, and the publication of a WHO health systems framework in 2007. These processes have enabled greater international agreement (while still the subject of some debate) on the definitions, boundaries and the conceptual and methodological foundations of health systems research, as well as the related area of health policy research.¹

**WHAT IS HEALTH SYSTEMS RESEARCH?**

The Alliance for Health Policy and Systems Research (AHPSR) defines it as “the production of new knowledge to improve how societies organise themselves to achieve health goals. It encompasses how societies plan, manage and finance health services as well as investigation of the role and interests of different actors in the health system.” (http://www.who.int.alliance-hpsr/en/).

This definition encompasses goals, structures and processes. One of the most common representations of a health system that spells out these various dimensions is the WHO Health System Framework\(^2\), summarised in Figure 1.

![WHO Health System Framework](image)

Figure 1: Health system building blocks and goals/outcomes (Copied from WHO, 2007, page 3)

The ultimate goals of a health system are not only improved health, but also greater responsiveness to citizens and household protection from social and financial risk. In this framework, six health system ‘building blocks’ – including service delivery (hospitals, clinics etc.), various inputs (financing, human resources etc.), and systems of governance/leadership – form the basis of ensuring access to effective health interventions (personal and non-personal).

Each health system block represents a potential area of research, and can also be examined in relation to other blocks. For example, a common measure of overall health system performance is the plot of health expenditure against health outcomes (e.g. life expectancy) by country. The general trend is for improved health outcomes with increased investment – however, at any given level of expenditure, individual countries will vary enormously, suggesting different degrees of system efficiency.

As with all other types of research, HSR can fulfill a number of purposes, from descriptive to evaluative. One of the challenges it faces is the interconnected nature of systems elements and the complex pathways and non-linear processes through which change is achieved. For example, policies such as the Occupation Specific Dispensation and Rural and Scarce Skills Allowances which seem straightforward on the surface, have had contradictory effects – promoting retention and redistribution of workers on the one hand, while also falsely raising expectations and diminishing trust in government, on the other hand.

HSR highlights the central place of ‘people’ – patients, providers, managers – as individuals and as groups embodying cultures, norms and values, through which all health system processes are filtered. Health systems thus have both ‘hardware’, financing, human resources and other building blocks, and ‘software’ elements.\(^3\) A growing area of interest in HSR is how to capture this complexity in research methodologies.

HSR is closely related to health policy research, which considers the social and political context of decision-making in systems, and the two are often referred to together as “Health Policy and Systems Research”.\(^3\)

**WHAT IS HSR NOT?**

HSR builds historically on the field of *health services research*, which has as its starting point the service delivery component of health systems, sometimes in relation to other components. Health services research may, for example, study the patient-provider relationship and interventions to improve uptake of clinical guidelines by health care practitioners. However, HSR is broader in scope and includes but is not limited to a focus on service delivery. It may begin from a completely different building block, such as

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governance, leadership or financing, without directly addressing the frontline of service provision during the research process.

HSR is thus more concerned with the generic structures and processes through which interventions are implemented, rather than specific disease (e.g. HIV/TB) or programme (e.g. maternal-child health) evaluations. A health system research perspective asks questions that are somewhat different from those of programme research (see Table 1). However, it is not uncommon for HSR to investigate a specific disease or programme:

- as a tracer for a systems issue e.g. the impact of district strengthening on child health outcomes
- because it has system wide implications and effects e.g. provision of antiretroviral therapy

Finally, HSR shares features with, but is not necessarily the same as operations research. Operations research tends to have an instrumental purpose, seeking to provide solutions, in short time frames, to the problems facing the practice environment. Examples would be evaluating the management skills of hospital CEOs in order to plan a capacity building programme; or assessing effects of interventions under “field” conditions, such as retention in care in scaled up nurse-based anti-retroviral services. HSR would be interested in these questions, but does not always have to be of immediate relevance, i.e. instrumental in nature. It can also take a longer-term perspective on systems, involve researcher (rather than practitioner)-generated questions, and seek to examine the underlying dimensions of health systems such as accountability relationships.4

WHAT KINDS OF QUESTIONS DOES HSR ASK?
Health systems research asks questions at macro, meso and micro levels depending on the scale and complexity of relationships being examined.3

Macro-level HSR questions describe or analyse the system as a whole, for example:
- To what extent has the policy of decentralised governance through the district health system been achieved in South Africa?
- How does the efficiency (health expenditure vs. outcomes achieved) of South Africa’s health system compare with that of other middle income countries?

