Engagement of Non-Governmental Organisations and Community Care Workers in collaborative TB/HIV activities including prevention of Mother to Child Transmission in South Africa: Opportunities and Challenges

Abstract
The implementation of collaborative TB/HIV activities requires interventions beyond facility fences in order to mitigate the impact of the dual epidemic on patients and communities at large. Engagement of Community Care Workers (CCWs) in delivery of integrated TB/HIV services is a potential avenue to enhance universal coverage and treatment outcomes and address human resource for health crisis in sub-Saharan Africa.

In South Africa, CCWs are employed by nongovernmental organization (NGO) with Health Department contracts funded by government to provide various TB/HIV community based activities. Using South Africa as a case, we report on engagement of NGOs and CCWs in the implementation of collaborative TB/HIV/PMTCT activities in rural South Africa, including extent of participation and constraints and opportunities to enhance effective participation.

Our mixed method study in Sisonke district, KwaZulu-Natal included facility and NGO audits, a household survey (n=3867), 33 key informants with provincial, district and facility managers, NGOs managers and six CCW focus group discussions. Results: The findings indicate that most contracted NGOs were providing TB or HIV support and care with little support for PMTCT. Only 11% of TB and HIV patients needing care and support at the community level were receiving support from CCWs, while 2% of pregnant women were counseled by CCWs on infant feeding options and HIV testing. Most facilities (83%) did not have referral mechanisms or any linkage with NGOs. Major constraints identified were system-related: structural, organizational and managerial constraints; inadequate CCW training and supervision; limited scope of CCW practice, inadequate funding, and inconsistency in supplies and equipment. Individual and community factors such as lack of disclosure and stigma related to HIV; and cultural beliefs were also identified as constraints.

Conclusions
We conclude that sub-optimal NGO/CCW engagement exists in implementation of collaborative TB/HIV/PMTCT activities, despite its potential benefits to enhance provision of integrated TB/HIV/PMTCT services at community level. Effective interventions that address contextual and health systems challenges are required and these interventions should combine systematic skills-building and consistent CCW supervision with a reliable referral and M&E system. Policy review to harmonise and expand the scope of CCW practice with task shifting to include home-based HIV counseling and testing is vital.

Published: 2 August 2012
Fix the Patent Laws: Campaigning for Pro-public Health Reform of South Africa’s Patents Act
Catherine Tomlinson and Marcus Low
A Treatment Action Campaign briefing document

Background
The Agreement on Trade Related Aspects of Intellectual Property (“the TRIPS agreement”), effective from 1 January 1995, set standards of intellectual property protection that member states of the World Trade Organisation (WTO) are required to uphold in their own national laws.

The TRIPS agreement requires WTO member countries to provide 20 years of patent protection on pharmaceuticals and all other products that meet patentability criteria (previously South Africa provided 16 years of patent protection). During this period the patent holder has exclusive rights to market the medicine – although it typically takes a few years before a medicine can be brought to market.

Given that pharmaceutical companies face no competition during the patent period, they often charge extremely high prices in order to maximise profits. During this period medicines will often remain unavailable through the public sector or to those whose medical schemes do not cover the full cost of medicines and cannot afford to pay the full or partial cost out of pocket.

Given valid concerns by WTO members that the TRIPS agreement would undermine countries’ ability to achieve the right to health, the Doha Declaration on the TRIPS agreement and public health (“the Doha Declaration”) was made on 14 November 2001. The Doha Declaration was important because it clarified the rights of members to use flexibilities contained in the TRIPS agreement to protect health and states that the TRIPS agreement “should not prevent Members from taking measures to protect public health... and should be interpreted in a manner supportive of WTO Members’ right to protect public health and, in particular, to promote access to medicine for all.”

On 16 November 2011, TAC and Médecins Sans Frontières held a press conference in which we explained that, more than a decade after the Doha Declaration, South Africa has not utilised the pro-public health flexibilities contained in the TRIPS agreement. In order to utilise the flexibilities existing in international trade law to protect health, they first need to be written into South Africa’s national legislation. We argue that the state has a constitutional obligation to make these legislative changes in terms of section 27 of the South African Constitution.

There is a pressing need for South Africa to take urgent steps to address the lack of access to many important, life-saving medicines and curb the rising costs of medicines. Through activism, complaints at the competition commission, the entry of generic medicines and successful tenders we are now able to access a number of affordable 1st line antiretroviral medicines for HIV. However, some important 1st and 2nd line medicines remain unavailable because of patent protection. Currently, there are no 3rd line antiretroviral treatments provided through the public sector, despite the growing number of patients in need of these medicines.

The barrier of cost created by the current patent system in South Africa extends beyond HIV. Many important cancer medicines are simply not provided in the public sector due to their high costs. The private sector also sometimes pays medicine prices far higher than charged even in some developed countries – this is partly due to the extremely high number of patents granted in South Africa.

Amending our laws to include public health safeguards will reduce the cost of key medicines for government, private medical schemes, and for patients and their families.

