



From Prof Helen Schneider, the Director of the School...

Dr Tanya Doherty appointed Extraordinary Professor at the School of Public Health

Dear colleagues

As you know Tanya Doherty has been a long time collaborator and very part-time employee of the SOPH. We recently applied to have Tanya formally recognised as an associate of the SOPH. The professorial appointments committee recognised Tanya's incredible achievements over the last few years and has appointed her as extraordinary (full) professor.

We congratulate Tanya on her new status and are delighted to have her continued association with the SOPH!

Regards

Helen



Prof Richard Laing, Extraordinary Professor at the School of Public Health, UWC Awarded Carnegie African Diaspora Fellowship

The Carnegie African Diaspora Fellowship Program, administered by the Institute for International Education, has awarded Richard Laing, a professor of Global Health at Boston University School of Public Health and Extraordinary Professor at SOPH, a Carnegie African Diaspora Fellowship to help develop pharmaceutical policy courses at the University of the Western Cape in South Africa.



Originally trained as a medical doctor, Richard Laing worked for the Ministry of Health in Zimbabwe for over 18 years, during which time he undertook postgraduate Masters and Doctoral studies on Community Health for Developing Countries and on Comparative Health Systems & Policy Analysis. After receiving his degrees, he spent 13 years working for Management Sciences for Health (MSH) and establishing the International Network for the Rational Use of Drugs. Following his work with MSH,

Dr. Laing taught international public health at the Boston University School of Public Health (BUSPH) before joining WHO as a medical officer. At WHO, he was responsible for editing the Essential Drugs Monitor and for leading the team responsible for Medicines Evidence and Information for Policy. He was one of the authors of the Priority Medicines for Europe and the World report 2004 (and the update in 2013), and of the report From Access to Adherence The Challenges of Anti Retroviral Treatment. He has been engaged in working on measurement of medicines pricing and availability as part of the joint WHO/HAI project on Medicine prices. Working with IMS Health, he has reported on the impact of the global recession on the pharmaceutical sector. Recently he has published research on the availability and price of chronic disease medicines. He was also the editor for the third edition of the World Medicines Situation Report.

The fellowship program (*see below for more on the Carnegie African Diaspora Fellowship*) is and was designed to encourage African scholars in the U.S. and Canada to help develop educational institutions in Africa. provides funding and a structure for African-born academics at accredited higher education institutions in the United States and Canada to collaborate with colleagues at accredited higher education institutions in Ghana, Kenya, Nigeria, South Africa, Tanzania and Uganda on capacity-building education projects.

While in South Africa, Laing will work on a project titled: “Curriculum Co-development and Graduate Teaching in Face-to-Face Short Courses and Online Modules in Pharmaceutical Public Health and Policy”. This project will support the establishment of a Pharmaceuticals track within the existing Master of Public Health Programme, offered at the School of Public Health at UWC as well as other initiatives in this field within the university.

THE UNIVERSITY OF THE WESTERN CAPE, SCHOOL OF PUBLIC HEALTH SELECTED TO HOST CARNEGIE AFRICAN DIASPORA SCHOLAR

Carnegie African Diaspora Fellowships to support 60 Projects in Africa

The University of the Western Cape was selected by the Carnegie African Diaspora Fellowship Program to host an African Diaspora scholar from the United States to work with on a collaborative project to help develop pharmaceutical policy courses at the School of Public Health.

UWC is one of 59 projects that will pair African Diaspora scholars with higher education institutions in Africa to collaborate on curriculum co-development, research, graduate teaching, training and mentoring activities. The winning projects in this second round of awards were submitted by 47 institutions in Ghana, Kenya, Nigeria, South Africa, Tanzania and Uganda.

The South African host universities include: Nelson Mandela Metropolitan University, Stellenbosch University, University of Cape Town, University of Johannesburg, University of Pretoria, University of South Africa, University of the Western Cape, University of the Witwatersrand.