Meso-level HSR questions focus in a holistic fashion on a particular delivery unit or system function, for example:
- What strategies achieve the greatest improvement in quality of care and patient safety at district hospitals?
- What factors in the drug procurement and distribution system explain drug stocks out in health facilities?

Micro-level HSR questions look at the individual in the system, for example:
- What is the impact of support/supervision on community health worker performance?
- What are the access barriers to chronic disease care experienced by households?

In general, identifying HSR questions, whether macro, meso or micro involves a shift towards thinking that is: broad, cross-cutting, at scale and systemic in nature. This is illustrated in Table 1 that contrasts how a health programme research perspective differs from a health system research perspective on TB control.

<table>
<thead>
<tr>
<th>Thinking broad (beyond the disease)</th>
<th>INH prophylaxis</th>
<th>Secondary prevention for other common diseases</th>
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</table>

Table 1: Programmatic and health system perspectives on TB research

WHAT METHODS ARE USED IN HSR?
“By nature [HSR] is inter-disciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape – and be shaped by – health systems and the broader determinants of health” (http://www.who.int/alliance-hpsr/about/hpsr/en/index.html)

As an applied field, health systems research starts with a problem or theme, and selects a research strategy and data collection methods, whether qualitative or quantitative, that address this in the most appropriate manner. HSR thus treats study design in a “flat” rather than hierarchical fashion, i.e. without regarding some designs as inherently better than others. The most appropriate method is selected depending on the study purpose and nature of the question. Health systems research generally does not, for example, hold the classical experimental design as its gold standard. Multi-method approaches to HSR are not uncommon.

Table 2 outlines the range of HSR strategies and published examples of each strategy.

Table 2: HSR research strategies and examples

<table>
<thead>
<tr>
<th>Research strategy</th>
<th>Example</th>
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<tbody>
<tr>
<td>Case study</td>
<td>The use of formal information by managers in different ‘cases’ of decision-making (Mutemwa et al, 2006)</td>
</tr>
<tr>
<td>Cross sectional</td>
<td>Surveys to assess factors attracting nurses to rural areas (Blaauw et al, 2010)</td>
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<tr>
<td>Longitudinal</td>
<td>Following households to assess barriers to health care access as they experience episodes of ill-health (Goudge et al, 2009)</td>
</tr>
<tr>
<td>Experimental</td>
<td>Assessing the impact (health service use and outcomes) of making information in the form of facility score cards available to community members (Bjorkman &amp; Svensson, 2009)</td>
</tr>
<tr>
<td>Ethnographic</td>
<td>In-depth study of the culture of accountability in one district health system through participant observation and interviews (George, 2009)</td>
</tr>
<tr>
<td>Action-research</td>
<td>Involving practitioners in research on how to improve use of patient records (Khresheh &amp; Barclay, 2007)</td>
</tr>
<tr>
<td>Mixed method and Multi-method</td>
<td>Understanding the factors associated with poor malaria control from different perspectives within a particular health system context (Morrow et al, 2009)</td>
</tr>
</tbody>
</table>

POSSIBLE ROLE OF SERVICE MANAGERS IN HSR
Health service managers have an important role to play in promoting HSR in the province. They can do this by:

- Informing themselves about the nature of health systems research
- Identifying short and long term HSR questions, based on their insider knowledge and everyday experience of the challenges of the health system
- Encouraging their staff members to develop skills and interest in HSR so that they can conduct small scale in-house HSR
- Engaging and developing partnerships with health system researchers in the province to undertake HSR in their facility or geographical area of focus
The WHO meeting on Social Determinants of Health in Brazil closed with two declarations, one an official, pre-agreed statement of member states, and the other a hard-hitting civil society contribution coordinated by the People’s Health Movement.

All people, everywhere, should have an equal chance of good health for as much of their life as possible. That’s not a revolutionary concept. But when, as Professor Sir Michael Marmot, of University College London (UCL), did, you examine the reasons for health inequalities, there is no escaping the conclusion: that those born into poverty and deprivation, without good education or prospects of a rewarding career, are much more likely to live shorter, unhealthier lives than those who were dealt a luckier and wealthier hand.

Marmot’s work on the social determinants of health, both for the UK government and for the UN, has been widely applauded. Many of the governments he has visited - he now spends a lot of time travelling the world to spread the word - say they are working on addressing health inequalities. But even though his expert commission spoke of the "toxic combination of poor social policies, unfair economic arrangements and bad politics that results in the unequal distribution of health-damaging experiences", the fundamental truth at the heart of this - that it is poverty and social injustice that condemn people to ill-health - is often diplomatically glossed over.