Access the full article at: http://www.fixthepatentlaws.org/
Inequality, like poverty, has many faces. Carnegie3 sought to focus attention on understanding the lived experiences of inequality and the causes and dimensions of persistent inequality, and considered policies and actions that are aimed at significantly reducing inequality and poverty in both the short- and long-term. This is a challenge that involves all South Africans, organised in many different ways.

What the Conference sought to address (Excerpt from the Pre-Conference Announcement)

Taking seriously the President’s call for a ‘national dialogue’ about the future, and acknowledging the mandate of tertiary institutions to engage in socially responsive research, the purpose of the conference is to provide a platform for sharing and debate amongst academic researchers, government and practitioners. We look forward to welcoming participants from universities and NGOs; from Government at national, provincial and local levels; from trade unions, faith-based organisations and the business sector.
The conference will seek to move towards new ways of considering poverty and inequality, focusing less on describing the problems, and more on practical strategies to overcome them. This requires shifts in thinking, which the conference hopes to stimulate by combining a focus on academic and applied research with a set of demonstrations from the NGO, Business and Trade Union world.

**Towards a new paradigm for research and intervention**

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

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

The conference will seek to provide a platform for serious and deep debate about difficult policy choices that must be made in tackling these issues of poverty, inequality and the underlying facts of massive unemployment. Thus, for example:
- Should the government promote further urbanisation or seek to stimulate growth in rural areas?
- What would be the consequences of a widespread subsidy to the youth wage?
- Is increased tariff protection a feasible way of generating more jobs in the country? At what cost?
- What practical steps can be taken in the short run to meet the challenges of literacy & numeracy in so many of the country's primary schools?

**Learning from experience: practical innovations**

The conference will combine formal presentations of new (including recently published) analytical research papers with panel discussions and presentations of on-the-ground innovation and interventions in practice. The aim is to ask questions about what works, what doesn’t work, and why. In particular, the conference will aim to stimulate thinking around the lessons that local-level initiatives have to offer. We will seek to show-case initiatives which may provide insight into:
- Ways of mobilising and supporting the energies of people at all levels of society to reduce poverty and inequality.
- Opportunities for establishing closer synergies between government, business, trade unions and the NGO sector
- Strategies for replicating and scaling up initiatives that work.

**On Health issues Carnegie3 looked at:**

Intersecting burdens of disease and poverty; health services that meet the needs of the poor; how the NHI can address inequalities and benefit the poor; addressing inequality in the burden of TB, HIV/AIDS and maternal and child mortality.
1. **Break this vicious Cycle**
*Poverty and Mental Illness can exacerbate each other.*

*Emmanuel Vuma and Pippa Green*

Poverty is strongly associated with mental illness yet mental health has often been neglected in international development policy. This is according to Professor Crick Lund of UCT’s Department of Psychiatry and Mental Health. Lund was talking on a panel yesterday that focused on poverty and inequality dynamics.

In a paper presented to the Towards Carnegie III conference, Lund argues that mental health and its relationship with poverty has tended to be ignored. “This is despite compelling arguments that mental illness contributes significantly to the global burden of disease,” he writes. People who live in poverty and who suffer from mental illness constitute a particularly vulnerable group.

He said some international findings suggested that there is a strong link between mental illness and poverty. It was a growing public problem, he told the conference audience. People with mental illnesses often drifted into poverty because of reduced productivity and the costs of health care. “People living with mental illness are more likely to drift into or remain in poverty as a result of their disability and associated stigma,” says Lund in his conference paper.

Likewise, the stresses of poverty mean that many poor people are exposed to increased stresses that put their mental health at risk. He told the panel it was important to break this “vicious cycle” of poverty and mental illness. In his paper, he writes that there are compelling human rights, health and economic development arguments for intervening in this “vicious cycle” by improving mental health.

From a human rights point of view, “people living with mental illness in circumstances of poverty are a vulnerable group, who are subject to stigma and discrimination, violence and abuse, restrictions in the exercising of their civil and political rights, (including rights to participate fully in society), and lack access to health and social services. They frequently lack educational opportunities, are denied employment and other income-generating activities and experience substantial disability and premature death.”

From a health point of view, he writes that there is “ample evidence that mental health intersects with a range of other communicable and non-communicable diseases. “The rallying cry “no health without mental health” captures the high level of comorbidity between mental illness and ‘physical’ illness,” For example, maternal depression had been shown to increase the risk of poor infant nutrition, stunting, early cessation of breastfeeding and diarrheal disease.

Likewise, if people infected with HIV/AIDS are treated for depression, they show better adherence to anti-retroviral treatment. From an economic development point of view, the economic benefits of treating mental health, far outweigh the costs to society and the economy of ignoring illnesses, he argues. “Investing in mental healthcare...therefore provides an opportunity to improve well-being and a broad range of social and economic outcomes.”
2. Lesbian Women are not exempt from HIV/AIDS  
Jacques de Satgé

Lesbians living with HIV were “invisible” as their experiences had been overlooked by prevention programmes, a qualitative study has found. “Misconceptions” and “gaps in HIV research” had left HIV-positive lesbians isolated from health care systems, said researcher Dr Zethu Matebeni. Matebeni, a Research Officer at the Institute for Humanities in Africa (HUMA) at UCT, was speaking in a session at the conference. Her study surveyed 24 women who self-identified as HIV-positive lesbians.