This innovative Fellowship program facilitates engagement between scholars born in Africa who are now based in the United States or Canada and scholars in Africa on mutually beneficial academic activities. The program is managed by the Institute of International Education (IIE) in collaboration with Quinnipiac University, which chairs the Advisory Council, and is funded by the Carnegie Corporation of New York.

The Carnegie African Diaspora Fellowship (ADF) Program Advisory Council, comprised of academic leaders from Africa and prominent African Diaspora academics, has remarked on the quick growth, increased quality, impact, and uniqueness of the program, which allows African universities to take the lead in hosting African diaspora scholars at their institutions.

According to the program’s Advisory Council, “The program contributes to brain circulation and global networking of ideas creating new knowledge in a non-hierarchical empirical manner--the exchanges are grounded in equality. The pool represents the future of the U.S. and Africa with new talents who represent their fields and the future of their disciplines. Creating large constituencies

across the Atlantic reinforces collaboration instead of domination, strategic partnership instead of academic distancing, and the various projects contribute to rethinking the epistemologies of knowledge.”

U.S. and Canada-based scholars can apply for Fellowships and African host institutions can submit project requests until December 8, 2014 to be considered in the third selection cycle. Project visits can begin as early as May 2015 and must be completed by August 2015.

Scholars born in Africa who live in the United States or Canada and work in an accredited college or university in either of those two countries can apply to be on a roster of available candidates. Candidates must have a terminal degree in their field and can hold any academic rank. For Fellows matched with a selected project, the Fellowship for the project visit includes a daily stipend, transportation and visa funds and health insurance coverage.

Public and private higher education institutions in Ghana, Kenya, Nigeria, South Africa, Tanzania and Uganda can submit a project request to host a scholar for 14 to 90 days. African institutions and prospective Fellows (scholars) can collaborate on ideas for a project that the institution submits. IIE maintains the scholar roster to facilitate matches, according to the discipline specializations, expertise, activities and objectives described in a project request.

All of the fellows and host institutions for the first two rounds of Carnegie African Diaspora Fellowships, along with the selected fellows, are listed on the program website, along with highlights of projects and comments from the first round of Fellows and Hosts.

Contact: Dr Hazel Bradley at hbradley@uwc.ac.za for further information

Lynette Martin Twenty Years of dedicated Service to UWC and the School of Public Health





UNSAM Delegation visits SOPH

A delegation led by Dr Carlos Ruta, president of the National University of San Martín (UNSAM), Argentina, paid a visit to SOPH on 15 October 2014. The delegation had a positive meeting with SOPH staff including Prof David Sanders and Prof Uta Lehmann.

This exploratory visit revolved around sharing experiences about the two institutions teaching and research engagements in general, and about SOPH's popular distance learning postgraduate programme and UNSAM's recent effort to develop a Health Institute in particular.

The meeting culminated in representatives of the two institutions pledging to engage further towards forging South-South cooperation, and UNSAM leadership inviting SOPH leadership for a similar work visit to Argentina.

*Woldekidan Amde
Program Manager/Researcher
School of Public Health, UWC*

Welcome to Dr Boroto Hwabamungu Postdoctoral Fellow on the Joint UWC-UCT Collaboration for Health Systems Analysis and Innovation (“CHESAI”) Project

Dr Boroto Hwabamungu joined the UWC School of Public Health (SoPH) early this September 2014 as post-doctoral fellow. During his post-doctorate fellowship he will undertake further research in the areas of health policy and systems research. He will further disseminate his PhD research in the form of journal and conference papers and workshop presentations and will also provide lecturing and co-supervision assistance in the area of Health Information Systems, and research methodology.