Not so in Rio. At a prestigious World Health Organisation global conference on Friday, intended "to build support for the implementation of action on social determinants of health", the stakes were raised publicly. More radical health campaigners rejected the official Rio Political Declaration on Social Determinants of Health, which had been carefully negotiated in advance in order not to upset sensitivities, and launched an alternative civil society Rio Declaration.
Their demands are an anti-poverty agenda: they want progressive taxation, wealth taxes and the elimination of tax evasion to pay for action on the social determinants of health. They have the big corporations in their sights, demanding that people everywhere be protected against the marketing strategies of companies selling tobacco, alcohol, baby milk substitutes, high fat and sugar foods, as well as those of the oil industry. They want equal access to affordable healthcare and oppose privatisation, and they want rich countries to compensate poor ones for recruiting their doctors and nurses.

Star of the day was Prof David Sanders, of the University of the Western Cape in South Africa and the People’s Health Movement, whose rousing speech slating the official declaration received a standing ovation from campaigners, while many member state representatives sat silent. It ought to tackle unfair trade, he said, in which agricultural subsidies lead to food insecurity and malnutrition, especially in Africa. He accused corporations of buying up land in famine-dogged Ethiopia to grow food for the west. And he accused the west of robbing poor countries of skilled healthcare staff.

Health has become a rallying cry for those who oppose poverty, privilege and greed. This is one genie that looks unlikely to go back in the bottle.

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**WHO Conference - International Trade and Public Health**

**Prof. Sanders’ Presentation:**

*Prof. David Sanders received a standing ovation during the final session of the conference. He demanded to know why unfair terms of trade, climate change, the brain drain of health workers from impoverished countries to wealthy countries, and other crucial and pressing issues of rights, equity and justice including food and nutrition adequacy and security, have been ignored in the official Rio Political Declaration.*

Dear Colleagues,

I want to focus on mothers and children in particular. There is an unacceptable gap between rich and poor. A woman in a poor country has a one in ten chance of dying in childbirth. A total of 35 per cent of deaths of children in the world are due to malnutrition.

What are we doing about this? Very little. Trade is sadly not mentioned in the Rio Declaration. Undernutrition is related to free trade agreements. Northern countries subsidise their agriculture and export food to impoverished countries, flooding their markets. For example, Japan subsidises its dairy industry to the tune of $US 2,600 a year per cow. Why should a Japanese cow enjoy an annual ‘income’ of five times that of an African citizen who earns on average $US 500 a year? And this leads to food insecurity. Why are we not talking about these things?

What is UNICEF doing about this? It is flying Plumpy’nut from France into Africa to treat malnutrition. This medicalises the problem and draws attention away from the fact that African countries import food and sell land to transnational food companies. Ethiopia, the largest
recipient of Plumpy’nut also receives 700,000 tonnes of food aid a year. It has just sold 3 million
hectares of prime land to a food transnational corporation. This is the context of the problem and
we are not addressing it.

Looking at noncommunicable diseases, again trade is the issue. South Africa is the third fattest
country in the world; and the importation and production of processed food products, and of
whey, an ingredient of snacks, has gone up exponentially. How are we going to control
malnutrition without regulating trade? Also, there is no reference in the Rio Declaration to the
unfair trade of health personnel. Africa and Asia have been stripped of health personnel and that
is very unequal trade, contributing to an increase in maternal mortality among other things, since
skilled health personnel are crucial to reducing this tragedy. It was estimated several years ago by
UNCTAD (the UN Conference on Trade and Development) that the US saves $US 184,000 in
training costs for each imported professional. Totalled up, this translates into hundreds of billions
of dollars. Again here is the South subsidising the North. We need compensation for what African
ministers of health a few years ago
called brain robbery – not a voluntary
code, like the present WHO code on
recruitment, which has no teeth to
enforce it.

I am also member of the People's
Health Movement, a global
movement active in about 70
countries, with several affiliated
organisations. We have a position in
PHM of unconditional but critical
support of the UN agencies. Although
they are imperfect, they represent the
views of the member states. However,
they have been weakened
substantially because countries are
not funding them as they should.
They should also be strengthened and
they should be bolder. But private
initiatives such as the Gates
Foundation are major funders and
they are influencing these agencies to
a great extent.

As Bob Dylan said, money doesn’t
talk, it swears. We need to speak about the financial crisis, a food crisis and a climate crisis (and
climate is not mentioned in the Rio Declaration). The financial crisis is a crisis of capitalism.
There is an alternative Rio declaration put up by civil society, with ten very clear demands,
including a Tobin tax. Why aren’t United Nations agencies calling for this? This is not a radical
thing; it’s a tax on the casino economy. Now poor people everywhere, including in Southern
Europe, are paying for the crisis. We should stand up for them.