The study group, described by Matebeni, was predominantly underemployed and poorly educated. “A third of participants had not finished high school and half of them had a primary school education... Only seven participants had full time employment.” Matebeni emphasised the dangers of assuming lesbian women are exempt from HIV-AIDS. “Nine women reported they had been infected through their former male partners. Eight reported they had been raped,” said Matebeni, as she alluded to the fact that rapists target women regardless of their sexual orientation. Five participants reported they had been infected through female partners, with no previous sexual contact with male partners or drug use in their lifetime. One participant claimed, “I couldn’t understand how it happened because I was fine and I thought we [lesbians] are safe...”

Matebeni said the assertion that lesbians were at no risk or ‘low risk’ [of contracting HIV] could no longer hold weight. These women were marginalised, said Matebeni, by a lack of research and understanding in South Africa. “HIV information targeting lesbians as a group is very difficult to access... This suggests huge gaps in information and knowledge.” Problems for HIV-positive lesbians were further compounded by “barriers” within healthcare, she explained. Health-care workers’ attitudes and the “stigma and prejudice” surrounding lesbianism could deter HIV-positive lesbians from seeking medical help.

3. Research goes to waste  
Håvard Ovesen

South Africa produces excellent quality research, often with public money, with little impact on policy. This is due to serious systemic failure of poor knowledge management that renders information invisible. “We need publicly funded research to be widely and easily available,” urges development consultant Rick de Satgé.

His message resonated strongly with the experiences of researchers and stakeholders gathered together for the “Synergies II” session on Wednesday afternoon. In the discussion many told their own stories of unobtainable data and research disappearing into the dark hole of knowledge mismanagement. De Satgé recounted his experiences of being commissioned by the Presidency to research whether there is a need for a poverty information service. The answer was a resounding yes.

But much knowledge is restricted either by subscription fees or pay-per-view deals that are out of reach for many NGOs and other institutions including government departments. Another recurring issue is that the information might exist somewhere, but is not available on the internet. Comparatively little is available through open access licensing.

De Satgé told Carnegie3 News that “there is an enormous amount of research and knowledge and information that relates to poverty [and] policy that has disappeared down a dark hole. It’s gotten lost, and it was extremely expensive to produce.” It doesn’t always come down to incompetence or lack of resources. In some cases, researchers and research institutions use intellectual property rights to build “information laagers” around data paid for by public funds. Keeping such knowledge out of the public domain for reasons of territorial jealousy is an act Conference Director Francis Wilson refers to as “theft.”

Several of the participants at the session recounted incidents in which funders insisted on controlling the intellectual property rights to the research output, only to bury the product
once the research produced inconvenient findings. “Knowledge is power,” de Satgé reminded the audience, and later told Carnegie3 News that “one of the reasons why you may have information laagers is around contestations of power (...) within the political system.” The fear is that people may use or retain research outcomes “to advance narrow sectional agendas,” rather than for the public good. In de Satgé’s area, land reform, there is certainly no shortage of research, ideas, or evaluations. However, “there is a refusal to engage with [it], to change practice. That’s what’s so scary. You can get program evaluations that just remain somewhere, locked away in a government archive or in a filing system. They don’t appear to impact on practice”.

In 2011, South Africa was one of the eight founding governments of the Open Government Partnership, thereby “[committing] to openness and making data and information available.” De Satgé stressed that unless openness becomes part of governmental management performance assessments, this commitment might come to naught. Access to information is important “so that people can hold government to account, so that people can co-create as well; they can participate in policy. They can become part of the conversation. That’s ideally what research should be doing. It should be enabling a more nuanced national conversation about key issues like poverty.

Access more news on Carnegie 3 at: http://www.carnegie3.org.za

Many South Africans are too poor to access free healthcare provided by the state, mostly due to the cost of transport.

Wilma Stassen

The cost of travelling to and from clinics or hospitals place even free health services out of reach of many poor South Africans, especially from remote areas of the country, Professor Di McIntyre said in a presentation on inequality in healthcare at the Carnegie III Conference focusing on Strategies to Overcome Poverty and Inequality at the University of Cape Town (UCT).

A study by UCT’s Health Economics Unit on two South African communities, investigated the costs involved in accessing health services. They found that on average TB patients had spent R100 and HIV-positive patients on antiretroviral treatment (ART) R81 on travel each month to access treatment, while pregnant women paid R321 to access obstetrics services during their pregnancy.

“While these amounts may appear to be ‘small’, they are in fact considerable relative to many households’ ability to pay,” said McIntyre. “For example, direct costs exceeded 10 percent of total household expenditure in two-thirds of households using obstetric services, in one-third of households with a member receiving TB treatment and in 23 percent of households with a member on ART.