Dr Boroto is originally from the Democratic Republic of Congo (DRC), the former Zaire. He holds a PhD in Information Systems from the University of Cape Town and specialised in Health Information Systems. He interrupted his fourth year of medical studies in the DRC in 1998 due to the political unrest in the DRC. He came to South Africa in 2000 with the hope of completing his medical studies and becoming a medical doctor. He struggled to get admitted in most South African medical schools/universities to pursue his medical studies. He then decided to enrol for the BCom Information Systems degree at the University of the Western Cape (UWC) in 2002.

After completing his BCOM and Honours degrees in Information Systems at UWC in 2005 and 2006 respectively), he enrolled for a Masters degree in Informatics at the University of Pretoria in 2007. Having completed his Masters degree with a distinction for his Masters' dissertation in 2009 and wishing to further his research interest, he enrolled for the 2010 PhD programme in Information Systems at the University of Cape Town. He successfully completed his PhD program in July 2014. His PhD research topic was “The influence of stakeholders' relations on the implementation of Information Systems strategy in public hospitals in South Africa: an activity theory perspective”. His research interests are: health information systems, strategic information systems planning (SISP), mHealth and Information and Communication Technology (ICT) for development (ICT4D). He has been a candidate/student researcher at the Council for Scientific and Industrial Research (CSIR) within the CSIR Meraka Institute in Pretoria from October 2006 to March 2014. He also worked as a SAP Junior consultant at the City of Cape Town's SAP R/3 ERP project between February 2006 and September 2006.

He recently married Patricia Namwezi Ndeko on 07 December 2013 in Pretoria.



Best poster (Student Category) among around 50 Posters.

Neupane S, Odendaal W, Friedman I, Jassat W, Schneider H & Doherty T. (November 2014). Paper and phone based monitoring and evaluation systems to support community-based services, South Africa. Poster presented at the Canadian Conference on Global Health, Ottawa Canada



Sunisha Neupane



Paper and phone based monitoring and evaluation systems to support community-based services South Africa

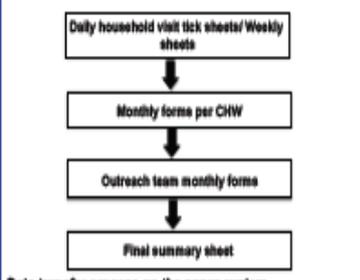
Sunisha Neupane, Willem Odendaal, Irwin Friedman, Waasila Jassat, Helen Schneider, Tanya Doherty, University of the Western Cape

BACKGROUND

- In an attempt to address a complex disease burden, including improving progress towards MDGs 4 and 5, South Africa recently introduced a re-engineered Primary Health Care (PHC) strategy, which includes development of a national community health worker (CHW) programme.
- The importance of CHWs, and their supervision as a key element to ensure the delivery of quality primary health care services, is well documented (1, 2, 3).
- Traditionally, CHWs use paper-based reporting forms that are regularly submitted to their supervisors.
- A mHealth system (using cell phones) for CHWs, mimicking the data required for the district health information system (DHIS) was tested in the North West Province.
- The system (called Moberzi Outreach) is implemented in a 're-engineering' pilot site and as such the 10 participating CHWs are employed in a ward-based outreach team managed by a professional nurse (team leader).

The Paper System

CHW Household Visit Tick Sheet	1/8 size	1/4 size	1/2 size	Page 1																																																																								
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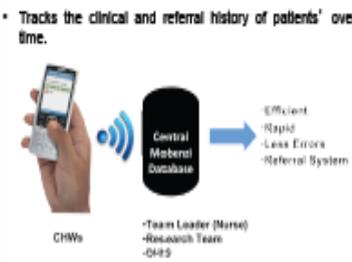
The Challenges of the Paper System

- Data loss
- Lack of supervision
- Inefficient filing
- Difficulty in tracing clinical referrals

The Phone System

- Functionalities of the phone system captures the same data as the paper system.
- The system strengthens the recording, reporting and supervision of CHW services.