David Sanders
David Sanders is Professor and founding Director of the School of Public Health at the University
of the Western Cape, South Africa. He is a founder member and on the Global Steering Council
of the People’s Health Movement (PHM) and is currently chairperson of PHM South Africa

Access the text at:
http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf
(official), and
(civil society).
Sweden is increasing its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria, committing 2 billion Swedish kronor ($302 million) for 2011-2013. The amount, the Global Fund noted Oct. 18, represents an 11 percent increase from the previous level.

“Sweden has been a long term strong supporter of the Global Fund and has played a lead in the work to strengthen the Global Fund’s risk management and fiduciary controls,” Global Fund Executive Director Michel Kazatchkine said in a press release. “We appreciate the trust and confidence Sweden has shown in the Global Fund and our current efforts to transform the institution to become a highly efficient channel for resources for a sustainable, long-term response to improve the health of millions of people.”

According to the fund, Sweden has been working closely with the organization in its reform efforts. The country was the first to express concern over allegations of Global Fund grant misuse earlier this year.

The Lancet—University of Oslo Commission on Global Governance for Health, in collaboration with the Harvard Global Health Institute

Governance challenges in global health have gained attention in recent years. This increased scrutiny is a welcome recognition of the fact that improving health worldwide is not merely a matter of technical intervention or resource mobilisation, but also demands credible, legitimate decision-making processes and effective, efficient, and equitable action. The debates around global health governance have usually addressed the governance of the global health system—that is, actors whose primary intent is to improve global health, and the rules, norms, and processes that govern their interaction.

What merits increased attention, however, is a broader consideration of the many actors and forces outside the global health system and the ways in which they influence health. The global context today differs dramatically from 1948 when WHO was created. Globalisation has tightened the links of interdependence binding together states, societies and economies; this has both increased the degree to which we face shared health threats, and opened up new opportunities for collaborative action by a diverse range of sectors. New players also bring new resources, interests, and agendas to the table: today, non-state actors, such as private firms and civil society organisations, wield significant influence, alongside sovereign nation states and...
intergovernmental organisations. Finally, there is growing recognition that global governance processes outside the health sector, such as those relating to security, trade and investment, environment, education, agriculture, and migration, increasingly affect health both negatively and positively. For example, international intellectual property rules may restrict national policy space to control the price of medicines, whereas global norms on tobacco control may facilitate the adoption of national measures like tobacco taxes that can positively impact public health. Similarly, climate change negotiations can influence the scope of, and responses to, one of the most pressing health threats of our time. There are, however, no satisfactory mechanisms to protect and promote health in these other governance arenas. Rather, health concerns often come into direct conflict with other powerful interests, such as protecting national security, safeguarding sovereignty, and pursuing economic activities.

An increased understanding of how public health can be better protected and promoted in various global governance processes is urgent, but complex and politically sensitive. These issues involve the distribution of economic, intellectual, normative, and political resources, and require a candid assessment of power structures. The Norwegian Minister of Foreign Affairs, Jonas Gahr Store, has argued that there is a scarcity of empirical knowledge on how health can be better promoted through foreign policy making and other global governance processes. In a speech at the Harvard Kennedy School in December, 2010, Store called for an academic commission on global governance for health to promote innovative thinking that would move beyond conventional wisdom.3

Therefore, we are launching an independent academic effort, The Lancet—University of Oslo Commission on Global Governance for Health, in collaboration with the Harvard Global Health Institute, to bring new research and analysis to bear on these questions. The Commission follows the Oslo Declaration of the Foreign Policy and Global Health Initiative,4 which has pointed to the need to engage beyond the health sector to solve key challenges in global health.

It is proposed that the Commission analyse the inter-relations between health and other governance sectors, to assess how policies and actions in these areas affect global health objectives—and hence identify how targeted actions outside institutions of health governance may contribute to global health. The Commission will propose recommendations on how public health can be more effectively protected and promoted in selected key policy-making domains. Moreover, the Commission will seek to build on, and relate to, ongoing work on achieving health in all policies5 as well as the social determinants of health.6

Under the leadership of Rector Ole Petter Ottersen, the University of Oslo will anchor the Commission and engage Commissioners who bring diverse geographical, disciplinary, and personal perspectives to its work. Over the course of 2 years, the Commission will examine aspects of governance, at both national and global levels, with the aim of making recommendations for improving global governance for health.

We are the Commissioners of The Lancet—University of Oslo Commission on Global Governance for Health, in collaboration with the Harvard Global Health Institute. We declare that we have no conflicts of interest. For further information or contribution, please contact Rector Ole Petter Ottersen.