“Households were reliant on financial support from family, friends and other social networks to cover these costs, but 20 percent of households had to borrow money or sell assets to cope with the direct costs of TB treatment and ART and 10 percent in the case of obstetric care. It is particularly concerning that about 40 percent of TB and ART service users in the one rural site had to borrow money or sell assets to cope with health care costs.”

Transport costs to health facilities accounted for the majority of direct costs, and are particularly high for TB patients who, in some areas, are expected to visit a health facility on a daily basis for directly-observed treatment.

Poverty is not only linked to health in the sense that health care costs impoverish households, but there is evidence that proves that due to socio-economic conditions, the poor become sick more often too.
“In South Africa the poor carry by far the greatest burden in most of the major causes of ill health,” said McIntyre. “And not just infectious disease such as TB or HIV, also some chronic illness such as hypertension and diabetes.”

Poor health also translates into absenteeism and lower productivity which also leads to less income (indirect costs), which, according to McIntyre, is often greater than the direct costs incurred by patients.

“While it is necessary to address the social determinants of health (e.g. improve living conditions such as housing and access to potable water and sanitation) it is equally important to ensure access to needed health care and to provide protection against the financial risks associated with illness,” said McIntyre.


National Health Insurance (NHI) Summit, Eden District, Western Cape Province
Thembalethu Community Hall, George
17-18 August, 2012
Report by Dr Busisiwe Nkosi

Introduction
The NHI summit was held in Thembalethu Community Hall, George, Western Cape Province. The aim of the summit was to mobilize broader stakeholder participation and consultation to shape the local and national agenda around piloting and overall implementation of the NHI. The summit was represented by civil society organizations and labour unions including COSATU, NEHAWU, TAC, DENOSA, SACC, SANGOCO, and the Thembalethu Community Health Forum. The expected outcome was to develop a health map in which the various stakeholders will commit themselves to playing a leading role in addressing various health and social challenges towards the realization of the NHI.

Panel discussions
Tony Ehrenreich, from COSATU spoke about the unremitting health disparities and poor service delivery in the health system and urged participants to continue to raise awareness, mobilize and speak against these inequities. This was followed by Mark Haywood of Section 27, focusing on the importance of meaningful community participation and civic engagement. Dr. Thulare, Technical Advisor to the National Minister of Health provided an overview of the NHI outlining the gaps and challenges regarding the piloting and/implementation of the NHI pilots.

The challenges included:
- slow uptake due to capacity constraints in some districts and sheer resistance from other sectors such as the private sector and political factions e.g. the absence of the Western Cape Provincial DoH, and local authorities raised concerns, and illustrated the extent of political factions between national and provincial government.
- multiple policy demands thus systems taking longer to put in place than anticipated
- fiscal and budgetary constraints

The DoH conducted an audit of health facilities to identify gaps and set priorities in preparation for the NHI. The audit covered broad issues including the range of health services provided, infrastructure including conditions of safety, cleanliness and compliance with building regulations; and availability of functional medical equipment. The audit report showed that in general, health facility fell short of meeting required standards, and quality of care grossly compromised. The final panelist, Victor Lackay, TAC spoke about the need to mobilize for health resources and continue to challenge the corruption within the government.
Participants then broke into four group discussions with a view to address specific topics and come up with resolutions which will be presented to the DoH. The group sessions topics comprised:

- **Claiming rights to health to ensure equitable health services**: paying attention to right to health campaigns, processes leading to the White Paper, and governance and institutional strengthening.
- **Community education, mobilization empowerment and building alliances and people’s power**: ensuring participatory approaches to public health priorities—policy engagement to ensure health equity, ensuring stakeholder engagements on NHI at all levels and across sectors (including government, business, organized labour and civil society organizations), and utilizing technology to effectively address barriers and to ensure a watch on health equity.
- **Monitoring and evaluation**: building capacities of all stakeholders to ensure accountability and community monitoring, and establishing a civil society/DoH M&E mechanism.
- **Fairly resourcing health systems, valuing and retaining health workers**: human resources challenges and gaps, what is needed to make the NHI work? what are the alternatives, and, the role of CHWs in the NHI vs the CHW policy.

**Summary**

The summit highlighted the messy and unresolved complexities of implementing a policy within a volatile environment. There were repeated calls to challenge the government on corruption and poor service delivery, and a need for a shift from paternalistic representation of communities to cultivate meaningful community participation and civic engagement.

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**NCD Global Framework: Delivering the Outcomes from the UN High-Level Meeting**

We believe that the wide-ranging commitments made by Member States at the UN High Level Meeting on NCDs should be seen as a comprehensive package of measures to deliver on the ambitions set out in the Political Declaration.

**We are calling for a global NCD framework:**

- spearheaded by a multisectoral global partnership which mobilises resources for NCDs and catalyses effective financing mechanisms
- which promotes the integration of NCD prevention and control into all relevant health and development policies, plans and programs
- has the mandate to fully develop and cost a multisectoral global plan with WHO
- a plan which includes a global monitoring framework with a broad range of indicators
- and global targets that drive progress to prevent and control NCDs

**The global monitoring framework, indicators and targets for NCDs**

Paragraphs 61 and 62 of the Political Declaration call upon WHO, with the full participation...
of Member States to develop a comprehensive global monitoring framework by the end of 2012, complete with a set of indicators, and a set of voluntary global targets to prevent and control NCDs.