The Phone System



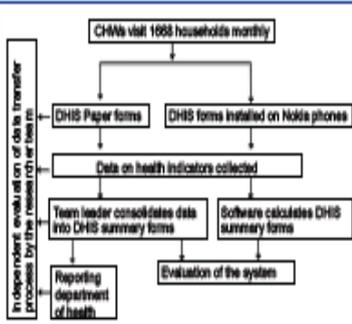
AIM

To evaluate phone and paper based systems to enhance the community health workers program.

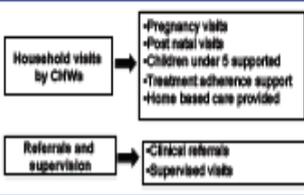
Parameters used

- Data Accuracy
- Patient Referral
- Supervision opportunity

The Study Design

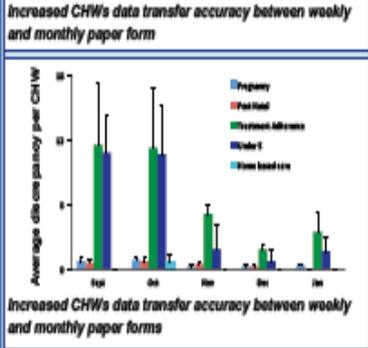
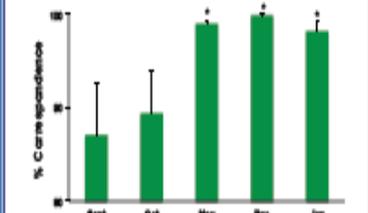


Indicators Used to Evaluate the Systems



RESULT

- Average size of the CHWs' catchment population was 146 households per CHWs
- Each CHW supported 150-200 active clients and had 3.5 visits per day
- September 2012 was the baseline and data was collected and analyzed for following five months (alpha = 0.05)



Patient Referral

- The phone system links each individual referral to its outcome and nature of the referrals.
- Patient referral data collected can also be used for needs assessment of the community.

Challenges of the Phone System

- Demands persistence and external funding so that it can be included in national policies
- Still perceived as a new system
- Specific government needs (ex. Signature)
- Functionalities not utilized by the team leader and the health manager

DISCUSSION

- The research team highlighted the instantaneous recording of services and visual display of real-time data as the most important benefit compared to paper-based monitoring and evaluation.
- However, it is emphasized that the system in itself does not guarantee improved supervision and the delivery of quality services. There is no alternative to well supervised visits to ascertain the quality of the service provided by the CHW, and the team had to invest considerable time to ensure that the team leader utilizes the system optimally.
- Extensive time investment was also needed during the first four months of implementation to ensure that the CHWs and participating facilities became proficient in using the system.

CONCLUSION

- The study clearly demonstrates need for regular supervision for both systems and assessment of data quality.
- Our study shows a way in which mHealth could strengthen the recording and reporting of CHW services and help supervisors monitor the CHWs' services.
- mHealth M&E system could furthermore improve the monitoring of referral uptake and also provide output data in the format required by the DHIS.
- Experience in implementing the system at scale is underway before final recommendations can be made on institutionalizing mHealth as part of the re-engineering of primary health care services in South Africa.

REFERENCES

1. Levin SA, et al. (2005). Lay health workers in primary and community health care. *Cochrane Database of Systematic Reviews*, 1, CD50470.

2. Anderson LI, Soper D. (2010). Community health workers: What do we know about them? *M&E Systems and Utilization for Policy*, Department of Human Resources for Health, Ottawa.

3. Pove AC, et al. (2010). The role and use of supervision in a project designed to strengthen supervision of Integrated Management of Childhood Illness in South Africa. *Health Policy and Planning*, 25, 125-134.

Frontline health workers as brokers: provider perceptions, experiences and mitigating strategies to improve access to essential medicines in South Africa

Bvudzai Priscilla Magadzire, Ashwin Budden, Kim Ward, Roger Jeffery and David Sanders

Abstract

Background:

Front-line health providers have a unique role as brokers (patient advocates) between the health system and patients in ensuring access to medicines (ATM). ATM is a fundamental component of health systems.