References

7 Department of Global Health and Population, Harvard School of Public Health, Boston, USA.
c The Lancet, London, UK.
Conflicts of interest and the UN high-level meeting on non-communicable diseases

Many non-governmental organisations and professional groups are increasingly concerned by the current UN approach to engaging with private-sector and trade associations whose products and marketing contribute to the development of non-communicable diseases (NCDs). The UN high-level meeting on NCDs (chiefly cancer, cardiovascular disease, diabetes, and chronic respiratory diseases) on Sept 19–20, 2011, will present an unprecedented opportunity to address this important but neglected global health issue. More than 140 public-interest organisations from around the world have signed up to the Conflict of Interest Declaration, which has been sent to the President of the General Assembly, and the co-convenors of the high-level meeting—the Ambassadors from Luxembourg and Jamaica.

Initiatives with the private sector, such as STOP TB and Roll Back Malaria, can be effective when the process is transparent and when the private-sector partners involved have few conflicts of interest. However, in the case of NCDs, there are clear conflicts for the corporations that contribute to and profit from the sales of alcoholic beverages; foods with high fat, salt, and sugar contents; and tobacco products—all of which are important causes of NCDs. These conflicts must be explicitly recognised and addressed, as acknowledged by WHO. Failure to do this will undermine the development of competent policy; the effectiveness and efficiency of programmes; and the confidence of the global health community and the public at large have in the UN and WHO’s ability to govern and advance public health, which will severely impair capacity to help member states address NCDs.

We recommend the following actions to manage the issue of conflicts of interest for NCDs and to protect the integrity of the UN’s public-policy decision making on NCDs:

1. WHO should develop a code of conduct that sets out a clear ethical framework to identify and address conflicts of interest, eliminating those that are insurmountable and managing those regarded as acceptable after a thorough risk/benefit analysis. Article 5 of the WHO Framework Convention on Tobacco Control provides an example of a framework that safeguards public health policy from the influence of the tobacco industry.

2. This code of conduct and ethical framework should be used to guide any interactions with the private sector in NCD prevention and control at UN, regional, or national level and to differentiate clearly between no involvement in policy development and appropriate involvement in implementation that complies with existing regulations and the principles established in the code of conduct.

3. This code of conduct should be mandated at the international UN level, and adopted as good practice recommendation for action by member states.

We urge the adoption of the above recommendations in the political declaration and follow-up actions to the high-level meeting on NCDs. The risks of not doing so are great. Without such safeguards, policies and recommendations will invariably be weakened to suit the interests of powerful corporations. The ability of member states—especially those in resource-poor settings—to take effective action and to regulate harmful marketing practices will also be severely weakened.

As a consequence, the public’s health, workforce productivity, and the economy will be undermined by prioritising the interests of the food and beverage industries, as well as the pharmaceutical, technology, and treatment companies, over the public good. These fundamental conflicts of interest need to be addressed at this crucial formative stage. Failure to address these concerns will mean that the effect of the UN high-level meeting process will be substantially impaired and demonstrate flawed public-interest leadership.

We declare that we have no conflicts of interest.

*Paul Lincoln, Patti Rundall, Bill Jeffery, Gigi Kellett, Tim Lobstein, Lida Lhotska, Kate Allen, Arun Gupta

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National Heart Forum, London WC1B 4AD, UK (PL); Baby Milk Action, Cambridge, UK (PR); Centre for Science in the Public Interest, Ottawa, ON, Canada (BJ); International Association of Consumer Food Organizations, Washington, DC, USA (RL); Corporate Accountability International, Boston, MA, USA (GG); International Association for the Study of Obesity, London, UK (TJ); International Baby Food Action Network, Geneva, Switzerland (LA); World Cancer Research Fund International, London, UK (KA); and Alliance Against Conflict of Interest, Delhi, India (AG)


Congratulations Bridget!

Kayla Basson, born to Bridget (SOPH Administrative Assistant) and Shaun Basson on 11.11.11

Triple Bundle of Joy, born to SOPH Student Tuduetso Mokgatlhe

Congratulations Tudu!

Earlier this year (Feb), I realised that I was pregnant with triplets and so was put on bed rest until delivery. They were born prematurely on 22 June 2011, and they are all doing well. They are bigger and I am now able to resume my school work.

Here is a picture of my triple bundle of joy... They were 3 months here & are now going on to 5 months! The girl is in the middle- Khetiwe. And the two boys are Andile on her right and Sandile on her left!

Tudu, tmokgatlhe@yahoo.co.uk

SOPH Secretary Lynette Martin turned Sweet 60 on the 11.11.11

Congratulations Lynette!