In order to fulfill this mandate, WHO has embarked upon a consultation process with Member States and other stakeholders around the set of ten suggested targets first introduced last summer. This consultation process has been ongoing throughout 2012, and will conclude at a formal Member state consultation at WHO in Geneva on 5–7 November 2012.

**Briefing on 2013-2020 Global Action Plan**
The NCD Alliance has produced a briefing note (see box below) in response to the first Discussion Paper for use by civil society advocates in discussions with their governments. We welcome feedback on the recommendations in this paper. Your comments will help the Alliance formulate its final submission to the WHO consultation before the 7 September deadline.

**Multisectoral NCD partnership options**
The NCD Alliance believes that the establishment of a mechanism to unite all sectors and stakeholders is critical to reduce NCDs deaths by 25% by 2025 and to fulfill the commitments made by Member States in the Political Declaration.

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**Briefing on 2013-2020 Global Action Plan for NCD Prevention and Control**

**Background**
The current 2008-2013 WHO Action Plan on Non-Communicable Diseases (NCDs) was developed to take forward the Global Strategy for the Prevention and Control of NCDs (2000) and has provided the political framework for action on NCDs. Significant progress has been made across the Plan’s six objectives during this period, due to the combined effort of WHO, Member States, international partners and civil society organisations, including the NCD Alliance.

Since 2008 NCDs have made a steady ascent onto the global health and development agendas, culminating with the UN Summit on NCDs and the adoption of the UN Political Declaration on NCD Prevention and Control in 2011. The Summit was a watershed event, catalysing political leadership and action on NCDs. Now as the expiry date of the current Action Plan fast approaches, Member States have an important opportunity to shape a new global NCD plan that will drive progress in this new era for NCDs.

To have maximum impact over the period 2013-2020, the NCD Alliance urges Member States to support a Global Action Plan on NCDs that meets the following four criteria:

- Builds on the progress and momentum achieved by the previous WHO Action Plan on NCDs, and through other vehicles during the same period such as WHO Framework Convention on Tobacco Control, Global Strategy on Diet and Physical Activity, Global Strategy on Alcohol, UN Global Strategy for Women's and Children’s Health, etc;
- Reflects the changed global political landscape, including the adoption of the UN NCD Political Declaration;
- Responds to the emerging challenges and opportunities in this coming period (2013-2020), including the end date of the Millennium Development Goals (MDGs);
- Sets the world on track to reach the recently adopted global target of a 25% reduction in premature NCD mortality by 2025.

We have an opportunity to shape a Global NCD Action Plan that will save millions of people from avoidable suffering, illness, disability and death. The NCD Alliance encourages Member States to fully engage in this process and has produced this briefing to inform and guide discussion. The briefing responds directly to the recently published WHO Discussion Paper on the Global Plan.

**Process**
A WHO Discussion Paper on the Plan was published on 26 July, and this will form the basis of the first round of consultations which includes the WHO consultation with Member States and UN agencies on 16-17 August in Geneva, WHO Regional Committee Meetings in September-October and a WHO online consultation. Member States, UN agencies, relevant NGOs and selected private sector entities are invited to submit comments to the online WHO consultation via email to ncdactionplan@who.int by 7 September.

**The NCD Alliance was founded by:**

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An “annotated zero draft” of the Global NCD Action Plan is then expected to be published in the last week of September, followed by a second informal Member State consultation on 1 November. Member States’ comments will be rapidly assimilated into the draft and sent to the WHO Executive Board for discussion at their meeting on 21-29 January. An updated draft will then be worked up by WHO. It is likely that this version will be the subject of a further series of consultations – of Member States, NGOs and private sector – that will take place in February or March before a final draft is submitted to the 66th World Health Assembly in May 2013 for adoption.

**NCD Alliance recommendations on key elements of the Global Action Plan Discussion Paper**

The NCD Alliance commends the WHO Discussion Paper, which outlines major elements for inclusion in the new global plan and a proposed structure. The NCD Alliance below recommends key points in the WHO Discussion Paper for Member States to support and identifies key areas that need to be strengthened during the consultation process.

1. **Purpose, scope and roles**

   **Support:**
   - The purpose of the plan is to define a “roadmap for implementation of the commitments in the UN Political Declaration on NCDs”.
   - The overarching goal is to achieve the global target to reduce premature mortality from NCDs by 25% by 2025; and the plan must identify specific actions and interventions to achieve that goal.
The scope must be relevant to all regions and countries, reflect existing political commitments and strategies on NCDs, and be integrated into global development processes, including sustainable development goals and the post-2015 development framework.

**Strengthen:**
- The lead UN agency for the plan is WHO, but the plan should be endorsed and implemented by all relevant UN agencies and international partners to harness the resources and expertise of the entire UN system.
- The plan should propose mechanisms to engage and mobilise stakeholders, including UN, Member States, civil society and the private sector to deliver and drive progress on the plan.