This paper examines in a South African context supply- and demand- ATM barriers from the provider perspective using a five dimensional framework: availability (fit between existing resources and clients' needs); accessibility (fit between physical location of healthcare and location of clients); accommodation (fit between the organisation of services and clients' practical circumstances); acceptability (fit between clients' and providers' mutual expectations and appropriateness of care) and affordability (fit between cost of care and ability to pay).

Methods:

This cross-sectional, qualitative study uses semi-structured interviews with nurses, pharmacy personnel and doctors. Thirty-six providers were purposively recruited from six public sector Community Health Centres in two districts in the Eastern Cape Province representing both rural and urban settings. Content analysis combined structured coding and grounded theory approaches. Finally, the five dimensional framework was applied to illustrate the interconnected facets of the issue.

Results:

Factors perceived to affect ATM were identified. Availability of medicines was hampered by logistical bottlenecks in the medicines supply chain; poor public transport networks affected accessibility. Organization of disease programmes meshed poorly with the needs of patients with co-morbidities and circular migrants who move between provinces searching for economic opportunities, proximity to services such as social grants and shopping centres influenced where patients obtain medicines. Acceptability was affected by, for example, HIV related stigma leading patients to seek distant services. Travel costs exacerbated by the interplay of several ATM barriers influenced affordability. Providers play a brokerage role by adopting flexible prescribing and dispensing for 'stable' patients and aligning clinic and social grant appointments to minimise clients' routine costs. Occasionally they reported assisting patients with transport money.

Conclusion:

All five ATM barriers are important and they interact in complex ways. Context-sensitive responses which minimise treatment interruption are needed. While broad-based changes encompassing all disease programmes to improve ATM are needed, a beginning could be to assess the appropriateness, feasibility and sustainability of existing brokerage mechanisms.

<http://www.biomedcentral.com/content/pdf/s12913-014-0520-6.pdf>

What Should the Ideal HIV Self-Test Look Like? A Usability Study of Test Prototypes in Unsupervised HIV Self-Testing in Kenya, Malawi, and South Africa

Roger B. Peck • Jeanette M. Lim • Heidi van Rooyen • Wanjiru Mukoma • Lignet Chepuka • Pooja Bansil • Lucia C. Knight • Nelly Muturi • Ellen Chirwa • Arthur M. Lee • Jeff D. Wellhausen • Olivia Tulloch • Miriam Taegtmeier

Abstract

HIV self-testing (HIVST) is increasingly being sought and offered globally, yet there is limited information about the test features that will be required for an HIV self-test to be easy to use, acceptable to users, and feasible for manufacturers to produce. We conducted formative usability research with participants who were naive to HIVST using five prototypes in Kenya, Malawi, and South Africa.

The tests selected ranged from early-stage prototypes to commercially ready products and had a diverse set of features. A total of 150 lay users were video-recorded conducting unsupervised self-testing and interviewed to understand their opinions of the test. Participants did not receive a test result, but interpreted standardized result panels.

This study demonstrated that users will refer to the instructions included with the test, but these can be confusing or difficult to follow. Errors were common, with less than 25 % of participants conducting all steps correctly and 47.3 % of participants performing multiple errors, particularly in sample collection and transfer. Participants also had difficulty interpreting results. To overcome these issues, the ideal HIV self-test requires pictorial instructions that are easy to understand, simple sample collection with integrated test components, fewer steps, and results that are easy to interpret.

AIDS Behav (2014) 18:S422–S432
DOI 10.1007/s10461-014-0818-8



Characteristics of sexually experienced HIV testers aged 18 to 32 in rural South Africa: baseline results from a community-based trial, NIMH Project Accept (HPTN 043)

Lucia Knight, Nuala McGrath, Heidi van Rooyen, Hilton Humphries, Alastair van Heerden and Linda Richter

Abstract

Background:

Young people in South Africa are at high risk of HIV infection and yet may have more limited access to prevention and treatment services than others in the population. Testing facilitates the sharing of prevention messages but also enables the linkage to care and treatment of those who test positive and therefore has wider public health implications.