2. Principles, objectives and approaches

**Support:**
- The principles of equity and sustainability to guide the objectives of the plan are articulated.
- The focus on a multisectoral approach to strengthening health systems; to integrating NCDs in all relevant programs and services, especially at primary health care level; to increasing human resources for health; and to adopting a life-course perspective in order to achieve universal access to healthcare.
- The need to increase efficiencies in health systems to tackle NCDs.

**Strengthen:**
- The plan should embrace the principles of patient empowerment, the alleviation of inequality and an end to discrimination for all people with NCDs.
- The objectives should be concise, and more cross-cutting issues identified to support implementation, including leadership, resources, partnerships, integration, evaluation and accountability.
- The commitment to health literacy – not only for individuals but also for society at large.

3. Implementation

**Support:**
- The leadership of Heads of Government/State in delivering whole-of-government commitment to the plan.
- The plan to be costed and adequately resourced, identifying actions to secure sustainable financing for the prevention and control of NCDs at the global, regional and national levels.
- The national capacity of Member States to be strengthened, including through external technical and financial support.
- The importance of collaborative partnerships and public-private partnerships to be promoted, with the appropriate safeguards in place.
- The prioritised research agenda, with a focus on operational research and support for innovation.

**Strengthen:**
- The resolve to develop a plan that can be adapted for use at national level to increase shared responsibility with Member States.
- The commitment to incorporate the global monitoring framework, targets and indicators currently being developed; and a biennial reporting cycle to the General Assembly (in addition to WHA) starting with a UN High-Level Meeting in 2014 called for in the Political Declaration.

### Structure of the Global NCD Action Plan 2012 - 2020

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<tr>
<th>GOAL</th>
<th>OBJECTIVES</th>
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<td>25% reduction in premature mortality from NCDs by 2025</td>
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| 1 | Reinforce political commitment to NCDs as a health and development priority and increase public awareness |
| 2 | Improve international cooperation to mobilise resources and strengthen national capacity |
| 3 | Promote and accelerate whole-of-government, multisectoral NCD plans, policies and programs |
| 4 | Reduce NCD risk factors and create sustainable and health-promoting environments |
| 5 | Improve care for people with NCDs through strengthened health systems and universal health coverage |
| 6 | Implement the prioritized NCD research agenda and improve NCD surveillance and reporting systems |

| CROSS-CUTTING ISSUES TO DELIVER RESULTS |
| Leadership | Resources | Partnerships | Integration | Accountability |
Underspending on Health Infrastructure

Five provinces under-spent on public hospital infrastructure to the tune of about R800-million last year (2011) according to Health Minister Aaron Motsoaledi.

In a written reply to a parliamentary question he said at the end of March this year, spending on government’s R4-billion hospital revitalisation grant was "at 79% of the total allocation".

The provinces affected included:
- Eastern Cape, which spent R169-million of R361-million allocated (47%);
- Free State, which spent R244-million of R378-million (65%);
- KwaZulu-Natal, which spent R273-million of R501-million (54%);
- Limpopo, which spent R234-million of R323-million (72%); and,
- Northern Cape, which spent R262-million of R420-million.

Motsoaledi said the under-spending stemmed from projects being delayed as a result of poor quality work by contractors, poor management of build programmes and land allocation problems.

Steps had been taken to correct the situation, including the appointment of technical advisers and engineers. "The national department...together with National Treasury is also engaging in the process of reviewing provincial capacity," he said.

http://www.polity.org.za/article/massive-underspend-on-hospitals-2012-09-06

Task Shifting of antiretroviral Treatment from Doctors to Primary-care Nurses in South Africa (STRETCH)
A pragmatic, parallel, cluster-randomised Trial

Fairall, et al.

Background

Robust evidence of the effectiveness of task shifting of antiretroviral therapy (ART) from doctors to other health workers is scarce. We aimed to assess the effects on mortality, viral suppression, and other health outcomes and quality indicators of the Streamlining Tasks and Roles to Expand Treatment and Care for HIV (STRETCH) programme, which provides educational outreach training of nurses to initiate and represcribe ART, and to decentralise care.

Methods

We undertook a pragmatic, parallel, cluster-randomised trial in South Africa between Jan 28, 2008, and June 30, 2010. We randomly assigned 31 primary-care ART clinics to implement the STRETCH programme (intervention group) or to continue with standard care (control group). The ratio of randomisation depended on how many clinics were in each of nine strata. Two cohorts were enrolled: eligible patients in cohort 1 were adults (aged ≥16 years) with CD4 counts of 350 cells per μL or less who were not receiving ART; those in cohort 2 were adults who had already received ART for at least 6 months and were being treated at enrolment. The primary outcome in cohort 1 was time to death (superiority analysis). The primary outcome in cohort 2 was the proportion with undetectable viral loads (<400 copies per mL) 12 months after enrolment (equivalence analysis, prespecified
difference <6%). Patients and clinicians could not be masked to group assignment. The interim analysis was blind, but data analysts were not masked after the database was locked for final analysis. Analyses were done by intention to treat. This trial is registered, number ISRCTN46836853.