Methods:

This baseline survey conducted in 2005 for a community randomized trial in rural KwaZulu-Natal explored factors associated with a history of ever, repeat and recent testing amongst sexually debuted men and women aged 18 to 32 years.

Results:

Over 35% of this rural population ever tested for HIV, with men less likely to ever (unadjusted OR 0.26, 95% CI: 0.21-0.32) and repeatedly test than women (adjusted OR (aOR) 0.68, 95% CI: 0.48-0.97). Men aged 24–28 years (aOR 2.02, 95% CI: 1.10-3.71) and 29–32 years (aOR 2.69, 95% CI: 1.46-4.94) were more likely to ever test than those <20 years. Those who reported having discussed HIV with others had significantly greater odds of reporting ever (men's aOR 2.83, 95% CI: 1.63-4.89; women's aOR 3.36, 95% CI: 2.50-4.53), recent (irrespective of sex, aOR 2.87, 95% CI: 2.02-4.09) and repeat testing (aOR 2.02, 95% CI: 1.28-3.19).

Conclusion:

These findings highlight the need for novel youth- and men-friendly testing services and emphasises the importance of discussions about HIV in the home and community to encourage testing.

<http://www.biomedcentral.com/1471-2458/14/1164>

Child Support Grant Access and Receipt among 12-weekold Infants in an Urban Township Setting in South Africa

Wanga Zembe-Mkabile, Tanya Doherty, David Sanders and Debra Jackson

Background:

Cash transfers (CTs) are increasingly used as a strategy to alleviate poverty and improve child health outcomes in low- and middle-income countries. The Child Support Grant (CSG) is the largest CT programme in South Africa, and on the continent, targeting poor children from birth until the age of 18 with a monthly sum of R300 (USD30). Evidence on the CSG shows that early receipt of the grant is associated with improved child health outcomes. Since its implementation, one of the major concerns about the grant has been take-up rates, particularly for younger children.

This paper reports results on take-up rates for 12-week-old infants residing in an urban township in South Africa.

Methods:

This is a descriptive study utilising data from a community-based, cluster-randomised trial which evaluated a programme providing pregnancy and post-natal home visits by community health workers to 3,494 mothers in Umlazi township, South Africa.

Results:

At the 12-week visit, half (52%) of the mothers who had enrolled in the study had applied for the CSG on behalf of their children, while 85% of the mothers who had not applied were still planning to apply. Only 38% (1,327) of all children had received the CSG.

Conclusions:

In this study, many mothers had not applied for the CSG in the first few months after delivery, and only a third of children had accessed the grant. Further research is needed to understand what the current barriers are that prevent mothers from applying for this important form of social protection in the early months after delivery.

Citation: Glob Health Action 2014, 7: 25310 - <http://dx.doi.org/10.3402/gha.v7.25310>

First population-level effectiveness evaluation of a national programme to prevent HIV transmission from mother to child, South Africa

Ameena E Goga, Thu-Ha Dinh, Debra J Jackson, Carl Lombard, Kevin P Delaney, Adrian Puren, Gayle Sherman, Selamawit Woldesenbet, Vundli Ramokolo, Siobhan Crowley, Tanya Doherty, Mickey Chopra, Nathan Shaffer, Yogan Pillay, for the South Africa PMTCT Evaluation (SAPMCTE) Team

Abstract

Background

There is a paucity of data on the national population-level effectiveness of preventing mother-to child transmission (PMTCT) programmes in high-HIV prevalence, resource-limited settings. We assessed national PMTCT impact in South Africa (SA), 2010.

Methods

A facility-based survey was conducted using a stratified multistage, cluster sampling design. A nationally representative sample of 10 178 infants aged 4–8 weeks was recruited from 565 clinics. Data collection included caregiver interviews, record reviews and infant dried blood spots to identify HIV-exposed infants (HEI) and HIV-infected infants. During analysis, self-reported antiretroviral (ARV) use was categorised:

- 1a: triple ARV treatment;
- 1b: azidothymidine >10 weeks;
- 2a: azidothymidine ≤10 weeks;
- 2b: incomplete ARV prophylaxis;
- 3a: no antenatal ARV and
- 3b: missing ARV information.

Findings were adjusted for non-response, survey design and weighted for live-birth distributions.

Results

Nationally, 32% of live infants were HEI; early mother-to-child transmission (MTCT) was 3.5% (95% CI 2.9% to 4.1%). In total 29.4% HEI were born to mothers on triple ARV treatment (category 1a) 55.6% on prophylaxis (1b, 2a, 2b), 9.5% received no antenatal ARV (3a) and 5.5% had missing ARV information (3b).

Controlling for other factors groups, 1b and 2a had similar MTCT to 1a (Ref; adjusted OR (AOR) for 1b, 0.98, 0.52 to 1.83; and 2a, 1.31, 0.69 to 2.48). MTCT was higher in group 2b (AOR 3.68, 1.69 to 7.97). Within group 3a, early MTCT was highest among breastfeeding mothers 11.50% (4.67% to 18.33%) for exclusive breast feeding, 11.90% (7.45% to 16.35%) for mixed breast feeding, and 3.45% (0.53% to 6.35%) for no breast feeding). Antiretroviral therapy or >10 weeks prophylaxis negated this difference (MTCT 3.94%, 1.98% to 5.90%; 2.07%, 0.55% to 3.60% and 2.11%, 1.28% to 2.95%, respectively).

Conclusions

SA, a high-HIV-prevalence middle income country achieved <5% MTCT by 4–8 weeks post partum. The long-term impact on PMTCT on HIV-free survival needs urgent assessment.

<http://jech.bmj.com/content/early/2014/11/04/jech-2014-204535>

Read this email...

On Sat, Oct 18, 2014 at 9:24 PM, Benjamin Sensasi <bsensasi@gmail.com> wrote:

Hi All

Am in the WHO team deployed in Liberia for Ebola response. Been here for one and half months now. The knowledge and resources I got from SOHP at UWC are invaluable in this outbreak. Thanks a lot UWC!

Benjamin Sensasi

MPH(Cum Laude- UWC)

Sulakshana Nandi, SOPH PhD Student and Health Rights Activist calls attention to Chattisgarh Deaths in India

Sulakshana Nandi <sulakshana.nandi@gmail.com> 2014/11/12 08:42 PM >>>

Dear Helen

A terrible incident has happened in Chhattisgarh. 13 women died after 'sterilisation' operation in a government organised camp. More women are critical and the death toll could rise. This has been due to the utter negligence of the govt and health department. Some of the issues have been tackled in the article below.

<http://scroll.in/article/689358/Focus-on-sterilisation-targets-makes-family-planning-tragedies-inevitable-claim-activists>

We are trying to put as much pressure on the govt to take responsibility and file criminal cases against all involved, including the health minister. All

women were below 32 years of age!!

There are just so many problems with the national family planning programme!

Sulakshana

You can see the statement by public health groups, including PHM regarding this murderous incident. It gives some details <http://kafila.org/2014/11/13/statement-on-sterilisation-deaths-in-chattisgarh-by-public-health-groups/>

Article...

The obvious errors by the doctor seeking to operate on a large mass of women in a short span of time with poor equipment and facilities is only the tip of the iceberg when it comes to the problems with implementing India's National Family Planning Programme, say activists.

The root of the problem, they believe, is that for decades, family planning campaigns have heavily emphasised achieving numerical targets for contraception, and prioritised female sterilisation over other contraceptive methods in an almost coercive manner.