**Findings**

5390 patients in cohort 1 and 3029 in cohort 2 were in the intervention group, and 3862 in cohort 1 and 3202 in cohort 2 were in the control group. Median follow-up was 16·3 months (IQR 12·2–18·0) in cohort 1 and 18·0 months (18·0–18·0) in cohort 2. In cohort 1, 997 (20%) of 4943 patients analysed in the intervention group and 747 (19%) of 3862 in the control group with known vital status at the end of the trial had died. Time to death did not differ (hazard ratio [HR] 0·94, 95% CI 0·76–1·15). In a preplanned subgroup analysis of patients with baseline CD4 counts of 201–350 cells per μL, mortality was slightly lower in the intervention group than in the control group (0·73, 0·54–1·00; p=0·052), but it did not differ between groups in patients with baseline CD4 of 200 cells per μL or less (0·94, 0·76–1·15; p=0·577). In cohort 2, viral load suppression 12 months after enrolment was equivalent in intervention (2156 [71%] of 3029 patients) and control groups (2230 [70%] of 3202; risk difference 1·1%, 95% CI −2·4 to 4·6).

**Interpretation**

Expansion of primary-care nurses’ roles to include ART initiation and represcription can be done safely, and improve health outcomes and quality of care, but might not reduce time to ART or mortality.

**Funding**

UK Medical Research Council, Development Cooperation Ireland, and Canadian International Development Agency.

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**Emile Efronson interns at SOPH...**

Emile Efronson is a Canadian American born in Miami, Florida. She graduated from Johns Hopkins University in Baltimore, Maryland with a degree in Public Health Studies and a concentration in International Health. She has worked in Baltimore, Maryland, Cordoba, Argentina, and Bogota, Colombia in both health and education and is looking forward to working at UWC for the next six months. Emilie will be working as a Research Assistant to Nikki Schaay on the Revitalizing Health for All (RHFA) project in addition to other projects. Emilie has been sent to UWC on behalf of Human Rights Internet and the Youth Internship Programme funded by the Canadian International Development Agency. Emilie loves to travel, spend time outdoors, and meet new people. She looks forward to becoming a part of the UWC team as well as gaining a greater understanding of public health issues within South Africa.
Sunisha Neupane interns at SOPH...

Sunisha Neupane is a Canadian International Development Agency (CIDA) intern through Human Rights Internet. She feels really lucky to call two beautiful countries her home, Canada and Nepal. She graduated with a double major in International Development Studies and Chemistry from Dalhousie University, Halifax and recently completed Masters in Public Health from University of Saskatchewan, Saskatoon.

She will be assisting Ms Lucy Alexander in putting together few courses for the School of Public Health. She will also be contributing on two on-going researches:
1) Evaluating the outcome and impact of the Master in Public Health on working graduates in Public Health setting: a comparative study across five countries, under supervision of Ms Lucy Alexander and
2) Mainstreaming a health systems approach to delivery of maternal health services: transdiciplinary research in Rwanda and South Africa under the supervision of Dr Thuba Mathole, Prof Christina Zarowsky and Prof Debra Jackson.

Sunisha says “I am looking forward to research experience here at the School of Public health and I hope to make most of this great opportunity. I am also excited to live as a ‘Capetonian’ life and be part of this welcoming city”.

She would like to thank everyone at the School of Public Health for hosting interns from Canada.

Words of Appreciation from a MPH Graduate...

>>> "Ogendo, Arthur" <aogendo@kemricdc.org> 2012/08/29 13:28 >>>

Hi Janine,
I want to give a special thanks to you and want to dedicate my graduation this year to you for the sacrifice you made to have me registered despite the difficult situation that I had early this year. I can say you were God sent to assist me and if you had not sacrificed on this then I would not have been in the graduation list this year. Kindly accept my special gratitude for the role you played in my long road to completing the MPH course. Sincerely I almost gave up but when you stepped in I got a new lease of life. I just thought of sending you this specific mail in appreciation.

Once again thank you very much!
I pray that God blesses you so much!
Arthur Ogendo

Dear Arthur
Congratulations on your graduation! We have certainly come a long way. It means so much to us at SOPH and me when a student personally thanks us like this. It makes one feel that one has played a part in their success and achievement. It has been a pleasure, now even more so, because of your great achievement.

I want to wish you everything of the best in your future endeavors.
Once again...Congratulations!!
Regards
Janine Kader,
Administrative Assistant,
Student Administration, SOPH
Executive summary
Margaret Chan, Director General of the World Health Organization, has stated that "Universal Health Coverage is the single most powerful concept that public health has to offer." In this themed issue of The Lancet, the first of three Series papers explores the evidence on the links between expansions in coverage and population health outcomes. The second paper looks at the political and economic dimensions of the transition to universal health coverage, and the third examines nine low-income and lower-middle-income countries in Africa and Asia that have implemented national health insurance reforms. Also, a Viewpoint calls for continued progress and argues for a large public sector role in health systems reform.

What becomes clear in this issue is that although universal health coverage is not a guarantee for progress, attention should focus now not on whether, but on how to make the most of the transition. In a Comment, Judith Rodin and David de Ferranti conclude: "what will emerge in the decades ahead in each country undertaking reform is not entirely clear, but, as this Series and many country examples suggest, we are getting closer to a time when this transition toward universal health coverage will be achieved and families will no longer be at risk of having the cost of sickness ruin their lives."

Universal health coverage: a third global health transition?
Judith Rodin, David de Ferranti

Universal health coverage: good health, good economics
Julio Frenk, David de Ferranti

Universal health coverage is a development issue
David B Evans, Robert Marten, Carissa Etienne

Series Papers
Does Progress Towards Universal Health Coverage Improve Population Health?
Rodrigo Moreno-Serra, Peter C Smith

Political and Economic Features of the Transition to Universal Health Coverage
William D Savedoff, David de Ferranti, Amy L Smith, Victoria Fan

Moving Toward Universal Health Coverage: Recent Health Insurance Reforms in Nine Lower Income Countries in Africa and Asia
Gina Lagomarsino, Alice Garabrant, Atikah Adyas, Richard Muga, Nathaniel Otoo

Related content published in The Lancet
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Julia Ravenscroft, Liliana Marcos

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Carrie Arnold

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Amelia Shepherd-Smith

World Report
Can Canada reckon with its health costs?
Paul C Webster

Tuberculosis explosion in South Africa blamed on weak public health system

Sue Valentine
10 September 2012

Urging TB patients to attend clinics for regular treatment is doing more harm than good, says leading health economist

Weaknesses in South Africa’s public health system have been cited as being among the reasons tuberculosis has increased four-fold in the past 15 years. Addressing the country’s failure to control and cure TB, Veloshnee Govender of the University of Cape Town’s Health Economics Unit told a major conference on poverty alleviation that there has been a 400% increase in TB incidence.

In line with recommendations by the World Health Organisation (WHO), treatment of TB follows the DOTS (directly observed treatment short course) protocol, which requires that TB patients take medication daily in front of a health worker who administers and "observes" that this is done correctly.

Treatment of TB usually requires a daily dose of drugs for six months, but in more severe cases it may require a longer period. Given the long distances some patients have to travel to get to clinics, or the inconvenience of fitting in daily visits, many patients do not take their medication as diligently as they should.

However, the WHO protocol also states that the "whole purpose of treatment observation would be defeated, were it to limit access to care, turn patients away from treatment or add to their hardships".

From a study of 1,200 patients in four health sub-districts in South Africa, researchers have investigated the barriers that patients face in taking their treatment consistently. Excluding those receiving their treatment through injections, Govender said that "more than half of
those who reported missing treatment doses were being observed at clinics”.

Taking treatment at a clinic was the key variable that determined whether someone missed their daily dose. Patients who missed treatment at clinics said the reasons they did so included the cost of transport, their distance from facilities and the conflict between taking medication and meeting work and other domestic responsibilities.

"I walk for more than an hour, where normally it took me half an hour to get there in the past,” said one patient surveyed in the study. "Every time I have to sit on the pavement to catch my breath [from] the pain in [my] chest. I only get three pills then I have to walk back home."

Govender said research showed that observation at clinics was not a necessary element in ensuring that patients took their TB treatment. In fact, less frequent clinic visits may contribute to "improved efficiency, higher adherence, and lower patient access barriers to care". She said that self-supervision, the same model used for patients living with HIV/Aids who take antiretroviral therapy, was a viable alternative model to consider for assisting TB patients to take their medicine.

Govender said it is vital that health authorities consider a more "patient-focused approach to the delivery of TB treatment”. This would benefit not only those suffering from TB who needed easily accessible treatment, but the resource-constrained health system in South Africa.

The conference is entitled Towards Carnegie III: Strategies to Overcome Poverty and Inequality. Two earlier conferences and research programmes, looking at similar issues in the 1930 and 1980s, were funded by the Carnegie Corporation of New York.

http://www.guardian.co.uk/global-development/2012/sep/10/tuberculosis-south-africa-weak-public-health?mkt_tok=3RkMMJWWF9wsRogu6rOZKXonjHpfsX66%2BQqXaOoI%2FoER3fOvrPFuGj14C8sNhI%2FqLAziCFspZo2FFcIf%2Fq
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Acknowledgements: Thanks for contributions to the September 2012 SOPH Bulletin to: Jeanine Uwimana, Christina Zarowsky, Harry Hauster, Debra Jackson, Catherine Tomlinson, Markus Low, Lynette Martin, Emmanuel Vuma, Pippa Green, Jacques de Satge, Havard Ovesen (Carnegie3 News articles), Busiswe Nkosi, Arthur Ogendo, Janine Kader, Emile Efronson, Sunisha Neupane, Wilma Stassen (Health-e.org), The Lancet, Guardian - UK