Women at a sterilisation camp in Chhattisgarh. Photo: Sulakshana Nandi.



“What happened in Bilaspur could have happened anywhere in the country, because it reflects a systemic failure,” said Sulakshana Nandi, a member of the Jan Swasthya Abhiyan in Chhattisgarh.

India’s family planning programmes were infamously intimidating in the 1970s. After the Emergency, it focused on setting targets on the number of women and men being brought in for sterilisation and other contraception methods. It was only in 1996 that India finally announced that it would adopt a target-free approach to family planning.

However, according to a 2012 report by the non-profit organisation Human Rights Watch, the situation on the ground is completely different. State- and district-level health officials routinely set targets of the number of people that health workers (including nurses, midwives and accredited social health activists) must bring in for sterilisation every month.

This has led to a situation where everyone involved in the sterilisation process has financial incentives to participate, from the patients themselves to the health workers motivating them to attend the camps as well as the doctors performing the surgery. In some states like Gujarat, according to the HRW report, health workers at anganwadis and health workers claim to have been threatened with salary cuts and job losses if they did not meet their targets. Consequently, these health workers often end up giving faulty information to women about other contraceptive options, so that they inevitably agree to sterilisation.

“When you don’t give people any other option, is it not forced contraception?” said Jashodhara Dasgupta, a public health activist and a member of the Health Watch Forum in Uttar Pradesh.

In Chhattisgarh, where Monday’s tragedy took place, activists give a bleak picture of the way in which sterilisation camps take place. In a written statement condemning the death of the Bilaspur women, the All India Democratic Women’s Association states:

“Such ‘camps’ keep getting organised daily in various parts of the state. The government gives unwritten targets to all its health functionaries. Sterilisations are often dependent on doctors coming from other blocks, district or the private sector....Many a times the ‘camp’ has to get cancelled because the doctor does not come or he/she comes only if certain number of cases has arrived. All this leads to extreme harassment of the women patients.”

A lack of specialists

While acknowledging the practice of target-based sterilisations, some doctors believe the situation is compounded by the lack of professionals qualified to perform tubectomies and vasectomies in India.

Around a decade ago, most Indian states moved from conventional sterilisation procedures to laproscopic sterilisation, a faster kind of surgery that requires a higher degree of skill and entails greater risk for the patient.

“There are very few people who can perform this surgery, and the public health system finds it very difficult to retain these specialists,” said Dr T Sundararaman, former director of the National Health Systems Resource Centre in Chhattisgarh. “This is why targets are set for the specialists, and they rush to get more and more patients operated in a short period of time.”

Coupled with unhygienic and low-quality surgical equipment and facilities for doctors, such rushed deadlines make for a lethal combination.

Gender imbalance

The bigger issue, however, say many activists, is the glaring gender imbalance in the family planning programme’s policies, which systemically place the responsibility of contraception on women.

“Even today, all the focus is on permanent methods of contraception – tubectomy and vasectomy – and between them, there is greater focus on tubectomies because it is easier to mobilise women,” said Nandi. “These operations are offered to women in the most inhuman conditions, and there is no emphasis on temporary contraceptives like intra-uterine devices, oral pills or condoms.”

The figures are telling – reports reveal that in 2008, 54% of the Indian population used contraception, of which female sterilisation accounted for 34% and male sterilisation accounted for just 1% of contraceptive use.

“The government works on the assumption that men will not step forward to opt for contraception, even if it is the simple condom,” said Sundararaman. “To increase male participation in contraception, we would have to invest a lot more in campaigning and also rethink sexual culture.”

Meanwhile, women continue to suffer the consequences of their burden at mass sterilisation camps such as the one gone wrong in Bilaspur.

“Such drives are a violation of a woman’s reproductive rights, her right to health and also a violation of gender justice,” said Dasgupta. “The entire government machinery needs to be pinned down and made accountable for this.”

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